STATE LEGISLATIVE BRIEF

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

The NAIC Network Adequacy Model Act

- *The NAIC Health Benefit Plan Network Access and Adequacy Model Act* (#74) *has been amended to strengthen protections for consumers while balancing the need for health insurance carriers to promote quality and reduce costs.*
- *The federal Affordable Care Act (ACA) requires Qualified Health Plans sold on the Exchanges to meet network adequacy standards. Currently, state standards have been deemed sufficient. However, the federal government has been considering establishing federal standards that would be applied in all states that use the federal Exchange. These "one-size-fits-all" standards would be applied unless the state has established its own standards based on the NAIC Model Act.*
- *The NAIC Model provides significant latitude for states to establish appropriate network adequacy measures that take into account the state's geography, density, and markets.*
- *Regardless of any changes that may be made at the federal level to the ACA, the issue of network adequacy isn't going anywhere and many states will still need to act.*

Background

In 2013, the NAIC began reviewing existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, it was clear that revising the *Managed Care Plan Network Adequacy Model Act* (#74) was a priority for regulators, health carriers and consumers. Soon after completion of this review process, the NAIC learned that the federal Center for Consumer Information and Insurance Oversight (CCIIO) was considering adopting regulations to establish federal network adequacy standards – a possible one-size-fits-all national standard. Realizing that a federal one-size-fits-all national standard would not benefit consumers or health carriers and that state insurance regulators are best positioned to balance cost, access and geographic considerations when developing network adequacy standards so that consumers can access promised services without unreasonable travel or delay, the NAIC made revising Model #74 an immediate priority.

In May 2014, an NAIC Subgroup began meeting via conference call to consider revisions to Model #74. In November 2014, the Subgroup released an initial draft of proposed revisions for comment. In response, the Subgroup considered over 100 comment letters and discussed a myriad of issues, including how to deal with tiered networks, provider directory information and accuracy, surprise bills received by consumers for out-of-network services provided at participating facilities, essential community providers (ECPs) and limited scope dental and visions benefit plans. The Subgroup released a second draft in August 2015. The Subgroup subsequently adopted revisions to Model #74 in October 2015 and the full NAIC membership adopted the final Model unanimously in November 2015.

Key Points

The revisions to Model #74 include a number of enhancements:

- ✓ Application of network adequacy standards to any health carrier that uses a network plan, which is defined broadly in order to apply to health benefit plans using any type of requirement or incentive for covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other innovative delivery system models.
- ✓ New requirements concerning network sufficiency, how network sufficiency is to be determined, and who is to determine network sufficiency.
- ✓ Quantitative standards, such as time and distance and provider/patient ratios, are to be determined by each individual state.
- ✓ A new section concerning what information to include in provider directories and a requirement for carriers to periodically audit them.
- ✓ A new section establishing a mechanism for consumers to deal with bills they received for services provided by out-of-network facility-based providers while receiving treatment at an in-network facility and establishing a mediation process for providers to dispute payments.

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