Association of American Cancer Institutes (AACI)

Suggested Revisions to Section 5 of the Health Benefit Plan Network Access and Adequacy Model Act

Section 5. Network Adequacy

A. A health carrier providing a network shall maintain a network that is sufficient in numbers and types of providers, including primary and specialty providers and facilities, to assure that all services to covered persons will be accessible in a timely manner appropriate for the covered person’s condition and without unreasonable delay or administrative barriers to access. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.

B. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria, including but not limited to: provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; geographic population dispersion; waiting times for visits with participating providers; hours of operation; new health care service delivery options, such as telemedicine or telehealth; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

C. 1. A health carrier’s network shall provide each covered person with an adequate number and choice of health care providers and facilities to ensure that they have access to all covered benefits. Providers that meet the criteria under the Affordable Care Act for designation as essential community providers shall be included in the provider network. Provider networks shall also include at least one National Cancer Institute (NCI)-designated cancer center or cancer center that is a member of the Association of American Cancer Institutes (AACI).

D. 1. A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

   a. The health carrier has a sufficient network, but has determined that it does not have a type of participating provider available to provide the covered benefit to the covered person; and

   b. The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person.

2. The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-participating out-of-network provider as provided in Paragraph (1) when:

   a. The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

   b. The health carrier:
i. Does not have a network provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

ii. Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay.

3. The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider.

4. Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal claims grievance and appeals processes.

E. 1. A health carrier shall establish and maintain adequate arrangements to ensure reasonable access of participating providers to the business or personal residence of covered persons. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

2. A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.