Market Conduct Examination Standards (D) Working Group
Conference Call
December 18, 2014

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Dec. 18, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jim Mealer, Vice Chair (MO); David Tucker (CO); Debra Peirce and Teresa Winer (GA); Lori Cunningham and Maggie Woods (KY); Matt Regan (MA); Paul Hanson (MN); Tracy Biehn and Lalita Wells (NC); Win Pugsley and Chuck Vanasdalab (NH); Cliff Day (NJ); Angela Dingus (OH); Brian Gabbert, Landon Hubbart and Joel Sander (OK); Chris Monahan (PA); Julie Fairbanks (VA); Christina Rouleau (VT); Jeannette Plitt (WA); Sue Ezalarab and Cari Lee (WI); and Mark Hooker (WV). Also participating was: Cindy Williamson (NE).

1. Discussed Health Reform Examination Standards—Direct Access to Providers

Director Ramge said that the draft health reform-related market conduct examination standards addressing direct access to providers are for inclusion in the Market Regulation Handbook, and are applicable to non-grandfathered plans in the individual and small group markets. The standards were based upon the model language found in the Individual Market Health Insurance Coverage Model Act (#36), the Small Group Market Health Insurance Model Act (#106) and the Model Language for Choice of Health Care Professional (#930-A).

Ms. Wells requested that review of utilization management policies and procedures be included in the Documents to be Reviewed section of Standard 1. Mary Nugent (U.S. Center for Consumer Information and Insurance Oversight—CCIIO) asked that the standards be made applicable not only to individual and small group market health insurance, but also to large group market health insurance. David Korsh (Blue Cross Blue Shield—BCBS) asked that the newly adopted model regulations Individual Market Health Insurance Coverage Model Regulation and Small Group Market Health Insurance Coverage Model Regulation, which were recently adopted by the NAIC Joint EX/Plenary Committee, be added to the NAIC references section of the standards, if they are applicable to the issue of direct access to providers. Mr. Korsh said that Model #930-A may not have been updated along with the newly developed model regulations, so the reference to that model may need to be removed from the standards.

Martin Mitchell (America’s Health Insurance Plans—AHIP) said that the standards should include a reference to direct access to providers with regard to preventive care, onsite health services and student health insurance. He said he would submit proposed language to address this issue. Timothy S. Jost (Virginia Organizing) said that he would be submitting some technical changes to the draft document. Director Ramge suggested an addition to the standard and to all subsequent standards that the Working Group will be developing—the addition of the following sentence at the end of the first paragraph on the first page: “Examination standards continue to be developed for the health reform-related requirements that became effective after January 1, 2014.”

Director Ramge said the comment deadline for the direct access to providers examination draft standards is Dec. 31, 2014. He said that if comments are received prior to the end of the year, NAIC staff will attempt to distribute and/or possibly incorporate submitted comments into the draft for the Working Group review at its first call in 2015.

Director Ramge said that Ms. Nugent had suggested that an examiner note be inserted into the standard, under the description of the metal levels, that “An issuer may convert an annual dollar limit that is imposed in the state’s essential health benefits benchmark plan to an actuarial equivalent visit limit.” Director Ramge said that while Ms. Nugent had indicated that the absence of the language did not detract from the examination standard, she indicated that it would be worthwhile to include the suggested language, if at all possible, into the adopted essential health benefits examination standard.

Director Ramge said that Brian Webb (NAIC) agreed that the language is factually correct and could be inserted into the standard. Director Ramge said that he wanted to make the Working Group aware of the change; he said that the suggested
language received from the CCIIO would be handled as a technical change that would be made and go through the consent agenda at the Joint Executive/Plenary Committee meeting at the 2015 Spring National Meeting.

Director Ramge said that the NAIC consumer representatives suggested a change to the introductory language to the essential health benefits standard, which was subsequently adopted at the 2014 Fall National Meeting. The consumer representatives suggested that the first sentence of the introductory paragraph—"Federal law defers enforcement of health reform to state insurance regulators."—be replaced by "Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual and small group insurance markets.

Director Ramge said that there had been discussion at the Working Group meeting at the Fall National Meeting that other already adopted health reform standards may need to be re-opened to include the language. Director Ramge provided an update on this issue, indicating that the already adopted health reform standards will not need to be re-opened to include the revised sentence suggested by the consumer representatives, as the introductory section will not re-occur in each examination standard; it will only appear once in the new health reform-related chapter of next year’s Market Regulation Handbook.

Director Ramge asked the Working Group for suggestions regarding which health reform-related examination standards the Working Group should be developing next, as well as what other areas of the examination standards the Working Group should focus on.

Director Ramge said that the Working Group will be on hold until the new NAIC committees are appointed in early 2015, and announcement of the first Working Group conference call of the year will be made when the Working Group is reconstituted in early 2015.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Washington, DC, Nov. 16, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jim Mealer, Vice Chair (MO); Lee Backus (DC); Russ Hamblen (KY); Victoria August (MD); Paul Hanson (MN); Tracy Biehn (NC); Win Pugsley and Chuck Vanasdalan (NH); Cliff Day (NJ); Angela Dingus (OH); Brian Gabbert (OK); Chris Monahan (PA); Don Beatty (VA); Christina Rouleau (VT); Leslie Krier (WA); Mark Hooker (WV); and Cari Lee (WI). Also participating were: Commissioner Todd E. Kiser (UT); Karl Knable (IN); and Martin Swanson (NE).

1. **Adopted its Oct. 29, Sept. 23 and Aug. 16 Minutes**

   Mr. Hooker made a motion, seconded by Mr. Mealer, to adopt the Working Group’s Oct. 29 (Attachment Eight-A), Sept. 23 (Attachment Eight-B) and Aug. 16 minutes (see NAIC Proceedings – Summer 2014, Market Regulation and Consumer Affairs (D) Committee, Aug. 18, 2014, minutes). The minutes were unanimously adopted.

2. **Adopted Revisions to Core Competencies, Oct. 29 Draft**

   Director Ramge said that at a Market Regulation and Consumer Affairs (D) Committee call in June, feedback was received from (D) Committee members suggesting that the Working Group perform a review of the core competencies to update the document regarding state insurance department oversight of contract examiners, in response to one of the recommendations found in the December 2013 FIO report.

   Director Ramge said that the draft core competencies were distributed Nov. 3 for discussion and review at the Working Group meeting, and many of the revisions discussed since the Working Group first started looking at the draft, in July, have been incorporated into the document.

   Director Ramge said during the Working Group call Sept 23, the Working Group agreed to accept the redlined revisions to Standard Two in the staff and training section and all revisions in Standard One, Standard Two and Standard Three in the contract examiner section of the draft. On the Oct. 29 call, the Working Group added additional language to Standard Five of the contract examiner section to: 1) address more detail regarding status reports that insurance departments require of contract examiners; and 2) provide additional regulator guidance regarding the handling of issues uncovered during an examination that are ancillary to the scope of an examination.

   Director Ramge said that comments were received from Missouri, and the comments had been incorporated into the draft document. Mr. Mealer said that his comments addressed the need for further clarification, in Standard Six, regarding regulator guidelines dealing with conflict of interest concerning corporate contractor firms, which work not only with insurance departments, but also with regulated entities.

   Mr. Mealer made a motion, seconded by Ms. Biehn, to adopt all revisions to the core competencies. The core competencies were unanimously adopted.

3. **Adopted Health Reform Examination Standards – Essential Health Benefits, Nov. 7 Draft**

   Director Ramge said that draft market conduct examination standards for essential health benefits were developed for inclusion in the Market Regulation Handbook, and the standards are applicable to non-grandfathered, insured plans in the individual and small group markets, on and off the marketplace. Director Ramge said the draft standards are based upon the model language found in the Individual Market Health Insurance Coverage Model Act (#36) and the Small Group Market Health Insurance Model Act (#106), as well as the Sept. 30 draft of the Individual Market Health Insurance Coverage Model Regulation and the Sept. 30 draft of the Small Group Market Health Insurance Coverage Model Regulation—which are both
currently under review by the Regulatory Framework (B) Task Force and are being considered for adoption at its meeting on Nov. 16.

Director Ramge said the Nov. 3 comments received from the NAIC consumer representatives were incorporated into the essential health benefits Nov. 7 draft. Timothy S. Jost (Virginia Organizing) said that while the NAIC consumer representatives’ comments were mostly technical in nature, one of the more substantive comments the consumer representatives made was to add the full definition of benefit design to the essential health benefits examination standard.

Director Ramge said that if the Working Group agreed with the NAIC consumer representatives’ revisions to the first sentence of the draft—replacing the language “defers enforcement of health reform to state insurance regulators” with “relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual and small group markets”—the revision could also be made to other health reform-related examination standards that have been already adopted by the Working Group, for the purpose of consistency.

Mr. Hooker made a motion, seconded by Mr. Mealer, to adopt the draft essential health benefits examination standards. The essential health benefits examination standards were unanimously adopted.

4. Discussed Other Matters

Director Ramge said that the Working Group will continue its discussions on the draft revisions to Chapter 14—Sampling of the Market Regulation Handbook on an upcoming Working Group conference call. Director Ramge said that the next Working Group conference call will tentatively be scheduled in early December; a save-the-date notice will be distributed prior to the call. Director Ramge said the Working Group will continue its work until the end of the year and will then be on hold until the new NAIC committees are appointed in early 2015.

Director Ramge said that the Working Group had been developing draft examination standards regarding health reform, for inclusion in the Market Regulation Handbook, for approximately three years, and the Working Group will continue its work on drafting market conduct examination standards corresponding to health reforms. Major working group accomplishments in 2014 include the adoption of new health reform market conduct examination standards regarding: 1) prohibition of rescissions; 2) extension of coverage for dependents to age 26; 3) guaranteed availability; 4) guaranteed renewability; 5) coverage of individuals participating in approved clinical trials; 6) prohibition of excessive waiting periods; 7) essential health benefits; and 8) revisions to core competencies concerning professional designations, contract examiner oversight and conflict of interest.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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Chapter XX—Health Reform

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace. 

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
## MARKET CONDUCT EXAMINATION STANDARDS

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<th>Provision Title</th>
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**PROVISION TITLE:** Direct Access to Providers

**CITATION:** PHSA § 2719A

**EFFECTIVE DATE:** Plan years, and in the individual market, policy years beginning on or after September 23, 2010

**PROVISION:** The provisions of the health reform act require that non-grandfathered small and large group employer plans and individual plans, which require or provide for designation by a covered person of a participating primary health care professional, shall permit covered individuals to designate any participating primary health care professional who is available to accept the covered person.

The provisions of the health reform act also require that a covered individual may, on behalf of a covered child, designate any participating pediatric physician as the child’s primary care health care professional, if the health care professional is available to accept the child.

12/30/14 Comment from Tim Jost The provisions of the health reform act prohibit a health carrier, that requires the designation of a primary care health care professional, from imposing prior authorization or referral requirements for access to an obstetrical and gynecological health care professional.

The health carrier shall provide a notice to a covered person that satisfies the requirements of HHS, DOL and the Treasury final regulations, regarding a covered individual’s right to designate a participating primary health care professional, including the designation of pediatric and obstetrical and gynecological specialists and the prohibition of a health carrier from imposing prior authorization or referral for a female covered person seeking coverage for access to an obstetrical or gynecological health care professional.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that for group health benefit plans, individual health plans or health carriers which require a participant to choose a participating primary care provider, the health benefit plan or health carrier must allow the participant to choose any participating primary care provider who is available to accept the participant.

With respect to a child, a health benefit plan or health carrier must allow the designation of a pediatrician as a child’s primary care provider if the provider participates in the health carrier’s health benefit plan network.

12/30/14 Comment from Tim Jost A health benefit plan or health carrier, that requires the designation of a primary health care professional, may not impose prior authorization or referral requirements for access to obstetrical and gynecological health care professionals for a female plan participant who seeks coverage for access to an obstetrical or gynecological health care professional.

A health benefit plan or health carrier must provide a notice informing the participants of the terms of the plan regarding designation of a primary care provider.
This provision applies to all health carriers in the individual market and to 3/11/15 Comment from CCIIO, small and large group employer plans. This provision applies to non-grandfathered individual market 12/18/14 Comment from CCIIO and 12/30/14 Comment from Tim Jost, and small group and large group market health plans.

**FAQs:**
See HHS website for guidance.

**NOTES:**
Standard 1
A health carrier providing individual, small group, and large group market health coverage under a health benefit plan, that requires or provides for designation of a participating primary health care professional, shall—

(1) permit a covered person to choose any participating primary care health care professional; and
(2) allow a covered individual, on behalf of a child, to designate any participating pediatric physician as the child’s primary care health care professional; and
(3) for health carriers providing coverage for obstetrical or gynecological care, be precluded from imposing upon an insured prior authorization or referral requirements with respect to care access to provided by participating health care professionals who specialize in obstetrics or gynecology.

Apply To: All group health products, (non-grandfathered products) for plan years beginning on or after September 23, 2010

Apply To: All individual health products, (non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, utilization management, and claims handling, including policies and procedures related to designation of participating primary health care professionals, including the designation of pediatric and obstetrical and gynecological specialists and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional.

_____ Policyholder files and supporting documentation, including a copy of the issued certificate of coverage or policy, letters, notices, telephone scripts, etc., regarding designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal appeals/grievance files, and adverse utilization review determinations, concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional.

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional.
access to

3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional

Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

Health carrier marketing and sales policies and procedures’ references to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding

12/30/14 Comment from Tim Jost

access to

3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional

Health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological and prior authorization or referral regarding

12/30/14 Comment from Tim Jost

access to

3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional

Training materials

Producer records

Applicable state and federal statutes, rules and regulations, and guidances

NAIC References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Model Act (#106)
Model Language for Choice of Health Care Professional (#930-A)

Other References

HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

3/19/15 Comment from AHIP
Examiner Note: PHS Act section 2713 and the federal regulations permit student health insurance coverage to coordinate with student health centers to ensure the provision of preventive health services. For example, an issuer can arrange for a student health center to serve as its in-network provider where students could receive preventive services without cost-sharing.

Federal regulations also permit a student health insurance plan to designate providers at a student health center as its in-network providers, thus allowing students to choose from among the student health center's providers for purposes of satisfying section 2719A, provided that the center has sufficient provider capacity and range of services available to support this designation. Federal regulators believe that provider selection from an adequate health center provider panel provides an adequate incentive for students to obtain health care at the student health clinic while they are on campus, while also providing them with choice of providers when away from campus. Examiners are encouraged to review CMS–9981–F with regard to federal regulations pertaining to student health insurance coverage.)

Verify that a health carrier, which requires the designation by an insured of a participating primary care health care professional, has established and implemented policies and procedures regarding (1) an insured’s right to designate any participating primary health care professional, who is willing to accept the covered person; (2) an insured’s right to designate, for a covered child, any participating pediatric physician as the child’s primary care
health care professional; and (3) for health carriers providing coverage for obstetrical or gynecological care, the prohibition by a health carrier of imposing upon an insured prior authorization or referral requirements with respect to 12/30/14 Comment from Tim Jost the insured’s access to participating health care professionals who specialize in obstetrics or gynecology, in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling, 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost, and claim handling, utilization management 3/11/15 Comment from CCIIO and prior authorization policies and procedures related to the designation of a primary health care professional, to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured to designate any participating primary health care professional, who is available to accept the covered person, as required under final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling and claim handling policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured, on behalf of a child, to designate any participating physician who specializes in pediatrics as the child’s primary care health care professional and who is available to accept the child.

Examiner Note: This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

12/18/14 Comment from CCIIO and 12/30/14 Comment from Tim Jost If a health carrier provides individual market, or small group or large group market health insurance coverage under a health benefit plan for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, review health carrier policyholder service, complaint handling and claim handling policies and procedures related to the designation of a primary health care professional to verify that the health carrier:

- Does not require any insured’s, including a primary care health care professional’s, authorization or referral in the case of a female covered person who seeks 12/30/14 Comment from Tim Jost access to coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and

- Treats the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

Examiner Note: The health carrier may require the health care professional to agree to otherwise adhere to the health carrier’s policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier. A health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care. This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to designation of participating primary health care professional and prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.
Review complaint records, to verify that, when an individual has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage, due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements upon the insured regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertaining if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or due to the health carrier imposing prior authorization or referral requirements upon the insured regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage was improperly restricted or denied, due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.

Review health carrier internal appeals/grievance register/logs/files 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost, as well as records of appeals of adverse utilization review determinations, to identify any individuals for whom coverage of was improperly restricted or denied due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.

Review 3/11/15 Comment from CCIIO of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.

Review policy form files to 12/29/14 WA Comment ensure verify approval(s) from the applicable state and, (if applicable) from the Marketplace 3/11/15 Comment from CCIIO and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to 3/11/15 Comment from CCIIO an in-network obstetrical and gynecological health care professional.
Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding an in-network obstetrical and gynecological health care professional.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to notices required to be provided to the insured, regarding the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding an in-network obstetrical and gynecological health care professional.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding an in-network obstetrical and gynecological health care professional.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Standard 2
A health carrier shall provide a notice to covered persons, addressing terms and conditions of the health benefit plan relating to (1) the insured’s right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist and (2) for health carriers providing coverage for obstetrical or gynecological care, which require the designation of a primary care health professional, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in compliance with final regulations issued by the federal Department of Health and Human Services (HHS), Department of Labor (DOL) and the Treasury.

Apply To: All group health products, (non-grandfathered products) for plan years beginning on or after September 23, 2010

Apply To: All individual health products, (non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling and new business-related policies and procedures related to health carrier-issued notices regarding the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Consumer notice-related requests and health carrier delivery logs or other related information or protocols

_____ Samples of notices, including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing notices

_____ Health carrier complaint records regarding notices (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures’ references to notices

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

NAIC References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Model Act (#106)
Model Language for Choice of Health Care Professional (#930-A)
Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the issuance and delivery of notices to insureds regarding (1) an insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and (2) for health carriers providing coverage for obstetrical or gynecological care, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding obstetrical and gynecological care, with respect to participating health care professionals who specialize in obstetrics or gynecology, in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling and new business-related policies and procedures to verify that the health carrier provides notice to covered persons of the terms and conditions of the health benefit plan and a covered person’s rights with respect to the following: (1) the designation of a participating health care professional, pediatric, or obstetrical/gynecological specialist, and (2) for health carriers providing coverage for obstetrical or gynecological care, the requirement, as set forth under final regulations established by HHS, DOL and the Treasury, that a health carrier shall not impose prior authorization or referral requirements regarding an in-network obstetrical and gynecological health care professional.

For group health insurance coverage, verify that the health carrier provides notices whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under a health benefit plan, in accordance with final regulations established by HHS, DOL and the Treasury.

For individual health insurance, verify that the health carrier provides notices whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance, in accordance with final regulations established by HHS, DOL and the Treasury.

Review notices issued to verify (1) that when a health carrier has not made available or has improperly issued such notice, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner and to ascertain (2) if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the issuance and delivery of such notices.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and regulations pertaining to issuance and delivery of such notices.

Review health carrier’s training materials to verify that the information provided therein is complete and accurate with regard to the issuance and delivery of such notices.
Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Hi Petra!

On page 7 of the draft we discussed in our last call, the second paragraph uses the word “ensure” when all the other steps use the word verify, which is more accurate.

Have a great New Year, Carla

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Washington State Office of the Insurance Commissioner
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810 Third Avenue, Suite 650, Seattle, WA 98104 | Fax: 206-587-4244
To: Director Bruce Ramge, Market Conduct Examination Standards Working Group

Fr: Timothy Jost, NAIC Consumer Representative

Re: Market Conduct Examinations Standards: Direct Access to Providers

Date: December 30, 2014

I am writing to comment on the proposed Market Conduct Examinations Standards on direct access to providers, which creates standards for examining carrier compliance with section 2719A of the Public Health Service Act and was added to the PHSA as part of the Affordable Care Act’s patient bill of rights.

This section of the ACA requires non-grandfathered group health plans and health insurance carriers that require or provide for designation by a covered person of a participating primary health care professional to provide primary care services to allow a covered person to designate any participating primary health care professional who is available to accept the covered person. The section also requires that carriers allow a covered individual on behalf of a covered child to designate any participating pediatric physician as the child’s primary care health care professional, if the health care professional is available to accept the child. The provisions of this section further prohibit a health carrier that requires the designation of a primary care health care professional from imposing prior authorization or referral requirements before a woman can designate an obstetrical or gynecological care professional for providing obstetrical and gynecological care.

Finally, section 2719A requires carriers to provide a notice to a covered person that satisfies the requirements of HHS, DOL and the Treasury final regulations, regarding a covered individual’s right to designate a participating primary health care professional, including the designation of pediatric and obstetrical and gynecological specialists and the prohibition of a health carrier from imposing prior authorization or referral for a female covered person seeking coverage from an obstetrical or gynecological care professional.

The proposed examination standard basically reflects the statutory and regulatory requirements and I have only a few comments.

First, I note that the requirements of this section extend not just to the individual and small group market, but also to all group health plans, and thus the examination standard should extend to large group insured plans as well.

Second, the statutory requirement does not prohibit insurers from requiring prior authorization for obstetrical and gynecological care, but rather from requiring prior authorization prior to access to an obstetrical or professional health care professional.

Third, the list of documents to be reviewed should include utilization review and prior authorization protocols and procedures, and the review criteria and procedures should include review of these documents.

Finally, the federal regulations (45 C.F.R. § 147.138(a)(4)(iii)) provides model notices for carriers to use to provide notices of rights under this section. The Standards should at least mention the availability of these model notices.
Chapter XX—Health Reform

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual and small and large group insurance markets. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace. [12/18/14 Comments from Director Ramge] Examination standards continue to be developed for the health reform-related requirements that became effective January 1, 2014.

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
## MARKET CONDUCT EXAMINATION STANDARDS

<table>
<thead>
<tr>
<th>Provision Title</th>
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<td>Direct Access to Providers</td>
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**PROVISION TITLE:** Direct Access to Providers

**CITATION:** PHSA § 2719A

**EFFECTIVE DATE:** Plan years, and in the individual market, policy years beginning on or after September 23, 2010

**PROVISION:** The provisions of the health reform act require that non-grandfathered small and large group employer plans and individual plans, which require or provide for designation by a covered person of a participating primary health care professional, shall permit covered individuals to designate any participating primary health care professional who is available to accept the covered person.

The provisions of the health reform act also require that a covered individual may, on behalf of a covered child, designate any participating pediatric physician as the child’s primary care health care professional, if the health care professional is available to accept the child.

12/30/14 Comment from Tim Jost The provisions of the health reform act prohibit a health carrier, that requires the designation of a primary care health care professional, from imposing prior authorization or referral requirements for access to an obstetrical and gynecological health care professional.

The health carrier shall provide a notice to a covered person that satisfies the requirements of HHS, DOL and the Treasury final regulations, regarding a covered individual’s right to designate a participating primary health care professional, including the designation of pediatric and obstetrical and gynecological specialists and the prohibition of a health carrier from imposing prior authorization or referral for a female covered person seeking coverage for obstetrical or gynecological health care professional.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that for group health benefit plans, individual health plans or health carriers which require a participant to choose a participating primary care provider, the health benefit plan or health carrier must allow the participant to choose any participating primary care provider who is available to accept the participant.

With respect to a child, a health benefit plan or health carrier must allow the designation of a pediatrician as a child’s primary care provider if the provider participates in the health carrier’s health benefit plan network.

12/30/14 Comment from Tim Jost A health benefit plan or health carrier, that requires the designation of a primary health care professional, may not impose prior authorization or referral requirements for access to obstetrical and gynecological health care professional, for a female plan participant who seeks coverage for obstetrical or gynecological health care professional.

A health benefit plan or health carrier must provide a notice informing the participants of the terms of the plan regarding designation of a primary care provider.
This provision applies to all health carriers in the individual market and to small and large group employer plans. This provision applies to non-grandfathered individual market 12/18/14 Comment from CCIIO and 12/30/14 Comment from Tim Jost, and small group and large group market health plans.

**FAQs:**
See HHS website for guidance.

**NOTES:**
Standard 1

A health carrier providing individual, small group, and large group market health coverage under a health benefit plan, that requires or provides for designation of a participating primary health care professional, shall (1) shall permit a covered person to choose any participating primary care health care professional; (2) shall allow a covered individual, on behalf of a child, to designate any participating pediatric physician as the child’s primary care health care professional; and (3) for health carriers providing coverage for obstetrical or gynecological care, shall be precluded from imposing upon an insured prior authorization or referral requirements with respect to care access to provided by participating health care professionals who specialize in obstetrics or gynecology.

Apply To: All group health products, (non-grandfathered products) for plan years beginning on or after September 23, 2010

Apply To: All individual health products, (non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

- Health carrier policyholder service, complaint handling, 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost and claim handling, utilization management and prior authorization policies and procedures related to designation of participating primary health care professionals, including the designation of pediatric and obstetrical and gynecological specialists and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

- Policyholder files and supporting documentation, including a copy of the issued certificate of coverage or policy, letters, notices, telephone scripts, etc., regarding designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

- Complaint register/logs/files

- Health carrier complaint records concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

- Internal appeals/grievance files, 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost and adverse utilization review determinations, concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

- Applicable external appeals register/logs/files, external appeal resolution and associated documentation related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional
Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

Health carrier marketing and sales policies and procedures’ references to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

Health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

Training materials

Producer records

Applicable state and federal statutes, rules and regulations, and guidances

NAIC References

*Individual Market Health Insurance Coverage Model Act* (#36)
*Small Group Market Health Insurance Model Act* (#106)
*Model Language for Choice of Health Care Professional* (#930-A)

Other References

HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that a health carrier, which requires the designation by an insured of a participating primary care health care professional, has established and implemented policies and procedures regarding (1) an insured’s right to designate any participating primary health care professional, who is willing to accept the covered person; (2) an insured’s right to designate, for a covered child, any participating pediatric physician as the child’s primary care health care professional; and (3) for health carriers providing coverage for obstetrical or gynecological care, the prohibition by a health carrier of imposing upon an insured prior authorization or referral requirements with respect to 12/30/14 Comment from Tim Jost the insured’s access to participating health care professionals who specialize in obstetrics or gynecology, in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling, 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost, and claim handling, utilization management and prior authorization, policies and procedures related to the designation of a primary health care professional, to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured to designate any participating primary health care professional, who is available to accept the covered person, as required under final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling and claim handling policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured, on behalf of a child, to designate any participating
physician who specializes in pediatrics as the child’s primary care health care professional and who is available to accept the child.

Examiner Note: This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

12/18/14 Comment from CCIIO and 12/30/14 Comment from Tim Jost If a health carrier provides individual market, or small group or large group market health insurance coverage under a health benefit plan for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, review health carrier policyholder service, complaint handling and claim handling policies and procedures related to the designation of a primary health care professional to verify that the health carrier:

- Does not require any insured’s, including a primary care health care professional’s, authorization or referral in the case of a female covered person who seeks 12/30/14 Comment from Tim Jost access to coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and
- Treats the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

Examiner Note: The health carrier may require the health care professional to agree to otherwise adhere to the health carrier’s policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier. A health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care. This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to designation of participating primary health care professional and prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review complaint records, to verify that, when an individual has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage, due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier having restricted the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or due to the
health carrier having imposing prior authorization or referral requirements upon the insured regarding 12/30/14

Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage was improperly restricted or denied, due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review health carrier internal appeals/grievance register/logs/files 12/18/14 comment from North Carolina and 12/30/14 Comment from Tim Jost,, as well as records of appeals of adverse utilization review determinations, to identify any individuals for whom coverage of was improperly restricted or denied due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier restricting the insured’s ability to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review policy form files to 12/29/14 WA Comment ensure verify approval(s) from the applicable state and, (if applicable) from the Marketplace and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to notices required to be provided to the insured, regarding the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional.
Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Standard 2

A health carrier shall provide a notice to covered persons, addressing terms and conditions of the health benefit plan relating to (1) the insured’s right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist and (2) for health carriers providing coverage for obstetrical or gynecological care, which require the designation of a primary care health professional, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional, in compliance with final regulations issued by the federal Department of Health and Human Services (HHS), Department of Labor (DOL) and the Treasury.

Apply To: All group health products, (non-grandfathered products) for plan years beginning on or after September 23, 2010

Apply To: All individual health products, (non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling and new business-related policies and procedures related to health carrier-issued notices regarding the insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and prior authorization or referral regarding 12/30/14 Comment from Tim Jost access to an in-network obstetrical and gynecological health care professional

_____ Consumer notice-related requests and health carrier delivery logs or other related information or protocols

_____ Samples of notices, including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing notices

_____ Health carrier complaint records regarding notices (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures’ references to notices

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

NAIC References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Model Act (#106)
Model Language for Choice of Health Care Professional (#930-A)
Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the issuance and delivery of notices to insureds regarding (1) an insured’s right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and (2) for health carriers providing coverage for obstetrical or gynecological care, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling and new business-related policies and procedures to verify that the health carrier provides notice to covered persons of the terms and conditions of the health benefit plan and a covered person’s rights with respect to the following: (1) the designation of a participating health care professional, pediatric, or obstetrical/gynecological specialist, and (2) for health carriers providing coverage for obstetrical or gynecological care, the requirement, as set forth under final regulations established by HHS, DOL and the Treasury, that a health carrier shall not impose prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

For group health insurance coverage, verify that the health carrier provides notices whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under a health benefit plan, in accordance with final regulations established by HHS, DOL and the Treasury.

For individual health insurance, verify that the health carrier provides notices whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance, in accordance with final regulations established by HHS, DOL and the Treasury.

Review notices issued to verify (1) that when a health carrier has not made available or has improperly issued such notice, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner and to ascertain (2) if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the issuance and delivery of such notices.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and regulations pertaining to issuance and delivery of such notices.

Review health carrier’s training materials to verify that the information provided therein is complete and accurate with regard to the issuance and delivery of such notices.

12/30/14 Comment from Tim Jost Examiner Note: Federal regulations 45 C.F.R §147.138(a)(4)(iii) provide templates of notices for health carriers to use, to provide insureds with notices of rights with regard to direct access to providers.
Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
From: Mitchell, Martin [mailto:mmitchell@ahip.org]
Sent: Thursday, March 19, 2015 3:32 PM
To: Wallace, Petra
Subject: NAIC Notice: Market Conduct Examination Standards (D) Working Group Revised Exposure Draft and Comments

Petra,

Further to our emails earlier this month, I would like to submit the following language for inclusion within the current exam standard under review by the Working Group.

Examiner Note: PHS Act section 2713 and the federal regulations permit student health insurance coverage to coordinate with student health centers to ensure the provision of preventive health services. For example, an issuer can arrange for a student health center to serve as its in-network provider where students could receive preventive services without cost-sharing.

Federal regulations also permit a student health insurance plan to designate providers at a student health center as its in-network providers, thus allowing students to choose from among the student health center's providers for purposes of satisfying section 2719A, provided that the center has sufficient provider capacity and range of services available to support this designation. Federal regulators believe that provider selection from an adequate health center provider panel provides an adequate incentive for students to obtain health care at the student health clinic while they are on campus, while also providing them with choice of providers when away from campus. Examiners are encouraged to review CMS–9981–F with regard to federal regulations pertaining to student health insurance coverage.)

Hope this is ok with you.

Marty

202-378-8927