ACA Consumer Protections and Regulatory Oversight of Network Adequacy, Balance Billing

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Affordable Care Act Network Adequacy Requirements

ACA requires HHS to establish following network adequacy requirements for Qualified Health Plans sold on Exchange:

• Ensure a sufficient choice of providers
• Provide information to enrollees and prospective enrollees on the availability of both in-network and out-of-network providers
• Include essential community providers that serve predominately low-income, medically-underserved individuals
HHS Regulations re. Network Adequacy Requirements

- HHS regulations for network adequacy within QHPs largely delegate oversight of network adequacy requirements and compliance to states operating the Exchange/Marketplace.

- Preamble of federal rule notes following policy goals and considerations:
  - Exchange should have discretion in how to ensure sufficient care.
  - QHPs must provide sufficient access to providers.
  - Network adequacy standards should reflect local geography, demographics, patterns of care and market conditions.
  - A national standard could misalign standards inside and outside the Exchange.
Choice of Health Care Professional

- Plans with networks must allow an individual to choose his/her primary care physician (PCP); if plan automatically assigns a PCP, individual must be notified of their right to change designation
- Plans may not require women to obtain preauthorization or referral for visit to OB/GYN
- Plans must provide notice of these rights to enrollees

Formulary Protections

- Plans must have procedures that allow patients to obtain “clinically appropriate” prescriptions not on the formulary; important distinction in “gain access to” and not simply request a drug
ACA Patient Protections: Coverage of Emergency Services

For patients receiving emergency services:

• Plans may not require preauthorization, regardless of whether facility or provider is in-network or out-of-network

• Copayments and coinsurance must be the same for services regardless of whether in-network or out-of-network

• Deductibles or out-of-pocket maximums applicable to out-of-network services may only be applied to emergency services if the requirement applies generally to out-of-network care, and must be applied towards the overall non-network services cost sharing requirements; in other words, no separate cost sharing for emergency out-of-network care
ACA Patient Protections:
Balance Billing of Emergency Services

To reduce the occurrence of balance billing for emergency services:

• Plans must pay the greatest of these three amounts:
  • The amount the plan would pay in-network providers
  • A payment that is calculated using the method the plan normally uses to pay for other out-of-network services (such as usual, customary and reasonable charges), but applying the in-network cost-sharing provisions; or
  • The amount Medicare would pay for the service

• Providers may balance bill patients for charges not paid by the health plan, but plans must pay a “reasonable amount” to providers before a patient is responsible
ACA Patient Protections: Nondiscrimination Requirements

ACA prohibits discrimination but regulations are vague as to interpretation and enforcement. Potential patient protections, depending on how regulators respond, could include:

- Requirement to include specialists who treat patients with specific disabilities/medical conditions
- Limitations on use of tiered networks if services are limited in a way that impacts individuals with disabilities
  - Should individuals be allowed to change plans mid-year if access to care is an issue?
- Coverage of out-of-network services at no additional cost to enrollee if medically necessary services are not available in-network
ACA Protections:
Claims and Benefit Appeal Standards

• ACA requires all plans in both group and individual market (including self-funded plans) to establish internal and external appeals process for coverage determinations and claims

• Plans must provide notice of appeal options to enrollees

• Enrollees may review their files, present evidence and testimony and receive continued coverage pending the outcome

• Additional requirements for emergency appeals
State Regulatory Requirements for Health Plan Network Adequacy

- Requirements differ by type of plan
  - HMO requirements more rigorous due to lack of coverage for out-of-network care
  - PPO requirements are generally less restrictive and allow more flexibility, less oversight by regulators
  - EPOs – somewhere in between

- Regulations may include
  - Time/distance requirements for patient access to care; difficult in states with large rural areas
  - Provider/enrollee ratios; may or may not vary based on type of specialty
  - Maximum average wait time for appointments
  - Percentage of providers accepting new patients
  - Access plan for situations where patients cannot obtain necessary services
Network Adequacy Requirements for Exchange vs. Non-Exchange Plans

- Network Adequacy requirements may differ for Exchange plans and non-Exchange plans; will vary by state
- In states operating the Exchange, the Exchange/state determines specific network adequacy requirements for plans and provides reviews for QHP certification
- For states with federally-facilitated Exchange:
  - HHS has delegated network adequacy reviews and approvals to states if they have an effective network adequacy review process
  - If state does not have an effective review process, HHS accepts health plans attestation if issuer is accredited; if not accredited, HHS requires plan to submit an access plan
Regulatory Review Process of Network Adequacy Compliance

• NAIC model establishes standards for insurance regulatory oversight of network adequacy, but state compliance varies significantly among state insurance departments
• Model recommendations for network adequacy analysis include at least an annual review of:
  • provider availability in each specific geographic service area (Texas has 26 separate service areas)
  • Medical care referral patterns and hospital admission privileges
  • Status of hospital-based providers and affiliations with in-network hospitals; whether in-network hospitals have exclusive contracts with hospital-based providers
  • Location and availability of essential community providers
  • Availability and accessibility of centers of excellence and specialty providers, including trauma centers, burn units, pediatric hospitals
Regulatory Enforcement of Requirements for Network Adequacy Varies Significantly

• Review process used by states varies considerably by state and by type of plan
• Factors contributing to state variations in oversight:
  • Insufficient staff
  • Lack of adequate training to conduct comprehensive analysis
  • Time limitations for review of policy form filings, including network composition and network adequacy reviews
  • Lack of Geo-Access software, or limitations in software, that limit ability to evaluate network adequacy
  • Lack of specificity in network adequacy requirements
  • Enforcement priorities and difficulty proving network adequacy violations
Early Response to Network Adequacy Concerns

- Numerous law suits by providers excluded from plans, particularly narrow networks
  - Plans are upfront: they’re competing on cost
  - Types of excluded providers include teaching hospitals/academic centers, children’s hospitals, facilities that serve large Medicaid and Medicare populations
  - Seattle Children’s hospital has sued state regulators; most Washington Exchange plans have excluded its services, including acute cancer care not available at any other facility in state
  - In Maine, state has used “reasonable access” standards and “best interest of the consumer” standard in decisions regarding network adequacy
- Expect revisions in network adequacy requirements in future; HHS has stated plans to review in future
ACA and Balance Billing

- With exception of emergency services, ACA is silent re. balance billing for out-of-network claims
- ACA assumes network adequacy provisions will minimize need to go out-of-network
- Out-of-network payments do not count towards deductibles or maximum out-of-pocket limitations
- Consumer options:
  - Challenge balance billing with provider and health plan, particularly in cases where they did not choose an out-of-network provider
  - Question health plan’s calculation of payment amount
State Approaches to Balance Billing

- States struggle to address problem; approaches vary for HMOs, PPOs
- NAIC and National Conference of Insurance Legislators (NCOIL) conducted extensive studies and issued recommendations
- **HMO balance billing restrictions** enacted by states according to 2010 Kaiser Family Foundation study:
  - 49 states and DC prohibit HMO in-network providers from balance billing HMO enrollees
  - 9 states restrict out-of-network providers from balance billing HMO enrollees
    - California prohibits balance billing for ER services
    - Illinois and New York prohibit ambulance service providers from balance billing HMO enrollees
    - Connecticut prohibits providers from billing any managed care enrollee for services covered under the managed care plan, except for copayments or deductibles; balance billing is considered an unfair trade practice
• **State Restrictions on PPO balance billing:**
  • 24 states prohibit in-network provider from balance billing **PPO** patients
  • 4 states prohibit or restrict balance billing by out-of-network providers
    • California restricts balanced billing for emergency services
    • Delaware prohibits out-of-network providers from billing for certain emergency services, medically necessary covered services not available through network providers, and medically necessary covered services not available within a reasonable time frame
    • New York prohibits balance billing by ambulance service providers
    • Connecticut prohibits balance billing by any provider for services covered under a managed care plan
Texas Balance Billing and Network Adequacy Regulations

- Following several failed attempts at balance billing legislation, Texas Legislature enacted “transparency” legislation (SB 1731) designed to provide consumers with information necessary to avoid balance billing, or make informed decisions about health care.
- Includes insurer disclosure requirements related to occurrence of out-of-network services.
- Notices to consumers regarding in-network facilities using out-of-network providers.
- Prospective estimates of health plan reimbursement for services.
- Publication of annual HMO/PPO consumer report.
- Mediation of out-of-network claims of $1,000 or more.
Texas Study of Balance Billing

- SB 1731 also created advisory committee on network adequacy and balance billing; mandated study and recommendations
- Committee included equal representation of health plans, hospitals, physicians
- Collected and analyzed out-of-network claims data that showed significant variations in claims costs and health plan reimbursement methodologies for out-of-network claims
- Virtually no agreement on a single solution or recommendation among advisory group
  - Commissioner of Insurance eventually used existing authority to adopt network adequacy requirements designed to reduce balance billing
  - Enforcement of regulations delayed by new commissioner
Challenges of Developing Solutions to Balance Billing Problem

• Joint problem of hospitals, providers and insurance plans, but most states do not regulate billing practices of hospitals and providers, and cannot solve problem solely through insurance regulations

• Prevalence of balance billing is unknown; most states do not collect information necessary to identify extent of problem and justify regulations

• Reluctance of legislators and regulators to regulate payment and contracting issues; area of commerce typically left to the market to determine

• Difficult to establish standards that apply to situations where patient chooses to go out-of-network vs no other choice
Key Issues to Monitor

• Composition and use of tiered networks, access to specialty care, and outcome of litigation
• Changes in network provider participation (reduction in number of providers)
• Enrollment growth and corresponding changes in network providers (are networks increasing providers to keep up with demand)
• Accreditation requirements related to network adequacy
• Reporting of out-of-network costs by insurers and potential balance billing
• Consumer complaints related to access to care, patient satisfaction surveys (i.e., CAHPS)
• Non-discrimination challenges and interpretations of ACA requirements as they apply to network adequacy/access to care
• HHS review of network adequacy requirements and potential changes
Questions and Contact Info

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