



ENSURING ACCESS TO CARE

SETTING AND ENFORCING NETWORK ADEQUACY STANDARDS IN GEORGIA

A PUBLICATION BY

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FEBRUARY 2016

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PROVIDER DIRECTOR ACCURACY

Please see our companion policy brief on provider directory accuracy and usability for a deep dive into transparency of provider networks.

A PUBLICATION BY



**GEORGIANS FOR A
HEALTHY FUTURE**

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Network adequacy serves as the link between having health insurance and accessing health care services. When consumers enroll in a health insurance plan, they gain access to a network of medical providers. Insurance companies contract with a range of providers, including both primary care and specialty physicians, to deliver health care services included within the plan's benefit package. This network of providers must be adequate to ensure that consumers enrolled in the plan have reasonable access to all covered benefits. This is what is meant by network adequacy.

While network adequacy is not a new concept, it has a new urgency in light of the sheer number of newly insured Georgians enrolled in individual plans; the move on the part of insurance companies toward narrow networks and tiered networks, which limit the number of providers plan enrollees can access; new federal standards; and a new model act from the National Association of Insurance Commissioners (NAIC) that provides updated guidance for states. Georgia health care consumers need and deserve clear standards and protections that ensure their coverage translates to access to care without financial hardship.

THE GOALS OF THIS POLICY BRIEF ARE TO:

- » explain the importance of network adequacy for access to care
- » outline current network adequacy standards in Georgia
- » summarize recent policy activity around network adequacy
- » set forth consumer-oriented principles for network adequacy standards in Georgia
- » provide policy recommendations to achieve network adequacy in Georgia

What is the NAIC?

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight.

83%

A 2015 study by researchers at the University of Pennsylvania found that Georgia had the highest percentage of narrow networks of any state at eighty-three percent.²

THE IMPORTANCE OF NETWORK ADEQUACY

Network adequacy is the key indicator of whether or not a health insurance plan truly provides access to timely, appropriate, and geographically accessible care. If a consumer enrolled in a plan has to travel far, wait weeks for a medical appointment, or pay higher out-of-network costs to see a specialist because they aren't covered in-network, then the link between health insurance and access to care has been broken. When this link is broken and the provider network is inadequate, consumers must choose between forgoing care or seeking care out-of-network, which can place consumers at risk of getting large medical bills they cannot afford to pay. Out-of-network providers can charge consumers for expenses not covered by their insurer, known as balance billing. This can be costly, especially for emergency services. A 2009 study found that the average potential balance bill amount in California was \$1,289 in addition to patient cost sharing amounts.¹ A 2011 study from New York found that consumers with surprise medical bills ended up paying an average of \$3,778 for out-of-network emergency care.

As provider networks narrow, the need to assess and monitor the adequacy of these networks has increased. Narrow networks are an approach insurance companies use to contain costs by offering a limited choice of providers and services in exchange for lower premiums. Similarly, tiered networks aim to contain costs by ranking providers in different groups, based on the insurer's assessment of cost and quality. Consumers are charged less for visiting providers in lower tiers. Narrow and tiered networks may be advantageous if they offer low costs coupled with meaningful access. To ensure they do, meaningful access standards must be defined and enforced. Historically, insurance companies have been able to use their own interpretation of reasonable access to assess whether their provider networks were adequate. In a market where narrow and tiered networks are becoming commonplace, however, it is more appropriate for insurance regulators to set and enforce these standards.

What is a narrow network?

Narrow networks can be created by excluding high-cost providers or using market power to negotiate lower reimbursement rates with providers in exchange for greater volume. Narrow networks are not new but are becoming more common.

What is a tiered network?

Tiered networks are designed by ranking providers, facilities, or drugs in different groups, based on the insurer's assessment of cost and quality. Consumers are charged less for visiting providers in lower tiers. It is often unclear what criteria are used to generate these rankings. Additionally, the effectiveness of tiered networks to deliver low-cost, high quality care is questionable because a consumer may select a tiered network over a traditional plan based on the low out-of-pocket costs in a lower tier but find out later that they can't access all of the providers or services they need on that tier, creating unexpected costs for consumers.

CURRENT NETWORK ADEQUACY STANDARDS IN GEORGIA

Georgia's current network adequacy standards are based in part upon the previous NAIC model act dating back to 1996. The Georgia Department of Insurance assesses network adequacy for managed care plans (HMOs, PPOs, POSs, and all other managed care products). The access to care standards under Georgia Code Section 33-20A-5³ require that managed care plans must make benefits available and accessible to each enrollee in the defined service area with reasonable promptness and ensure continuity of care. When medically necessary a plan must provide health care services twenty-four hours a day and seven days a week. And a plan must provide payment or reimbursement for emergency services and out-of-area services. While Georgia's standards focus on requiring plans to have a sufficient number of providers and facilities available with reasonable promptness, they do not quantify what is meant by "sufficient" and "reasonable promptness." Georgia's standards also do not specify requirements for inclusion of types of providers that are culturally competent or essential community providers. In all of the aforementioned areas the interpretation of "sufficient" and "reasonable" is in the hands of insurers, who can contend with regulators if there is disagreement. This also creates a variety of definitions of network adequacy across plans, which leaves consumers with no guaranteed benchmark for services and enforceable rights.

What types of plans rely on provider networks?

Preferred Provider Organizations (PPOs): Enrollees have the choice to get care from in-network or out-of-network providers. An enrollee pays less for care from an in-network provider and more if care is received from an out-of-network provider

Point of Service (POS) Plans: An enrollee can get care from an in-network or out-of-network provider. Enrollees must choose a primary care doctor from a list of participating doctors and that primary care doctor will make referrals to other providers if needed. Costs for a visit out of network may be higher than if it were in-network

Health Maintenance Organization (HMO): Enrollees are usually limited to getting care from providers who work for or contract with the HMO. Out-of-network care is not covered except in cases of emergency. If an enrollee uses a doctor or facility out-of-network they may have to pay the full costs of the services. Enrollees must have a primary care doctor and that doctor must give a referral before an enrollee may see a specialist

Accreditation: Helpful, but not a substitute for enforceable standards

Health insurance plans may opt to do accreditation for network adequacy through the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). NCQA and URAC differ in their assessments, but in general, insurance plans are accredited based on their established network access plans, goals and performance improvement. To become accredited the plans must include standards for access to medical care, primary care and emergency care. Although these accreditation processes are helpful, they are not a proxy for state oversight and regulation. For the NCQA accreditation process, each element of the accreditation process does not have to be met in order for a company to be accredited. Accreditation is achieved via a points scoring system, so a plan does not have to achieve points in network adequacy to become accredited. Also, accreditation is not a pass/fail system. A plan can be accredited even if it is at a low level that has far less or nothing achieved in network adequacy. Network adequacy issues still persist in Georgia because current standards and optional accreditation are insufficient.

RECENT POLICY ACTIVITY AROUND NETWORK ADEQUACY

In recognition that the major changes that have occurred in the health insurance market in recent years have implications for consumers and their access to care, policymakers at both the federal and state levels have identified network adequacy as an important issue requiring attention. According to existing federal law and regulation, provider networks must be adequate to ensure that consumers enrolled in a plan have reasonable access to all covered benefits. To be considered adequate, a network must provide adequate numbers, types, and geographic distribution of providers; must ensure that access to care is timely; and must include essential community providers that serve predominantly low-income, medically underserved individuals.⁴ Because of the dual role of federal and state governments with respect to health insurance regulation, however, how these network adequacy standards are defined and enforced is generally up to the states.

To assist states in developing new standards or bringing their existing standards up to date, the National Association of Insurance Commissioners (NAIC) updated its network adequacy model act in November 2015 after a lengthy process that included input from a range of stakeholders. The model act creates a framework that states can tailor to accommodate certain variations in insurance markets and regulatory authority among states and enact into law if they choose. Key provisions of the act include requiring state insurance regulators (rather than insurance companies) to determine network adequacy; giving states the option to set measurable, quantitative standards when setting criteria for network sufficiency (such as provider to covered person ratios by specialty, geographic accessibility of providers, or wait times for an appointment with an in-network provider); allowing enrollees to go out of network at no extra cost if the plan cannot provide access to an in-network provider without unreasonable travel or delay; requiring insurers to submit an access plan whenever they create a new network or make a material change to an existing network; guaranteeing continuity of care for enrollees whose providers leave or are removed from a network while they are in the middle of care for a serious condition; improving the accuracy and usability of provider directories by setting new standards; and limiting consumer exposure to surprise out-of-network medical bills.⁵

Here in Georgia, Senate Bill 158 (introduced in the 2015 Legislative Session) included network adequacy provisions and, while the legislation was not enacted that year, it sparked the creation of the Consumer and Provider Protection Act Study Committee that met throughout the fall of 2015 to examine a number of issues, including network adequacy. The study committee included state legislators and a range of stakeholders including representatives from the insurance industry, medical community, and consumer organizations. The committee's final report recommended developing a multi-stakeholder process to conduct a careful review of the NAIC model act and determine whether Georgia should develop legislation and/or regulations to address network adequacy based on this model act.⁶

“The committee recommends a careful review of model legislation recently promulgated by the National Association of Insurance Commissioners concerning these issues. This review should determine whether legislation, further regulation, and or additional appropriations for the Georgia Department of Insurance is needed to protect or provide an appropriate level of access to healthcare of the citizens of the State of Georgia. This review should involve the input of all stakeholders in the process, including consumer advocates, insurance/payer industry, provider industry, the Georgia Department of Insurance, other State of Georgia health related departments/divisions and the Georgia State Legislature.”

Final report of the 2015 Senate Study Committee on the Consumer and Provider Protection Act, voted on affirmatively by all committee members

While most of the recent policy activity around network adequacy has taken place at the NAIC and in the states, the United States Department of Health and Human Services, in its 2017 Benefit and Payment Parameters Proposed Rule, also included provisions around network adequacy. Notably, the proposed rule asks states participating in the Federally Facilitated Marketplace (including Georgia) to use quantifiable network adequacy metrics (time and distance standards as well as provider to enrollee ratios for certain specialties) and establishes a process for fallback standards in the event states don't adopt their own. This is still in proposed rule form and is subject to change as it goes through the federal rule-making process.⁷

CONSUMER PRINCIPLES FOR NETWORK ADEQUACY

Availability of Providers

One of the most important features of a health plan is the listing of covered services. Access to these covered services, however, is dependent on there being sufficient numbers and types of appropriate providers to deliver them. Health plans should maintain provider networks that have the right mix and the right number of providers to ensure enrollees have access to medically and culturally appropriate covered services in-network.

Timely Access to Care

Long wait times or travel distances interfere with access to appropriate and timely care. Health plans should maintain provider networks that can provide enrollees with access to care in a timely manner. Providers and facilities should be geographically accessible to where enrollees live or work.

Financial Protection & Affordability

One of the major functions of health insurance is to provide financial protection against high medical costs. Health plan enrollees should not have to pay out-of-network rates for medical services that are covered in their plan because the provider network is inadequate.

Transparency

Health care consumers should receive accurate information about health plans' provider networks. This means that provider directories, the primary tool enrollees and potential enrollees have to determine which providers are in-network, should be accurate and usable. Please see our companion policy brief on provider directories for more information about transparency.

POLICY RECOMMENDATIONS FOR NETWORK ADEQUACY

The health insurance market has changed rapidly over the past several years, yet the protections in place for Georgia consumers have not kept pace with these changes. Outdated and inadequate standards place health care consumers at risk of not being able to access the medical care they need in a timely manner or of facing out-of-network charges when they do. We encourage policymakers to set and enforce up-to-date network adequacy standards by adopting the National Association of Insurance Commissioners (NAIC) model act with appropriate modifications for Georgia. More specifically and within this context, Georgians for a Healthy Future supports the following policy recommendations for network adequacy.

1 Establish minimum requirements for provider-to-enrollee ratios by primary and specialty care that consider differences in rural, urban, and suburban areas.

To ensure availability of providers, the number of primary care physicians, specialists, labs, clinics, hospitals, and other medical facilities must be sufficient to accommodate the number of plan enrollees. Georgia policymakers should determine appropriate standards for our state.

2 Set maximum time and distance standards to ensure plan enrollees don't have to travel so far to receive care that this creates barriers to access.

Long travel times or distances can inhibit access to care. To accommodate the fact that there are fewer providers and more limited transportation options in rural communities, these standards should consider differences in urban, rural, and suburban areas to ensure they are realistic while ensuring meaningful access. There is precedent for such standards right here in Georgia through our Medicaid managed care plan standards, which can serve as a reference.

3 Set maximum appointment wait times to ensure timely access to care.

An important component of network adequacy is the ability to see a doctor for routine and urgent care without unreasonable delay. Georgia's Medicaid managed care standards for appointment wait times can serve as a reference, as can examples from other states.

4 Hold consumers harmless for out-of-network care when there is no in-network provider available without unreasonable travel or delay.

It is incumbent upon health plans to include providers that can deliver medical services for all covered benefit in their networks. If there are no providers to deliver needed care for a covered benefit, consumers should not be made financially worse off by the fact that they must go out-of-network. In these cases, plans should cover out-of-network care at in-network cost-sharing levels, and patients should not be balance billed.

5 Require plan networks to include providers that meet the needs of persons with limited English proficiency and other cultural and linguistic needs.

Cultural and linguistic needs should be considered when creating a provider network. Consumers typically seek care from providers who speak their language and understand their cultural and medical needs. Patients are also more likely to adhere to medical recommendations and have better outcomes when their provider can speak their language.

6 Plan networks should meet the needs of low-income and medically underserved enrollees by including Essential Community Providers (ECPs).

ECPs care for people who are predominantly low-income and underserved. Examples of ECPs include Federally Qualified Health Centers, Ryan White HIV/AIDS providers, and hemophilia treatment centers. These types of providers have historically played an important role in meeting the medical needs in underserved communities. Plans should be required to include at least thirty percent of available ECPs in each plan's service area and offer contracts in "good faith" to at least one ECP from each of the federally established ECP categories in each county in the service area where available. This would align with federal standards for the inclusion of ECPs in plans sold on the Health Insurance Marketplace.⁸

STATE EXAMPLES

CALIFORNIA



In California, a person enrolled in a managed care plan can expect that for every 1,200 enrollees there will be one physician. For every 2,000 enrollees there is one primary care physician.⁹

WASHINGTON



In Washington, people can expect to wait ten business days to see a primary care provider and fifteen days to see a specialist for a non-urgent visit.¹⁰

DELAWARE



In Delaware, a person can expect a plan to cover out-of-network care when there is not a sufficient number of providers that are geographically accessible and available within a reasonable period of time or at the request of a network provider when medically necessary services are not available in-network. In these scenarios, a provider may not balance bill the enrollee.¹¹

NEW MEXICO



In New Mexico, people enrolled in managed care plans are assured that the information and services available in their networks are in languages other than English and are provided in a manner that takes into account their cultural needs.¹²

CONCLUSION

Network adequacy is the connection between health insurance and access to care. Clear network adequacy standards provide consumers the protections they need and create a level playing field for health plans. Georgia's current standards are outdated and lack the specificity and comprehensiveness needed to protect and safeguard consumers. Georgia policymakers can and should set and enforce network adequacy standards that are appropriate for today's health insurance market by drawing upon the NAIC model act, best practices from other states, and the expertise of regulators, stakeholders, and consumer groups. Such standards can help keep the link between health insurance and access to care strong and ultimately improve the health of insured Georgians.

APPENDIX A

COMPARISON OF NETWORK ADEQUACY STANDARDS

	Law or Code	Regulatory Agency	Number and Types of Providers	Essential Community Health Providers	Enrollee to Provider Ratio	Geographic Access	Timley Access
Marketplace Plans (Qualified Health Plans)	Affordable Care Act	CMS	“sufficient”	minimum 30% of ECPs in the area	no standard	no standard	no standard
Managed Care Plans	Georgia Code Section 33-20A-5	Georgia DOI	“available and accessible”	no standard	no standard	“in the defined services area”	“reasonable promptness
NAIC Act	2015 NAIC The Health Benefit Plan Network Access and Adequacy Model Act	N/A	“sufficient and accessible without unreasonable delay”; include providers that serve cultural, specific needs	networks include providers that serve low income and medically underserved	ratios by primary care and specialty	geographic variations and dispersion	appointment wait times
Recommendations for Georgia	Georgia Code Section 33-20A-5 and DOI regulations	Georgia DOI	minimum quantitative standards	minimum 30% of ECPs in the area	ratios by primary care and specialty (consider urban, rural and suburban areas for urgent/ non-urgent care)	maximum travel distance for primary care and specialty (consider urban, rural and suburban areas for urgent/ non-urgent care)	maximum appointment wait times for routine and urgent care in urban, rural and suburban areas

APPENDIX B

QUALIFIED HEALTH PLANS ON INSURANCE EXCHANGES

The ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish criteria for the certification of health plans as Qualified Health Plans (QHPs) to be offered on a state's health insurance Exchange. These criteria include requirements to:

- » Ensure a sufficient choice of providers;
- » Provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers, and providers not accepting new patients, online and in hard copy upon request; and
- » Include within plan networks essential community providers, where available, that serve low income and medically underserved individuals

Final rules published by HHS in 2012 elaborate on network adequacy requirements for QHP issuers to maintain a provider network that meets the following standards:

- » Includes essential community providers in accordance with 45 CFR § 156.235;
- » Is sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without reasonable delay; and
- » Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act

For 2016 plans, QHPs must publish provider directories that are “up-to-date, accurate, and complete”. The directories must include:

- » The provider's location
- » The provider's contact information
- » The provider's specialty
- » The provider's medical group
- » Any of the provider's institutional affiliations

APPENDIX C

HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2017 (PROPOSED RULE)

State minimum network Adequacy changes proposed

- » FFE/FFM are required to use quantifiable NA standards to determine adequacy
- » HHS will determine if a FFE/FFM has acceptable quantifiable metrics if the state selects one or more of the standards from the HHS list; assessment will be done in advance of the certification cycle
- » HHS will provide guidance with metrics that can be used later but the list of metrics will include at least time:
 - Distance standards
 - Minimum provider-enrollee ratios for the specialists that have the highest utilization rates in the State (may not include in-hospital physicians)
- » In states that don't review QHPs for NA, HHS proposes a Federal default standard to be a time and distance standard calculated at the county level (-Medicare Advantage method); county-specific parameters will be included in annual letter to issuers
- » Issuers may submit a justification if unable to meet set standards and the FFE/FFM will determine if it is reasonable

Additional network adequacy standards

- » Issuers are required to notify an enrollee 30 days prior to the effective date of change or otherwise as soon as practicable, when there is a discontinuation in network coverage of a provider that they regularly see
- » Issuers are encouraged to notify enrollees of other comparable in-network providers in their service area
- » Issuers are required to ensure continuity of care until treatment is completed or for up to 90 days (whichever is shorter), at in-network cost-sharing rates, when a provider is terminated without cause for 4 scenarios: when receiving on-going treatment for life-threatening condition, a serious acute condition, for a condition that would worsen or interfere with outcomes or in the 2nd or 3rd trimester of pregnancy
- » If an enrollee received care from an OON provider for an EHB in an in-network setting, and was charged OON cost-sharing rates, that cost-sharing would apply towards the annual limitation on cost-sharing; does not protect enrollee from OON cost-sharing, BB for non-EHB services received from OON providers
- » The plan may provide written notice to the enrollee about potential OON costs incurred (probably during preauthorization) at least 10 business days before the service is provided; if a plan fails to disclose this notice the OON cost-sharing incurred must be applied toward the enrollees' out-of-pocket limit
- » HHS is also considering providing HealthCare.gov a rating of each QHPs relative network coverage
- » FOR QHP certification cycles beginning in 2018, HHS is considering allowing plans to count multiple contracted full-time equivalent ECPs practicing at a single location as separate ECPs for meeting ECP participation ratios

APPENDIX D

§ 33-20A-5. STANDARDS FOR CERTIFICATION

The Commissioner shall establish standards for the certification of qualified managed care plans that conduct business in this state. Such standards must include the following provisions:

(1) Disclosure to enrollees and prospective enrollees.

(A) A managed care entity shall disclose to enrollees and prospective enrollees who inquire as individuals into a plan or plans offered by the managed care entity the information required by this paragraph. In the case of an employer negotiating for a health care plan or plans on behalf of his or her employees, sufficient copies of disclosure information shall be made available to employees upon request. Disclosure of information under this paragraph shall be readable, understandable, and on a standardized form containing information regarding all of the following for each plan it offers:

(i) The health care services or other benefits under the plan offered as well as limitations on services, kinds of services, benefits, or kinds of benefits to be provided, which disclosure may also be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(ii) Rules regarding copayments, prior authorization, or review requirements including, but not limited to, preauthorization review, concurrent review, postservice review, or postpayment review that could result in the patient's being denied coverage or provision of a particular service;

(iii) Potential liability for cost sharing for out-of-network services, including, but not limited to, providers, drugs, and devices or surgical procedures that are not on a list or a formulary;

(iv) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket expenses for items and services (both in and out of network);

(v) The number, mix, and distribution of participating providers. An enrollee or a prospective enrollee shall be entitled to a list of individual participating providers upon request, and the list of individual participating providers shall also be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(vi) Enrollee rights and responsibilities, including an explanation of the grievance process provided under this article;

(vii) An explanation of what constitutes an emergency situation and what constitutes emergency services;

(viii) The existence of any limited utilization incentive plans;

(ix) The existence of restrictive formularies or prior approval requirements for prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon request, to a description of specific drug and therapeutic class restrictions;

(x) The existence of limitations on choices of health care providers;

(xi) A statement as to where and in what manner additional information is available;

(xii) A statement that a summary of the number, nature, and outcome results of grievances filed in the previous three years shall be available for inspection. Copies of such summary shall be made available at reasonable costs; and

(xiii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, that such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan.

(B) Such information shall be disclosed to each enrollee under this article at the time of enrollment and at least annually thereafter.

(C) Any managed care plan licensed under Chapter 21 of this title is deemed to have met the certification requirements of this paragraph.

(D) A managed care entity which negotiates with a primary care physician to become a health care provider under a managed care plan shall furnish that physician, beginning on and after January 1, 2001, with a schedule showing fees payable for common office based services provided by such physicians under the plan;

(2) Access to services. A managed care entity must demonstrate that its plan:

(A) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner that promotes continuity in the provision of health care services, including continuity in the provision of health care services after termination of a physician's contract as provided in Code Section 33-20A-61;

(B) When medically necessary provides health care services 24 hours a day and seven days a week;

(C) Provides payment or reimbursement for emergency services and out-of-area services; and

(D) Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out of network health care providers and hospitals

APPENDIX E

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) THE HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT

In 2015 the National Association of Insurance Commissioners (NAIC) updated the Managed Care Plan Network Adequacy Model to assist insurance regulators in setting standards for managed care plan provider networks. The Health Benefit Plan Network Access and Adequacy Act provides the following framework provisions for states to consider when setting network adequacy and provider directory standards:

Network adequacy

- » 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
- » Covered persons shall have access to emergency services twenty-four (24) hours, seven (7) days a week
- » The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:
 - Provider-covered person ratios by specialty;
 - Primary care professional-covered persons ratios;
 - Geographic accessibility of providers;
 - Geographic variation and population dispersion;
 - Waiting times for an appointment with participating providers;
 - Hours of operation;
 - The ability of the network to meet the needs of covered persons, which may include low-income persons, children, adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;
 - Other health care service delivery options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and
 - The volume of technological and specialty care services available to serve the needs of covered person requiring technologically advanced or specialty care services

- may be determined by the insurance company based upon provider-to-enrollee ratios, geographic accessibility, waiting times for appointments, hours of operation, supply of technology and special services, and other criteria
- » A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when the network does not a type of provider available to provide a covered benefit or a sufficient number of providers to provide a covered benefit without unreasonable travel or delay

Provider directory

- » A health carrier shall post electronically a current and accurate provider directory for each of its network plans with information and search functions (see below)
- » In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab without creating or accessing an account or entering a policy contract
- » The health carrier shall update each network plan provider directory at least monthly
- » The carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request
- » A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information (see below) upon request of a covered person or prospective covered person
- » For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:
 - A description of the criteria the carrier has used to build its provider network
 - If applicable, a description of the criteria the carrier has used to tier provider

- » A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency
- » The health carrier shall make available through an electronic directory, for each network plan, the following information in a searchable format: for health professionals- name, gender, participating office location(s), specialty (if applicable), medical group affiliations (if applicable), facility affiliations (if applicable), participating facility affiliations (if applicable), languages spoken other than English (if applicable) and whether accepting new patients. For hospitals- hospital name, type, participating hospital location, and accreditation status. For facilities other than hospitals by type- facility name, type, types of services performed, and participating facility location(s).
- » For electronic provider directories for each network plan, a health carrier shall make available the following information in addition to all of the information listed above: for health care professionals- contact information, board certification(s), and languages spoken other than English by clinical staff (if applicable). For hospitals- telephone number. For facilities other than hospitals- telephone number.
- » The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan: for health care professionals- name, contact information, participating office location(s), specialty (if available), languages spoken other than English (if applicable), and whether accepting new patients. For hospitals- hospital name, type, participating hospital location and telephone number. For facilities, other than hospitals, by type- facility name, type, types of services performed, and participating facility location(s) and telephone number.
- » The health carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website of the appropriate customer service telephone number to obtain current provider directory information.

END NOTES

- ¹ Hoadley J, et al. California HealthCare Foundation. Unexpected Charges: What States Are Doing About Balance Billing. April 2009
- ² UPenn Leonard Davis Institute of Health Economics. State Variation in Narrow Networks on the ACA Marketplaces. August 2015, <http://kff.org/private-insurance/issue-brief/surprise-medical-bills/>
- ³ O.C.G.A. § 33-20A-5, “Managed Health Care Plans Patient Protection”
- ⁴ 42 U.S. Code § 18031, “Affordable Choices of Health Benefit Plans”; 45 CFR § 156.230, “Network Adequacy Standards.”
- ⁵ Health Benefit Plan Network Access and Adequacy Model Act, National Association of Insurance Commissioners, <http://www.naic.org/store/free/MDL-74.pdf>
- ⁶ Final Report of the Senate Study Committee on the Consumer and Provider Protection Act, <http://www.senate.ga.gov/sro/Documents/StudyCommRpts/2015ConsumerProviderProtectionActFinal.pdf>
- ⁷ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 available at <https://www.federalregister.gov/articles/2015/12/02/2015-29884/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>
- ⁸ 42 U.S. Code § 18031, “Affordable Choices of Health Benefit Plans”; 45 CFR § 156.235
- ⁹ California: 10 CCR § 2240.1, “Adequacy and Accessibility of Provider Services,” implementing California law CA INS § 10133.5, “Contracts with Providers for Alternative Rates; Regulations; Guidelines; Reports”; 28 CCR § 1300.67.2, “Accessibility of Services.”
- ¹⁰ Washington: Washington State Office of the Insurance Commissioner, Insurance Commissioner Matter No. R 2013-22 (Olympia: Washington State, April 26, 2014), available online at <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf>.
- ¹¹ Delaware: 18 Del. Admin. C. § 11.3.1.2
- ¹² New Mexico: N.M. Admin Code 13.10.22.11, “Managed Health Care Plan Compliance: Cultural and Linguistic Diversity.”



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