

Recommendations to NCDOL from Summer NAWG Meetings Consumer Advocates – July 27 and September 1, 2016

Section 5 – Network Adequacy

Model essentially provides a regulatory structure which requires that a health carrier maintain a network that is sufficient in numbers and appropriate types of providers to assure that all covered services to all consumers will be accessible without unreasonable travel or delay.

Group's Recommendations

- 1) In addition to other suggested standards for defining network adequacy, define network adequacy using quantitative standards for travel time and distance, wait times for appointments which are applied based upon tiers of provider types such as primary, specialty, pharmacy, etc., and provider to population ratios.
- 2) The standards for appointment wait times should vary according to the type of care/provider such as primary, specialty, emergency, and should recognize if the consumer is a new patient or existing patient.
- 3) The standards for travel time/distance should be set using county population types (metro, micro, rural) and use provider categories like those that used to be reported on NCDOL's Managed Care Reports, with additional delineation in the area of specialty care providers.
- 4) The standards for provider to population ratios should be set using same provider groupings and county population types as found in recommendation #3, and should be applied at the total population (by county) basis.
- 5) Consumer documentation relating to a network product should explain how a consumer can request that out-of-network covered services be covered on an in-network basis (including cost-sharing) when the consumer has experienced an unreasonable delay to access in-network providers (further clarification to requirements of NCGS § 58-3-200(d)). Set standards on timeframes for response and tie the timeframes to those found in NC's appeals and grievance procedures (NCGS §58-50-62, et seq.).
- 6) Apply network adequacy standards to the lowest cost-sharing network¹ in a tiered network product. Consumer documentation about tiered network products should include plain language explanations of how tiered networks function.

Guiding Principle – Do not reinvent the wheel, build upon what already exists; align standards with Medical standards and other market standards where possible.

¹ Lowest cost-sharing network in a tiered product typically means the most preferred network which includes the lowest cost-sharing amounts.

Suggestions Not Making the Recommendation List

- 1) Define what a material change is which prompts a health carrier to resubmit an amended access plan to NCDOL.
- 2) Assure that there are an adequate number of providers on a specific, benefit by benefit basis.

Section 6 –Requirements for Health Carriers and Participating Providers (i.e. provider contracting)

This section includes standards relating to contracting between health carriers and providers.

Group’s Recommendations

- 1) To protect consumers, establish a standard that provides that a contracted providers is prohibited from making excess charges above their contracted rates for covered services.
- 2) With regard to Section 6.G. of the model act, provide the insurance commissioner with authority to approve the health carrier’s criteria for credentialing and provider participation, including tiering.
- 3) Continuity of care standards/provisions should protect consumers when there are tiering changes during the policy/plan year, should include a minimum 90-day continuity of care time period, and should include that determinations of when care is no longer necessary under a continuity of care situation are appealable decisions.
- 4) Support adoption of standards found in Section 6.F.3(a) relating to non-discrimination in selection and tiering standards to assure that providers are not discriminated against because of the population or area they serve.
- 5) Adopt all recommendations from Section 6 of the NAIC model act, and then build off of that where state specific standards are allowed.

Other Suggested Related Initiatives for DOI – Consumers should be provided clear language explanations of consumer appeals and recourses; participating PBMs and health carriers, if they do not use a PBM, should be not allowed to tier drugs in a discriminatory fashion.

Section 7&8 – Requirements for Participating Facilities with Non-participating Facility-based Providers (i.e. Surprise Billing) and Disclosure and Notice Requirements

These sections set out suggested requirements for addressing “surprise billing” which includes situations where a consumer receives services at a participating facility from a non-participating facility-based provider and the consumer was not aware of the participation level of the ancillary service provider or had no choice as to that provider. This typically occurs in the situation when a consumer is being treated in the emergency department by a non-participating emergency physician (or other provider) and has no choice of provider, and in situations when the consumer chooses an in-network provider for their primary treatment, but has ancillary providers (such as radiologists, pathologists, anesthesiologists, etc.) which they did not select.

Additionally, this section suggests requirements for health carriers to develop a written disclosure or notice to be provided to consumers at the time of pre-certification. The notice should inform the consumer that there is the possibility that the consumer could be treated at the participating facility by a health care professional who is not in the same network as the consumer’s network and should provide the consumer with reasonable alternative choices of in-network providers in the same facility.

Group’s Recommendations

- 1) The consumer should not be balance billed or charged higher cost sharing for non-participating providers at participating facilities in emergency situations or for ancillary providers in non-emergency situations (except as allowed below). Balance billing and higher cost sharing amounts is prohibited in all emergency situations, and in all non-emergency care situations except in cases in which the consumer receives pre-service disclosure which identifies reasonable alternative choices of an in-network provider in the same facility with enough advance notice to make a meaningful choice. The consumer may be subject to balance billing and higher out-of-pocket costs if he or she received advance notice of the availability of reasonable alternative in-network providers in the same facility in sufficient time to select an in-network ancillary provider, but chose to use an out-of-network provider.
- 2) Establish a mediation process between the health carrier and providers to help negotiate payment. The mediation process should establish some type of payment standards via the use of a benchmark which defines reasonable reimbursement, such as a fixed percentage of Medicare payments or the health carrier’s average contracted rate for the services, whichever is greater.
- 3) The process for handling surprise billing issues should be automatic and should not require any action on the part of consumers. Consumers should not be balanced billed and should only be subject to in-network cost sharing amounts unless the consumer was

informed about available in-network alternatives in sufficient time to make a meaningful choice, and the consumer chose to select a non-participating provider.

- 4) Require facilities to have ancillary services providers that participate in the same network as the facility, or address by requiring health carriers to include provisions in their provider contracts with participating facilities.
- 5) Require disclosure by hospital ancillary providers that they do not participate in the network and the notice should be made in advance of receiving services, or address by requiring health carriers to include provisions in their provider contracts with participating facilities.

Guiding Principle – Do not weaken the consumer protections relating to unreasonable delay and inadequate networks currently found in NC laws.

Suggestions Not Making the Recommendation List

- 1) Require health carriers to inform the consumer at the time of prior authorization of the in-network ancillary providers at the in-network facility.
- 2) Require facilities to provide a balance bill notice before services which indicates that the balance bill will be separate from other paperwork and require that the notices relating to and indicating a balance is due be written in plain language.

Section 9 – Provider Directories

This section establishes requirements for health carriers related to electronic and print provider directories.

Group’s Recommendations

- 1) Set a standard that requires health carriers to include in their provider directory all of the requirements from the NAIC model act. In addition, health carriers should be required to include information on: accessibility for people with disabilities, hours of operation, the tiering level (if participating in a tiered network plan) and a disclosure on each page (written in plain language) that indicates the directory may not be up-to-date and instructions for where to get up-to-date information.
- 2) When a provider leaves a network or is moving to a less favorable tier (in a tiered network plan), require the directory to be updated, and hold the consumer harmless until the consumer had been notified that the provider is leaving the network (or changing tier levels) and until the point the consumer has reasonable access to a participating provider. If a network is changed such that a large percentage of network providers is lost (especially specialty care providers), consumers should be notified of the change.

- 3) Establish a standard that protects the consumer if the consumer reasonably relied upon an inaccurate directory.
- 4) Require directories to be updated every two weeks.
- 5) Follow the NAIC Model, with modifications as noted.

Suggestions Not Making the Recommendations List

- 1) Encourages adoption of standards that promote uniformity and alignment with other regulatory standards for directories.
- 2) Health carriers should be required to archive provider directories for some period of time in order to facilitate review of consumer complaints in times of question.