Consumer Protections in NCQA Health Plan Accreditation

Strong consumer protection is essential to NCQA's vital mission of improving health care quality through measurement, transparency and accountability. We can only achieve the "triple aim" of improving people's experience of care, improving population health, and reducing overall costs if strong consumer protections are woven throughout our work. That is why the NCQA "gold-standard" health plan ratings measure a long list of essential consumer protections, from fair marketing to sound coverage decisions, access to care, timely appeals and more. Close to 500 health plan products – covering over 107 million Americans – make the extra effort to earn NCQA's prized Accreditation. They do so by achieving high scores on how well they provide these protections and other essential insurance elements. That is one reason why so many employers, states and federal programs require or encourage NCQA Accreditation.

Fair Marketing: We require plans to accurately and thoroughly communicate with prospective members. We evaluate how well they explain what is covered, provider availability, any network, benefit or service restrictions, and how they make coverage decisions.

Member Rights and Satisfaction: Plans must clearly inform members of their rights and responsibilities, including to be treated with respect, participate in treatment decisions, complain and appeal. Plans must demonstrate how they protect members' privacy and how members can access and request amendments to, restrictions on or accountings of how their personal health information is used and disclosed. Plans must assess members' linguistic needs, provide interpreters or bilingual services based on those needs, and offer information on what languages providers speak. Plans also must survey members' experience using the Consumer Assessment of Health Plans Survey (CAHPS), monitor complaints and appeals, and explain the steps they will take to fix problems.

Quality: We score plans on both their clinical quality and member experience of care. They must have programs to monitor and improve quality – including patient safety – take action when quality problems are identified, and inform members and providers about this at least annually. They must identify and notify prescribers about harmful drug interactions, and promptly notify members and providers about drug recalls for patient safety reasons. They must ensure that their network providers meet appropriate credentialing standards. And they must have patient-centered, evidence-based case and disease management programs for patients who both need and want them.

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Coverage: We require plans to make fair, impartial and consistent coverage decisions. They must use sound clinical evidence to establish formularies and administer drug benefits. They must have qualified professionals make timely decisions taking clinical evidence, individual circumstances and local delivery systems into account. They must clearly communicate reasons for denials, provide written policies on which denials are based, and offer knowledgeable staff to provide further explanations.

Very importantly, plans also must not reward employees or providers for denying care. They must track consistency and address any inconsistencies in coverage decisions, and regularly evaluate new treatment developments.

Access: Plans must explain benefits and help members track the status of claims, including out-of-pocket costs, by phone and internet. They must provide timely access to non-preferred drugs when clinically necessary. They must have a rigorous process to select and evaluate practitioners – including review of sanctions and malpractice. We require plans to assess the adequacy of provider networks and score them on consumer reported access. We also require emergency care coverage under the "prudent layperson" standard.

We prohibit plans from restricting what treatment options providers can discuss with patients. When plans discontinue provider contracts, they must let enrollees getting active treatment from those providers continue seeing them for at least 90 days. We evaluate how well plans help members with multiple or complex conditions to obtain access to care and services and coordinate their care.

Appeals: Plans must explain appeal rights every time they deny coverage – not just when members file an appeal. These explanations must include the rights to: appeal any adverse decision, representation, copies of all relevant documents, language services, and submit additional information. Plans must give members at least 180 days to file appeals and respond within specific timeframes based on how urgently care is needed. Appeals must be reviewed by professionals who have the same or similar training and experience as the treating provider. These reviewers must be different from and not subordinate to the ones who made the initial denial.

We review whether plans provide easy-to-understand written explanations of appeal decisions, including policies on which they were based, qualifications of the reviewers and clear descriptions of the next level of appeal. We allow no more than two levels of internal appeals before plans must provide access to free, independent review organizations for binding decisions. And we document that the plan implemented the independent appeal decision.

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