Section 5. Network Adequacy

A. A health carrier providing a network plan 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.

NOTE TO SUBGROUP: THE SUBGROUP DECIDED TO ADD THE DRAFTING NOTE BELOW REGARDING POTENTIAL ISSUES WITH TIERED NETWORKS. THE SUBGROUP ALSO SAID IT WOULD REVISIT THIS ISSUE TO DETERMINE IF SUBSTANTIVE LANGUAGE SHOULD BE ADDED TO THE MODEL.

Drafting Note: States may want to pay particular attention to network sufficiency, marketing and disclosure issues that may arise with respect to certain health carrier network designs, such as so-called “tiered networks.” Tiered networks may be designed, marketed and sold in different ways. Regulators should review what information carriers are providing to consumers on a particular tiered network at the time of sale. In some cases, the network may be designed such that not all covered services are provided in every tier. Regulators should pay close attention to the benefits promised to the consumer by the carrier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

B. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care provider-covered person ratios;

(3) Geographic accessibility;

(4) Geographic population dispersion;

(5) Waiting times for visits with participating providers;

(6) Hours of operation;
New health care service delivery system 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.

**Drafting Note:** Instead of the general standards provided in Subsection B for determining network sufficiency, some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), maximum travel distance to providers, maximum travel time to providers and maximum waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

C. (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.

D. 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.

E. Cost-sharing paid by, or on behalf of, a qualified individual for designated services provided outside of a health carrier’s network shall be at in-network benefit cost sharing levels and any out-of-network cost sharing shall count towards the covered person’s out-of-pocket maximums for in-network services (including the annual limitation on cost sharing required by the Affordable Care Act (as defined in 42 C.F.R. § 156.130(a)). For purposes of this subsection:

(1) “Qualified individual” means a covered person who a referring health care professional has concluded requires treatment for a life-threatening disease or condition.

(2) “Life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(3) “Designated services” means those services deemed by a referring health care professional as medically necessary to treat the life-threatening disease or condition.

(4) The foregoing shall not apply if there is a determination that the life-threatening disease or condition can be adequately treated by an in-network provider. Such determination shall be made by an independent reviewer organization or other entity that has no affiliation with the health carrier.

F. A health carrier’s networks should be designed to provide services for all levels of complexity among covered persons of all ages, including for rare conditions. Utilization review and pre-authorization procedures
may not be established in a manner that creates unreasonable administrative or cost barriers for covered persons. In plans with tiered provider networks, the lowest cost-sharing tier shall contain a sufficient number of in-network specialty providers, including essential community providers and other specialty facilities, such as children’s hospitals and at least one NCI-designated cancer center. Covered persons must be informed of cost sharing requirements associated with the tiers.

G.(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.

HE. Option 1. Prior Approval of Access Plan

(1) Beginning [insert effective date], a health carrier shall submit to the commissioner for approval prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the network plans the carrier offers in this state.

Drafting Note: States will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to submit the access plan to the insurance commissioner for prior approval. Some states may prefer that a health carrier file the access plan with the insurance commissioner, but not require that the insurance commissioner take any action on the plan. This is Option 2 of Paragraph (1) below. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

Option 2. Filing of Access Plan

(1) Beginning [insert effective date], a health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the network plans the carrier offers in this state.

Drafting Note: States will establish different requirements for the access plan. Option 2 of Paragraph (1) above requires a health carrier to file the access plan with the insurance commissioner, but does not require the commissioner to take action on the plan. Some states may want require the commissioner’s approval of access plans, which is in Option 1 of Paragraph (1).
Other states may prefer that a health carrier not file the access plan with the insurance commissioner but, instead maintain the plan on file at the health carrier’s place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, on its business premises and shall provide them to any person upon request.

(b) For the purposes of this subsection, information is [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier’s competitors to obtain valuable business information.

Drafting Note: States should be aware that the intent of Paragraph (2) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is [proprietary, competitive or trade information] and, as such, no provision of the plan may be made public. States should review their open records laws in determining whether a particular provision, if any, of an access plan is [proprietary, competitive or trade secret] information and should not be made public based on information received from the health carrier supporting its request. For purposes of this paragraph, states also should review their laws or regulations to determine which term “proprietary,” “competitive” or “trade secret” is appropriate to use or if some other term is more appropriate.

(3) The carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The health carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an updated an existing access plan.

Drafting Note: States may want to consider defining “material change” for purposes of Paragraph (3) above.

Drafting Note: States should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

IF. The access plan shall describe or contain at least the following:
The health carrier’s network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards;

The health carrier’s procedures for making and authorizing referrals within and outside its network, if applicable;

The health carrier’s process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network, which must be made available through the health carrier’s on-line and in-print provider directories;

The health carrier’s efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

The health carrier’s methods for assessing the health care needs of covered persons and their satisfaction with services;

The health carrier’s method of informing covered persons of the plan’s services and features, including but not limited to, the plan’s grievance procedures, its process for choosing and changing providers, its process for updating its provider directories for each of its network plans, a statement of services offered, including those services offered through the preventative care benefit, if applicable, and its procedures for providing and approving emergency and specialty care;

The health carrier’s system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

The health carrier’s process for enabling covered persons to change primary care professionals;

The health carrier’s proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier’s insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier’s insolvency or other cessation of operations, and transferred to other providers in a timely manner; and
(11) Any other information required by the commissioner to determine compliance with the provisions of this Act.

**Drafting Note:** States may want to consider requiring that an access plan include information on the health carrier’s efforts to ensure that its participating providers meet its quality of care standards and health outcomes for certain types of network plans, such as HMOs and narrow network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.