Hogan Lovells

Health Alert
3 December 2015

See note below about Hogan Lovells

Print Forward

CMS Proposes Network Adequacy Standards for 2017 as State Regulators Approve Network Access and Adequacy Model Law

On November 22, 2015, the National Association of Insurance Commissioners (NAIC) approved new standards designed to ensure that consumers have adequate access to doctors, hospitals, and other health care providers under health benefit plans that use provider networks. That action was the culmination of nearly two years' work by state insurance regulators, with input from health insurance carriers, health care providers, consumer representatives, and others. The standards take the form of extensive amendments to an NAIC model law. Each state may choose to enact the amended model law, enact it with modifications, or disregard it entirely.

Meanwhile, on November 20, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a proposed Notice of Benefit and Payment Parameters for 2017 qualified health plans (QHPs), including proposed network adequacy standards (the Notice). CMS acknowledged the NAIC's work in the area of network adequacy, and committed to considering the NAIC's final recommendations as it assesses its proposed network adequacy protections.

Here, we provide an overview of three aspects of these two sets of proposed network adequacy standards: determining network adequacy, continuity of care requirements, and limitations on out-of-network cost sharing in certain situations.

Determining Network Adequacy

NAIC Model Law Approach

The amended model law requires all health insurance carriers that issue health benefit plans using provider networks to obtain a determination from the state insurance commissioner that those networks are adequate. It expands the factors an insurance commissioner may consider in making network adequacy determinations, including, among others, primary care and specialty provider-to-enrollee ratios; provider geographic accessibility; geographic variation and population dispersion; appointment waiting times; hours of operation; and the network's ability to meet the needs of enrollees, "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."

Carriers must have a written "access plan" to assure that an enrollee receiving services from an out-of-network provider obtains covered benefits at in-network levels, including in-network cost sharing obligations, when the carrier does not have a type of participating provider available to furnish the covered benefit to the

Contacts

Melissa Bianchi
Partner, Washington, D.C.
melissa.bianchi@hoganlovells.com
+1 202 637 3653

Ken Choe
Partner, Washington, D.C.
ken.choe@hoganlovells.com
+1 202 637 5675

Therese Goldsmith
Partner, Baltimore
therese.goldsmith@hoganlovells.com
+1 410 659 5071

enrollee without unreasonable travel or delay. Carriers also must make available to the public a plain language description of the standards used to select participating providers and to assign them to "tiers" with different reimbursement, cost sharing, or provider access requirements.

CMS Proposal

Under existing federal regulations, each QHP issuer that uses a provider network must ensure that it "maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." 45 CFR § 156.230(a)(2). The Notice proposes that QHPs in a federally-facilitated exchange (FFE) [1] could meet that standard in one of two ways. First, the QHP could satisfy a network adequacy metric established by a state that "implements an acceptable quantifiable network adequacy metric commonly used in the health insurance industry to measure network adequacy." A metric is "acceptable" if it is included in a list of metrics that the Department of Health and Human Services (HHS) includes in an annual Letter to Issuers. HHS expects to include metrics related to prospective time and distance standards as well as prospective minimum provider-to-enrollee ratios for the specialties with the highest utilization rate in the respective state.

If a state does not select a network adequacy standard acceptable to HHS, the FFE would apply a federal default time and distance standard. In the preamble to the proposed Notice, CMS explains that it expects to calculate a time and distance standard at the county level, and to evaluate QHP issuer networks "on the numbers and types of providers, in addition to their general geographic location." The details of the federal default standard also will be set forth annually in conjunction with the Letter to Issuers. QHPs that cannot meet the federal default standard could satisfy network adequacy requirements by "reasonably justifying variances from [the] standard based on such factors as the availability of providers and variables reflected in local patterns of care." CMS noted that its default standard would be "consistent with the levels generally maintained in the market today, so that generally a very small number of plans would be identified as having networks deemed inadequate."

Continuity of Care

NAIC Model Law Approach

The amended model law requires carriers and participating providers to give each other at least 60 days written notice before the provider is removed from or leaves the network without cause. Further, it requires carriers to make a good faith effort to give enrollees written notice that a provider will be leaving the network within 30 days of the carrier's receipt of the 60-day notice from, or issuance of the 60-day notice to, the provider.

Carriers must establish reasonable procedures to transition an enrollee who is in an active course of treatment to a participating provider in a manner that provides for continuity of care. An "active course of treatment" is (1) an ongoing course of treatment for a life-threatening condition; (2) an ongoing course of treatment for a serious acute condition; (3) the second or third trimester of pregnancy; or (4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. The terms "life-threatening health condition" and "serious acute condition" also are defined in the amended model law.

If an enrollee wants to continue receiving care at in-network cost sharing rates from a provider that is leaving the network, the enrollee or the enrollee's authorized representative must request that the carrier provide a continuity of care period. For enrollees who are in their second or third trimester of pregnancy, the continuity of care period must extend through the post-partum period. For other enrollees undergoing an active course of treatment, the period must extend to the earliest of five events: (1) the enrollee or treating provider terminates the course of treatment; (2) the expiration of 90 days (or such other period as a state may determine is appropriate), unless the carrier's medical director determines that a longer period is necessary; (3) care is successfully transitioned to a participating provider; (4) benefit limitations under the plan are met or exceeded; or (5) care is not medically necessary.

A carrier may grant a continuity of care request only when the provider leaving the network agrees in writing to accept in-network payment rates and to hold the enrollee harmless for any payment amount for which the enrollee would not have been responsible if the provider were still an in-network provider.

CMS Proposal

Similar to the notice period in the amended model law, CMS proposes to require QHP issuers in FFEs to make a good faith effort to notify enrollees 30 days before a provider leaves the network, or otherwise "as soon as practicable," if the enrollee receives primary care from the provider or is seen by the provider "on a regular basis." The proposed Notice seeks comments on an appropriate definition of "regular basis" and on the proposed timeframe for notification.

CMS also proposes that FFE QHP issuers ensure continuity of care where a provider is terminated from a network without cause by allowing an enrollee in "active treatment" to continue treatment until it is completed or for 90 days, whichever is shorter, at in-network cost sharing rates. The proposed rule defines "active treatment" in a manner identical to the definition of "active course of treatment" in the NAIC's amended model law. CMS seeks comments on defining "active treatment," "life-threatening condition" and "serious acute condition"; whether exceptions should be allowed for existing state continuity of care standards; whether continuity of care requirements for enrollees in their second or third trimester of pregnancy should be extended through the post-partum period; and whether continuity of care requirements should extend to QHPs in all exchanges, rather than being limited to QHPs in FFEs.

Limitation on Out-of-Network Cost Sharing

NAIC Model Law Approach

The NAIC's amended model law includes a provision intended to address "surprise bill" situations in which an enrollee receives services at a participating facility from a non-participating facility-based provider, such as a pathologist, anesthesiologist, radiologist, or emergency room physician. If the difference in the non-participating provider's billed charge and the plan's allowable amount is more than $500, the carrier has the option of paying the billed charge amount or a benchmark amount set by the state. The benchmark is presumed to be reasonable if it is based on the higher of the carrier's in-network rate or a prescribed percentage of the Medicare rate for the same or similar services in the same geographic area. States may choose to use other benchmark reimbursement methodologies, such as a percentage of usual, customary, and reasonable charges in the state. Non-participating providers objecting to the application of the benchmark rate may avail themselves of a mediation process to be established by the carrier.

CMS Proposal

In another effort to address "surprise bills" from out-of-network facility-based physicians at in-network facilities, the proposed Notice provides that a QHP network will be "deemed adequate" only if the QHP (1) counts cost sharing paid for an essential health benefit (EHB) furnished by an out-of-network provider in an in-network setting toward the enrollee's annual limitation on cost sharing; or (2) provides the enrollee with written notice at least 10 business days before the EHB is furnished that the enrollee may incur additional costs for an EHB provided by an out-of-network provider in an in-network setting, unless those costs are prohibited under state law, and that those additional costs may not count toward the annual limitation on cost sharing. As proposed, this limitation would apply to all QHPs in all exchanges.

Comments on the proposed Notice are due no later than 5:00 P.M. on December 21, 2015.

1 For 2016, 27 States have FFEs. *See* Kaiser Family Foundation, State Health Facts: State Health Insurance Marketplace Types, 2016, *available at* http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

So that we can send you this email and other marketing material we believe may interest you, we keep your email address and other information supplied by you in a database. The database is accessible by all Hogan Lovells offices, which includes offices both inside and outside the European Economic Area (EEA). The level of protection for personal data outside the EEA may not be as comprehensive as within the EEA.

To stop receiving email communications from us please click here.