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Welcome to

Network Adequacy:
Using the New NAIC Model Law to Protect Consumers

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Welcome and Introduction

Lynn Quincy

Director, Health Care Value Hub

Hosted Jointly by:

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POLICY & ACTION FROM CONSUMER REPORTS

American Heart Association | American Stroke Association
life is why™

COMMUNITY CATALYST

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

national partnership for women & families

Housekeeping

- **Thank you for joining us today**
- **All lines are muted until Q&A**
- **Technical problems? Please text/call Tad Lee at 703-408-3204 or our office at 202-462-6262**

Agenda for Today

Welcome & Introduction	**Lynn Quincy** (Health Care Value Hub)
Overview of the Law	**Claire McAndrew** (Families USA)
Areas to Improve Upon the Model	**Stephanie Mohl** (American Heart Association)
Current State Strategies	**Cindy Zeldin** (Georgians for a Healthy Future)
	Leni Preston (Maryland Women's Coalition for Health Care Reform)
	Tam Ma (Health Access California)
Resources and Next Steps	**Lynn Quincy** (Health Care Value Hub)

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Overview of the Law

Claire McAndrew

Private Insurance Program
Director, Families USA

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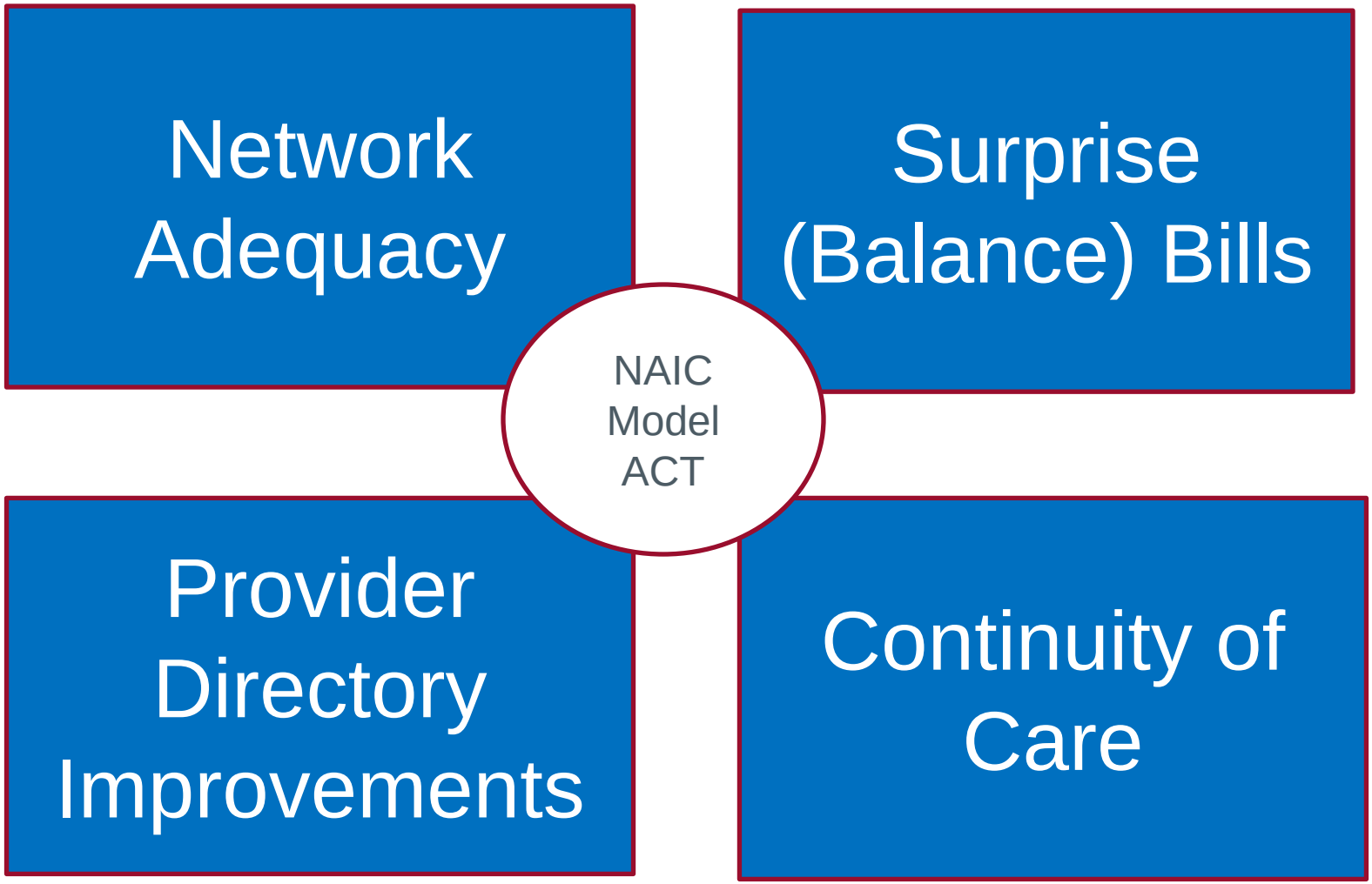
NAIC Network Adequacy Model Act and 2017 Proposed Benefit and Payment Parameters Rule

Claire McAndrew, Private Insurance Program Director

December 14, 2015

NAIC Network Adequacy Model Act



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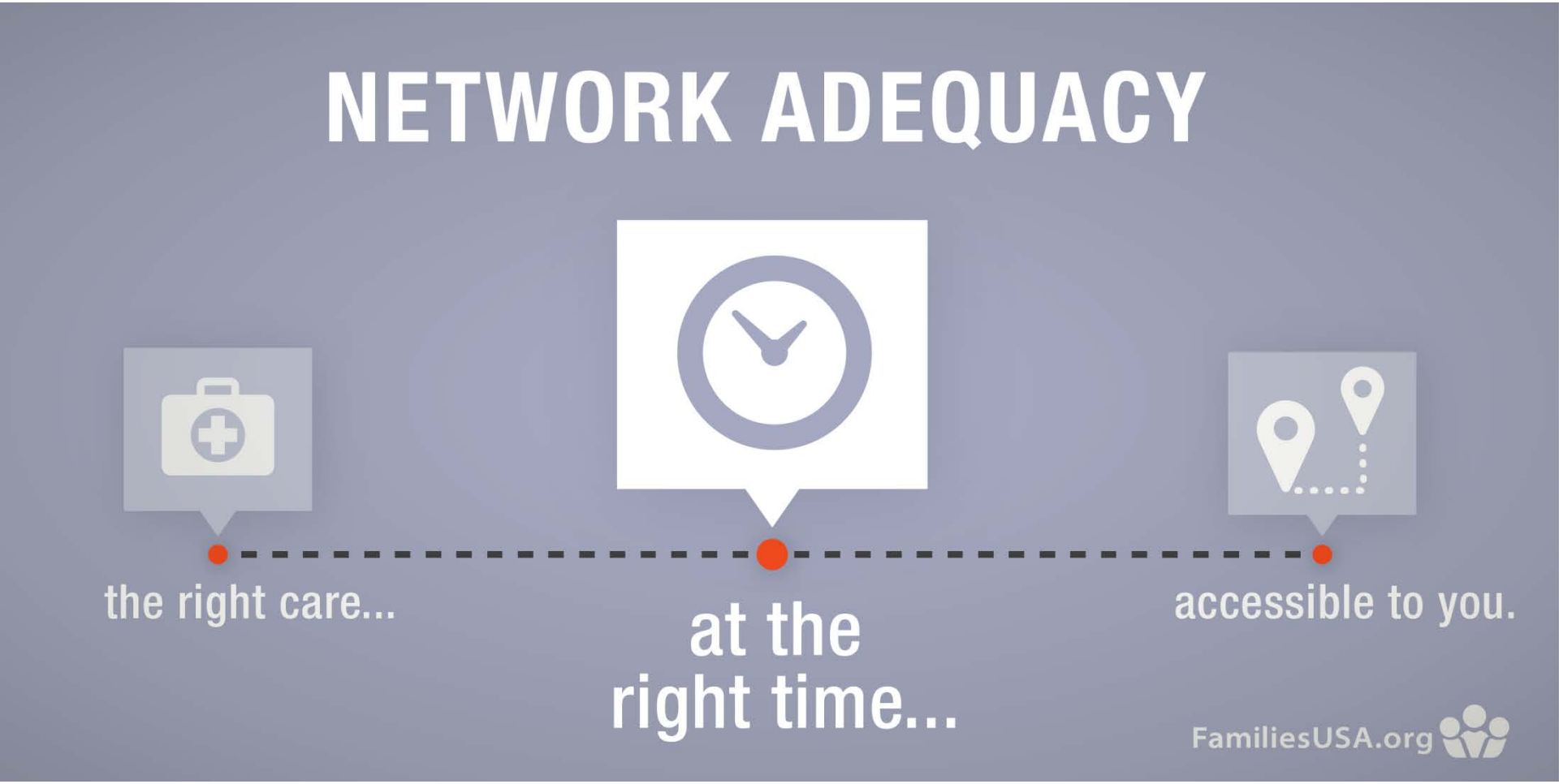
Section 5: Network Adequacy



Section 5: Network Adequacy

A health carrier providing a network plan shall maintain a network that is sufficient and numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

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Section 5: Network Adequacy

- Determining adequacy
- Quantitative standards
- Rights to go out of network
- Access plans

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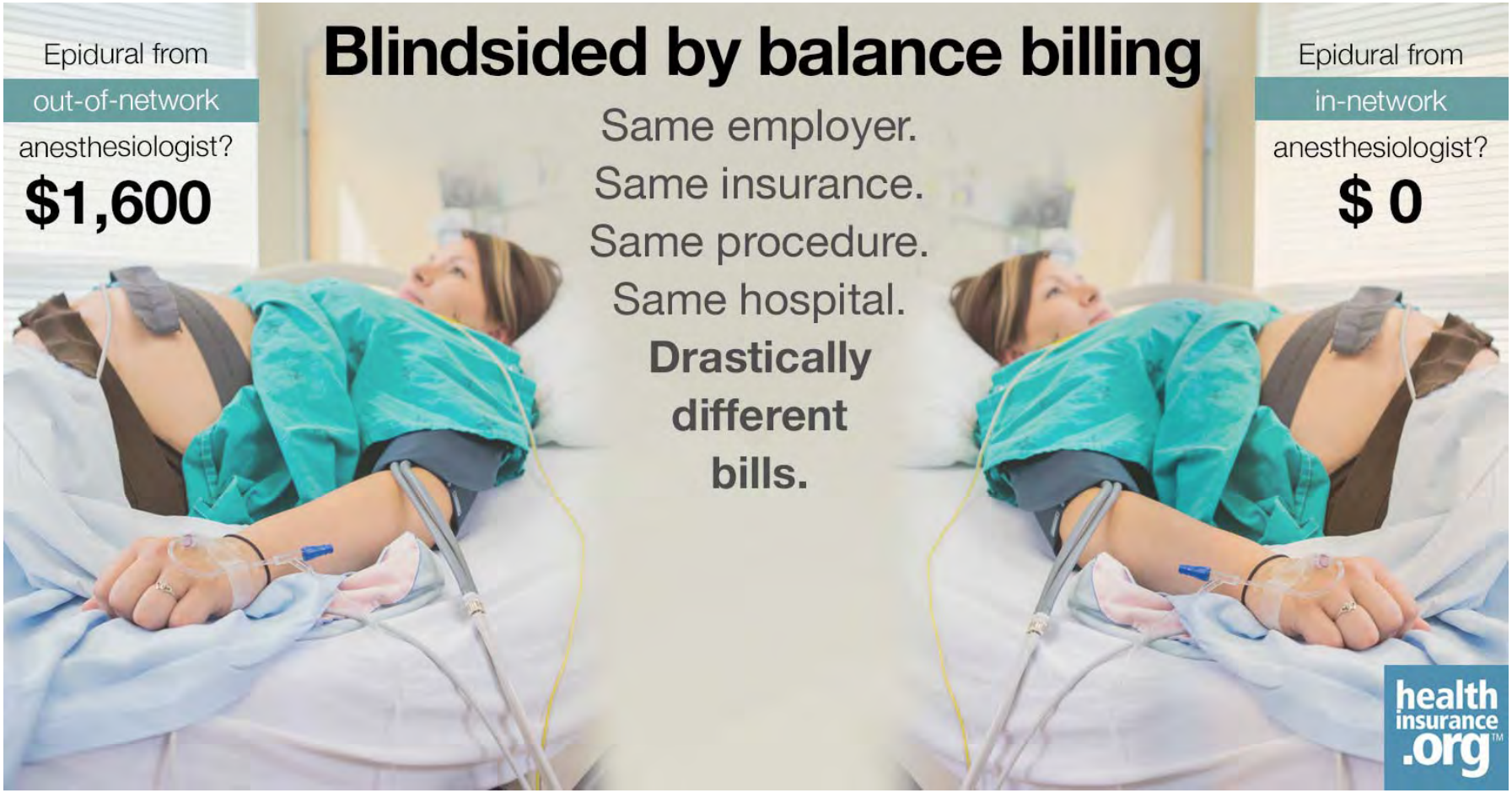
Access Plans

Must contain content including but not limited to:

- Description of the network
- Factors used to build networks (including criteria to select, and if state chooses, tier providers)
- Efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy; diverse cultural or ethnic backgrounds; physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes efforts, when appropriate, to include various types of essential community providers in-network.

Surprise Medical (Balance) Bills



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Section 7: Balance Billing

Protections in Non-Emergencies

- In-network facility must provide notice that out-of-network providers could be involved in care & estimate of charges
- Notice states enrollee can accept charges, contact insurer for help, or rely on any other legal rights
- **Mediation:** If enrollees receive balance bill of more than $500, option for mediation.
    - Pay what they would pay for in-network care, forward bill to insurer to trigger mediation. Enrollees surprise bill costs may be eliminated under mediation process.

Section 7: Balance Billing

Protections in Emergencies

- Enrollees pay only what they would pay for care from in-network providers.
- If they receive balance bill more than $500, must forward to insurance company for mediation to receive protection.
- Enrollees do not have to take additional steps and are held harmless from the balance bill.

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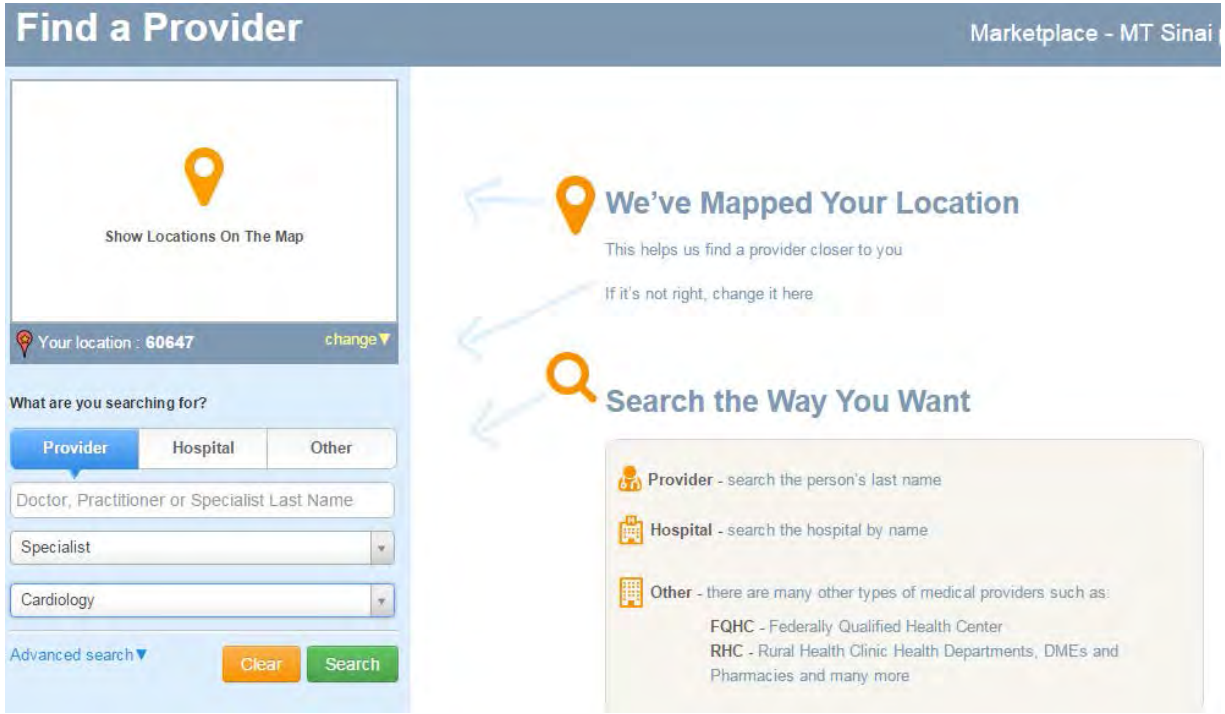
Section 9: Provider Directories

- Insurers must post online directories that are current, accurate, and searchable; updated monthly.
- Printed directories must be available upon request.
- Directories must accommodate needs of individuals with disabilities and people with limited English proficiency.



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Section 9: Provider Directories

Must contain content including, but not limited to:

- Contact information/ location; specialty; whether accepting new patients; non-English languages spoken
- Plain-language description of provider selection and tiering criteria
- Indications, if applicable, of tier for each given provider or facility

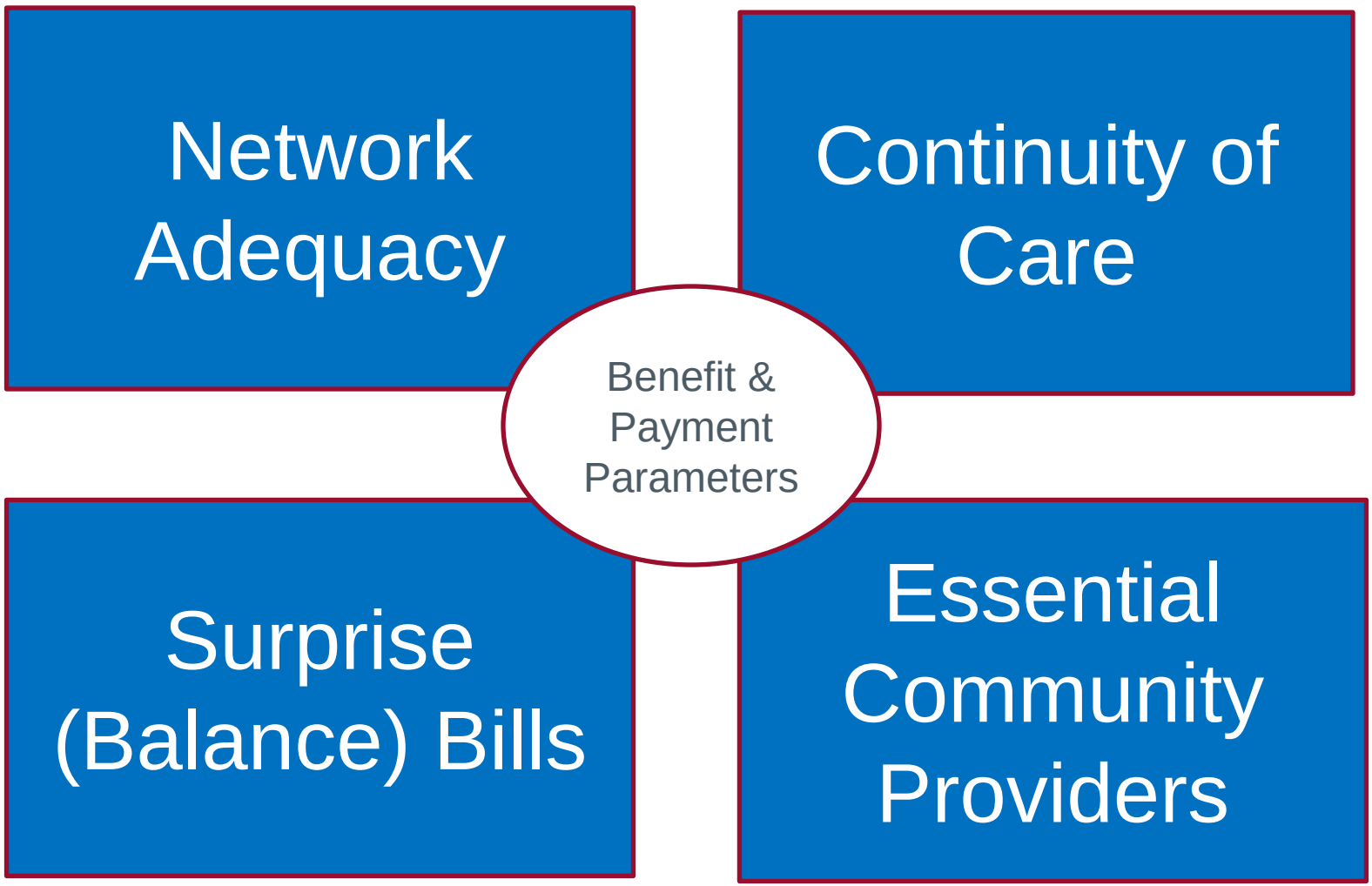
Provisions to improve directory accuracy

- Insurers must periodically audit at least a reasonable sample of their directories for accuracy
- Directories must include email address and phone number/ electronic link for public to report inaccuracies

Section 6: Continuity of Care

- Provides protections for enrollees in “active treatment”
- When provider leaves network, for enrollees in active treatment insurers must:
  - Establish transition procedures
  - Provide written notices/ in-network provider list
- Enrollees in active treatment can request continuity of care w/ providers who leave:
  - Pay what they would pay for in-network
  - Lasts up to 90 days, can request extension

2017 Proposed Benefit & Payment Parameters



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2017 Proposed Benefit & Payment Parameters

Network Adequacy in FFM

- Requires states to implement quantitative, measurable standards or rely on federal fallback

Continuity of Care in FFM

- Good faith effort to notify patients 30 days in advance of their providers leaving network
- Continuity up to 90 days if in active treatment

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2017 Proposed Benefit & Payment Parameters

Balance billing for all marketplaces

- Cost-sharing for EHBs from OON providers at in-network facilities counts toward annual limit if enrollees do not receive 10-days advance notice regarding OON providers.

Essential Community Providers

- Back-step: Counts each provider in an ECP as a separate ECP, makes it easier for insurers to meet FFM ECP requirements.

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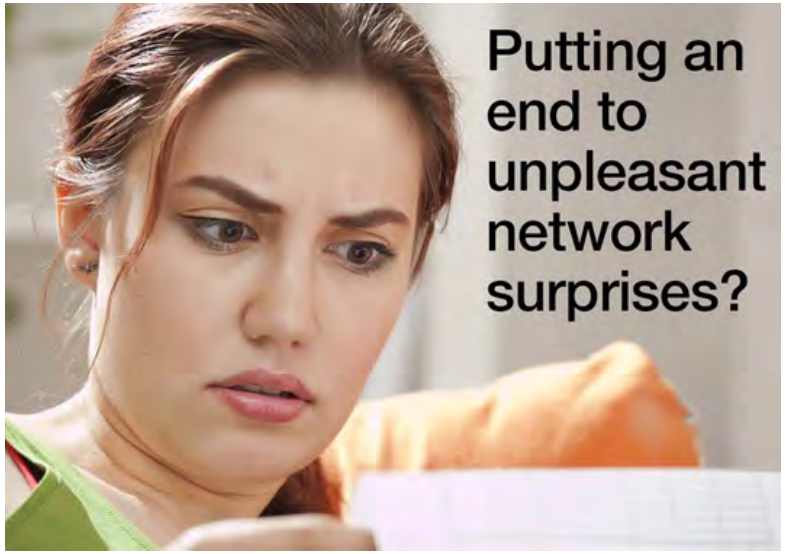
2017 Proposed Benefit & Payment Parameters

Also open for comment until Dec 21

- Transparency of provider selection and tiering criteria
- Creation of system to classify QHP relative network coverage (breadth)



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Contact Information

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Questions for the Claire?

Click the “raise hand” icon at the top of your screen

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Areas to Improve Upon the Model

Stephanie Mohl

Senior Government Relations Advisor,
American Heart Association/ American Stroke Association

Network Adequacy: Using the New NAIC Model Law to Protect Consumers

Stephanie Mohl, Senior Government Relations Advisor,
American Heart Association/American Stroke Association

December 14, 2015

Priorities for Improving the Act

- Require use of quantitative standards to measure sufficiency
- Require prior approval of access plans by insurance departments
- With respect to tiered networks, require that consumers have access to all covered services in lowest cost-sharing tier

Other Areas for Strengthening the Act

- Stronger continuity of care protections to provide greater certainty, longer transition period
- Broader definition of emergency services – including pre-hospital services
- Apply minimum Essential Community Provider requirements to all network plans, not just QHPs
- Require reporting to Insurance Depts on use of "5C" process, provider directory audits at least annually

Other Areas for Improving the Act, cont.

- Clarify that telemedicine services should not be only means consumers have of accessing covered services
- Require health carriers to explain how they convey the breadth of their provider network
- Hold consumers financially harmless when provider is moved to higher cost-sharing tier
- Define “material change,” “regular basis”

Other Areas for Improving the Act, cont.

- Require insurers to hold covered persons financially harmless when they rely on inaccurate provider directory info
- Require a SEP when consumers enroll in a plan based on inaccurate provider directory info and when provider leaves network or is moved to higher tier

Questions for the Stephanie?

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Current State Strategies (GA)

Cindy Zeldin

Executive Director

Georgians for a Healthy Future

GEORGIANS FOR A HEALTHY FUTURE

Network Adequacy: The Georgia Experience

Cindy Zeldin
Georgians for a Healthy Future
December 14, 2015

Network Adequacy in Georgia

- Consumer and Provider Protection Act (introduced in 2015 legislative session; did not pass)
- Study Committee on the Consumer and Provider Protection Act (SR 561)
- Advocates working on network adequacy, balance billing, provider directories
- Tricky stakeholder politics
- Interest among legislators and regulators, but may take some time

Thank you!

GEORGIANS FOR A HEALTHY FUTURE

100 Edgewood Avenue, Suite 1015
Atlanta, GA 30303
Phone: 404-567-5016
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info@healthyfuturega.org

healthyfuturega.org

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Current State Strategies (MD)

Leni Preston

Maryland Women's Coalition for Health Care Reform, Chair and Volunteer Executive Director

Working together toward health care for everyone in Maryland

Maryland Women's Coalition FOR HEALTH CARE REFORM

Network Adequacy:

A Maryland Perspective

14 December, 2015

Leni Preston

leni@mdchcr.org

301.351.9381

www.mdhealthcarereform.org

The Coalition: Who We Are

- Collaborative Alliance: 1,800+ individual & 100 organizational members
- Mission: Promote health equity through access to high-quality, comprehensive and affordable health care for all Marylanders
- Partnerships with public & private sectors
- Strategic Agenda: Policy, Legislation, Education, Engagement, Advocacy & Action

Network Adequacy Report

- Why?
  - Demonstrate challenges all consumers face in using MD's QHP online provider directory
  - Provide context for recommendations
- What?
  - Secret Shopper for OB/GYNs: (1) provide well woman visits; (2) accepting new patients; (3) available for appointment within 4 weeks
- When?
  - November 2014 – November 2015

Barriers to Access

The Reality

Fewer than 1 in 4 OB/GYN providers

accept new patients, offer well-woman visits and have appointments available in 4 weeks

Recommendations

Project Outcomes

- Action – Proposed 2017 Plan Certification Standards www.marylandhbe.com
  - Essential Community Providers: Expanded definition
  - Transparency
    - Report plan metrics for network adequacy
    - Information on accepting new patients
    - Access to carrier directory without login
  - Directory Accuracy
    - Consumer reporting
    - 2016-2018 process

Next Steps

- Keep up the pressure
- Educate legislators
- Legislation
  - Maryland Insurance Administration
  - Advocates

Working to advance health equity in Maryland

Maryland Women's Coalition FOR HEALTH CARE REFORM

Leni Preston

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301.351.9381

www.mdhealthcarereform.org

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Current State Strategies (CA)

Tam Ma

Health Access California,
Policy Counsel

CALIFORNIA'S TIMELY ACCESS TO CARE STANDARDS

TAM M. MA, HEALTH ACCESS CALIFORNIA

A LONG ROAD TO TIMELY ACCESS

Knox-Keene Act (1975) - Governor Jerry Brown 1.0

- Regulates HMOs; Requires timely access to care
- Each HMO developed internal guidelines for timely access; Little adherence

AB 497 (Wildman, 1997) - Governor Pete Wilson

- HMO Bill of Rights legislative package
- Would have set time-elapsed standards- **VETOED**

AB 2179 (Cohn, 2002): - Governor Gray Davis

- Directed the Department of Managed Health Care to set standards to guarantee timely access to health care.
- Can adopt standards other than time-elapsed standards if appropriate.
- Alternative standards (vague, watered-down, discretionary) would not guarantee timely access.
- **Eight years of regulatory struggle:** Final regulations became effective January 17, 2010. Governor Arnold Schwarzenegger
- **Specific standards** for timely access + **strong oversight and enforcement.**

APPOINTMENT WAIT TIMES

Urgent Appointments	Wait Time
for services that don't need prior approval	48 hours
for services that do need prior approval	96 hours
Non-Urgent Appointments	**Wait Time**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

TELEPHONE WAIT TIMES

24/7 access to qualified health professional available
30-minute call-back

Language Access + Timely Access are not mutually exclusive.

ONGOING IMPLEMENTATION & ENFORCEMENT OF TIME-ELAPSED STANDARDS

Time-Elapsed Standards for Timely Access: Governor Schwarzenegger

- Regulators allowed different health plans to use different metrics and approaches for determining compliance.
- Difficult to determine compliance.

SB 964 (Hernandez, 2014): Governor Jerry Brown 2.0

- Standardizes the data to be annually reported by health plans.
- Allows the further development of standardized annual reporting on timely access.
- Plans must file separate reports if using different networks for plan products (Medicaid, individual & small group markets, etc).

SB 964 IMPLEMENTATION

- Determine a rate of compliance - allow comparison across plans
- Developent of standard methodology to measure compliance
- Survey and audit options

MY 2015: Survey

Specialist Physician Categories:

- Allergist
- Dermatologist
- Cardiologist
- Psychiatrist
- Pediatric & Adolescent Psychiatrist

Ancillary Care Appointments:

- MRI, Physical Therapy, Mammogram

- Standard format for submission of timely access reports
- Future years: audit methodology

Any Questions?

Tam M. Ma
Policy Counsel, Health Access California
tma@health-access.org

SELECTED RESOURCES

- The Story on Winning Timely Access to Care:
  http://www.health-access.org/images/pdfs/timely_access_back_story_01-19-2010.pdf
- Blog Post about SB 964:
  http://blog.health-access.org/?p=3637
- Timely Access to Care Regulations: § 1300.67.2.2
  http://wpso.dmhc.ca.gov/regulations/docs/15ccrp.pdf
- DMHC Timely Access Reporting Forms:
  http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx#timely

Questions for the panelists?

Click the “raise hand” icon at the top of your screen

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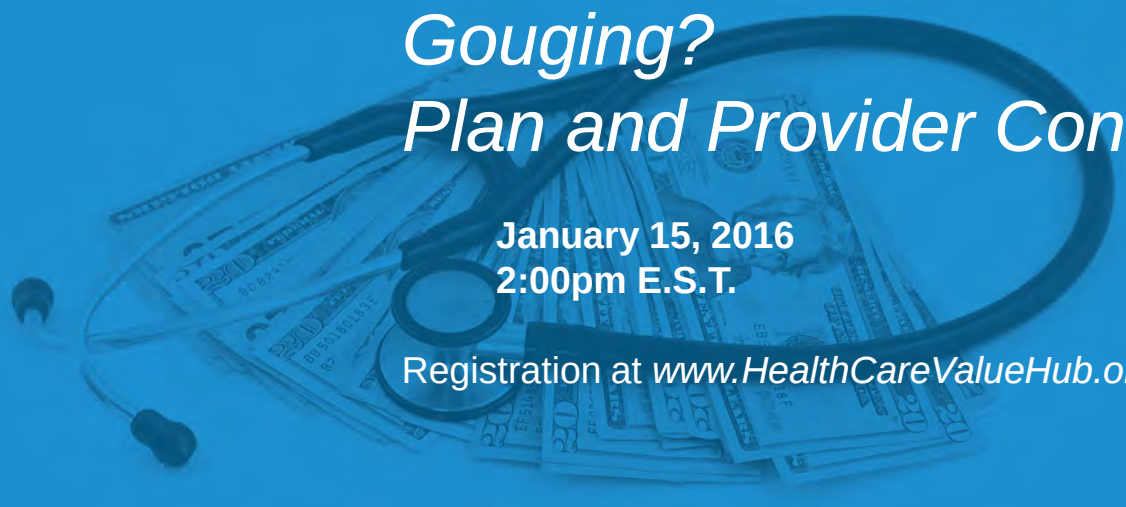
Next Steps

Lynn Quincy

Health Care Value Hub, Director

Join the Hub for our January webinar:

Better Coordination or Price Gouging?
Plan and Provider Consolidation



January 15, 2016
2:00pm E.S.T.

Registration at *www.HealthCareValueHub.org/events*

Thank You!

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