FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act Summary of Key Provisions

On November 22, 2015, the NAIC voted unanimously to adopt an updated version of its Network Adequacy Model Act (the Act), which was first adopted in 1996. This Act serves as draft legislation that states can enact into law. The Model Act contains many important provisions, including but not limited to:

- Protections to help guarantee that health insurance consumers have access to the services they need through in-network health care providers.
- Provisions to address surprise medical bills that consumers receive from out-of-network providers even when they obtain care at in-network facilities.
- Requirements to ensure that health plans' provider directories include necessary, accurate information.

Below, we provide a summary of key provisions of the updated NAIC Network Adequacy Model Act. We have not included all provisions—rather, we summarize those that are most relevant to consumers and their advocates.

Key Provisions of the NAIC Network Adequacy Model Act

Section 3: Definitions

This section defines key terms that are used throughout the Act. The updated Act includes definitions for some terms that were not included in the original version, such as "balance billing" (i.e., surprise medical billing), "essential community provider," "specialist/ specialty care," "tiered network," and "telemedicine/ telehealth." The definition of "health care services" was updated to specify that such services include mental health, behavioral health, and substance use disorder services, not just physical health care services.

Section 4: Applicability and Scope

This section clarifies that the Model Act applies to any "network plans," which are those that either require or incentivize (financially or otherwise) enrollees to use providers that are managed, owned, under contract with, or employed by an enrollee's insurer.

Section 5. Network Adequacy

- **Adequacy overall:** This section requires that: *A health carrier providing a network plan shall maintain a network that is sufficient in 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.*

  This requirement builds on the Affordable Care Act requirements for network adequacy in marketplace plans and expands those requirements to all plans that are regulated by the NAIC model act.

FamiliesUSA.org
1201 New York Avenue, NW, Suite 1100
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

- **Determining adequacy:** Whereas the original NAIC network adequacy Act permitted insurers to define criteria for determining whether their networks were sufficient, the updated version establishes that insurance regulators will determine if plans' networks are sufficient.
- **Quantitative standards:** The Act states that network sufficiency should be determined by reasonable criteria that could include measurable, quantitative standards, but it does not require states to implement such standards. (Consumer groups advocate that such standards should be required.) Standards the Act suggests for consideration include, but are not limited to: geographic accessibility of providers; waiting times for an appointment with participating providers; provider to covered person ratios by specialty; the ability of the network to meet the needs of covered persons, which may include low-income persons; children and adults with serious, chronic, or complex health conditions or physical or mental disabilities; or persons with limited English proficiency.
- **Rights to go out of network:** The Act requires insurers to have a process in place to allow enrollees to go out of network at an in-network benefit level if the plan's network cannot provide enrollees with access to an appropriate provider without unreasonable travel or delay.
- **Access plans:** The Act requires insurers to file "access plans" whenever they propose to sell a new network or if there is a material change to an existing network. The Act allows each state to decide whether insurance regulators must approve access plans before insurers sell their products, or whether access plans must simply be on file with insurance departments (consumer groups advocated that prior approval should be required).

  Insurers' access plans must include information including, but not limited to:
  - A description of their network
  - The factors used by the insurers to build provider networks, including a description of the criteria used to select, and, if the state chooses, tier providers
  - Insurers' 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 their networks.

Section 6: Requirements for Health Carriers and Participating Providers

- **Selecting and tiering providers:** This section requires health carriers (insurers) to develop standards for how they select and tier (when applicable) in-network providers, and to make those standards available to state regulators for review (or formal approval, if the state chooses). It also requires insurers to make plain language descriptions of the standards available for the public. This section prohibits discrimination in the selection of providers, such as the exclusion of providers who treat high-risk patients from networks. It also gives states the option to prohibit discrimination in provider tiering.
- **Continuity of care:** The Act provides protections for enrollees who are in "active treatment" if their providers leave their plans' network. Its definition for active treatment includes: an ongoing course of treatment for a life-threatening condition, serious acute condition, or a condition for which a treating provider attests that discontinuing care by the provider would worsen the condition or interfere with anticipated outcomes. It also includes care for

someone in the second or third trimester of pregnancy.

The continuity of care protections include:

- When a provider leaves a network, insurers shall establish reasonable procedures to transition enrollees who are in active treatment to new, in-network providers and shall provide written notice to the enrollees that the provider is leaving, along with a list of in-network providers who could meet the enrollees' needs.
- Enrollees who are in active treatment can request "continuity of care" under which they can continue to see providers who are no longer in their networks. Under this provision, providers must charge enrollees what they would pay to see in-network providers. Continuity can last for up to 90 days (with the possibility of requesting an extension).

Section 7: Requirements for Participating Facilities with Non-Participating, Facility-Based Providers

This section provides protections for consumers who go to an in-network facility but who end up receiving care from an out-of-network provider. It is designed to eliminate or reduce the burden of resulting "surprise medical bills" or "balance bills."

- **Protections in non-emergency situations**
  - When an in-network facility schedules or seeks prior authorization for care, it must provide notice to the consumer that some out-of-network providers could be involved in care, along with an estimate of those providers' charges for which the enrollee could be responsible. The notice must state that the enrollee can accept the charges, contact the insurer for assistance, or rely on any other legal rights. The notice must also indicate that the enrollee can contact the insurer for a list of in-network providers in the facility and can request one of those providers for care.
  - If enrollees receive a balance bill of more than $500 for a non-emergency, they have a new option under the NAIC Act via a mediation process. If they opt for mediation, they pay what they would pay for in-network cost-sharing and then forward the balance bill to the insurer for a mediation process that takes place between the insurer and the provider. Under the mediation process for the bill, the enrollee's costs may be eliminated.
- **Protections in emergency situations**
  - In emergencies, under the NAIC Act, enrollees have to pay only what they would pay for care from in-network providers. To receive this protection if they receive a surprise bill from an out-of-network provider that is more than $500, they must forward the bill to their insurance company so the insurer and provider can address it in the mediation process described above. Enrollees do not have to take any additional steps and are guaranteed protection from the bill.

Section 8: Disclosure and Notice Requirements

- In addition to the notice requirements that apply to health care facilities (described above), when insurers approve care at in-network facilities in advance, they too must notify enrollees that some providers at in-network facilities may be out of the enrollees' network.

- Facilities must also develop written notices within 10 days of an appointment or at the time of non-emergency admission confirming that a facility is in-network but informing enrollees that some providers in the facility may not be in their network.

Section 9: Provider Directories
This section requires insurers to post online provider directories that are current, accurate, and searchable and that are updated at least monthly. It also incorporates federal requirements to make printed directories available upon request. Directories must accommodate the needs of individuals with disabilities and people with limited English proficiency.

Directories must contain information including, but not limited to:

- Contact information/ location, specialty, whether providers are accepting new patients, and languages spoken other than English, if applicable
- Plain language descriptions of the criteria used to select and tier providers
- Indications, if applicable, of which tier a given provider or facility is in

The Act takes the following steps to improve provider directory accuracy:

- Insurers must periodically audit at least a reasonable sample of their directories for accuracy and retain documentation of audits that is to be available to regulators upon request.
- Directories must include an email address and phone number or electronic link that people can use to report directory inaccuracies to insurers.

Section 11: Filing Requirements and State Administration
Insurers must file with regulators samples of the forms they use to contract with providers. States can opt to require that insurers file these sample forms for prior approval. Insurers must also file with regulators any changes to the contract forms that would affect provisions of the Act or corresponding regulations. Insurers must make any actual provider contracts available for regulator review with advance notice.

Section 13: Enforcement
To enforce compliance with this Act, a regulator shall require a modification to the insurer's access plan or institute a corrective action plan, as appropriate, or may use any of the insurance commissioner's other enforcement powers.

Section 14: Regulations
This section allows regulators to promulgate regulations to implement the Act. (Same as the 1996 version of the Model Act.)

Section 15: Penalties
This section clarifies that violations of the Act will result in penalties as appropriate under state law. (Same as 1996 version of the Model Act.)