Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

| Children’s Hospital Association (CHA) | *** Drafting Note: In addition to applying the standards articulated in this Act to fully insured benefit plans, including qualified health plans (QHPs), states should consider adopting these standards for Medicaid managed care plans operating in the state. This standardization will assure that all networks are adequate to provide access to the covered services and will also support continuity of care for covered persons that transition back and forth between Medicaid and fully insured plans. |

Section 2. Purpose

The purpose and intent of this Act are to:
A. Establish standards for the creation and maintenance of networks by health carriers; and
B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:
   (1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and
   (2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks.

| American Academy of Family Physicians (AAFP) | B. *** (2) Requiring network plans to have and maintain up-to-date clinician listings and publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. |

| American’s Health Insurance Plans (AHIP) and BlueCross and BlueShield Association (BCBSA) | B. *** (2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5BE of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. |
| American Medical Association (AMA) | B. Assure the adequacy, accessibility, **and** transparency **and** quality of health care services offered under a network plan by:  
(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and  
(2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. |
| Illinois Hospital Association (IHA) | B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:  
(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and  
(2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. |
| Missouri Department of Insurance, Financial Institutions & Professional Registration (MO DOI) | B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:  
(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and  
(2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. 
*** Establishing requirements for public disclosure of plan documents that address the sufficiency of provider networks, including but not limited to the written access plan described in Section 5B of this Act. |
| Maine Bureau of Insurance | B. ***  
(2) Requiring network plans to have and maintain and follow publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. |

### Section 3. Definitions

| A. Balance Billing | “Balance billing” means the practice of a (non-participating) provider billing for the difference between the provider’s charge and the health carrier’s allowed amount. |
| Biotechnology Industry Organization (BIO) | “Balance billing” means the practice of a (non-participating) provider billing for the difference between the provider’s charge and the health carrier’s allowed amount. |
| MO DOI | “Balance billing” means the practice of a (non-participating) provider billing for the difference between the provider’s charge and the health carrier’s allowed amount. |
| **B. Commissioner** | “Commissioner” means the insurance commissioner of this state.  
**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.  
No comments received |
| **C. Covered Benefits** | “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.  
No comments received |
| **D. Covered Person** | “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.  
No comments received |
| **E. Emergency medical condition** | “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in:  
(1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy;  
(2) Serious impairment to a bodily function;  
(3) Serious impairment of any bodily organ or part; or  
(4) with respect to a pregnant woman who is having contractions:  
(a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or  
(b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.  
AMA  
“Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in:  
(1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy;  
(2) Serious impairment to a bodily function;  
(3) Serious impairment of any bodily organ or part; or  
(4) with respect to a pregnant woman who is having contractions:  
(a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or  
(b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.  
CHA  
“Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in:  
(1) Placing the individual’s physical or mental health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy;  
***
| **American Psychiatric Association (APA)** | “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in: (1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy; (2) Serious impairment to a bodily function; (3) Serious impairment of any bodily organ or part; or (4) with respect to a pregnant woman who is having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child; or (5) a threat to the individual’s safety or the safety of others. |
| **Maine Bureau of Insurance** | “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in: (1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy; *** |
| **Shriver Center** | “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in: (1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy; (2) Serious impairment to a bodily function; (3) Serious impairment of any bodily organ or part; or (4) with respect to a pregnant woman who is having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child. |
| **Wisconsin Hospital Association (WHA)** | “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in: (1) Placing the individual’s health or, with respect to a pregnant woman, the woman’s or her unborn child’s health in serious jeopardy; *** |
| **F. Emergency Services** | “Emergency services” means with respect to an emergency medical condition, as defined in subsection E: (1) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (2) any further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. |
| **CHA** | “Emergency services” means with respect to an emergency medical, psychiatric or behavioral condition, as defined in subsection E: (1) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (2) any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. |
**IHA**

“Emergency services” means with respect to an emergency medical condition, as defined in subsection E: (1) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (2) any further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition.

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**G. Essential community provider**

“Essential community provider” means a provider that serves predominantly low-income, medically underserved individuals, including a provider defined in Section 340B(a)(4) of the PHS and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that section.

**Drafting Note:** The term “essential community provider” is not used in this Act. However, the term is defined in this section to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

**American Cancer Society Cancer Action Network (ACS CAN)**

“Essential community provider” means a provider that serves predominantly low-income, medically underserved individuals, including a provider defined in Section 340B(a)(4) of the PHS and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that section.

**Drafting Note:** The term “essential community provider” is not used in this Act. However, the term is defined in this section to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

**American Hospital Association (AHA), NAIC Consumer Representatives**

“Essential community provider” means a provider that serves predominantly low-income, medically underserved individuals, including a provider defined in Section 340B(a)(4) of the PHS and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that section.

**Drafting Note:** The term “essential community provider” is not used in this Act. However, the term is defined in this section to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

**AHIP/BCBSA**

SEE SUGGESTED REVISION FOR SUBSECTION K (Health care provider) “Essential community provider” means a provider that serves predominantly low-income, medically underserved individuals, including a provider defined in Section 340B(a)(4) of the PHS and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that section.

**Drafting Note:** The term “essential community provider” is not used in this Act. However, the term is defined in this section to alert
states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

**CHA**

***

**Drafting Note:** The term “essential community provider” is not used in this Act. However, the term is defined in this section to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations. States should consider applying ECP network adequacy requirements to all aspects of their insurance market to ensure access to the most appropriate providers for their target populations. As effective ECP standard for carriers would require commissioners to evaluate networks to verify that they contain all ECPs that are available to provide sufficient in-network access to the full range of health care providers with the capacity, expertise and experience to treat children and adults with serious, chronic or complex medical or behavioral health conditions. In some geographic areas, the ECP may be in another state. For example, it may be necessary for children to travel significant distances and to other states to receive treatment from an appropriate children’s hospital ECP.

**H. Facility**

“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

**Drafting Note:** States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities, such as end-stage renal facilities, hospice, and home health agencies.

**AAFP**

“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings; and outpatient and solo or group practitioner offices.

**American Academy of Pediatrics (AAP)**

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**Drafting Note:** States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities, such as end-stage renal facilities, hospice, and home health agencies.

***

**ACS CAN**

“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, oncology facility, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Definition</th>
<th>Drafting Note</th>
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</thead>
<tbody>
<tr>
<td>AHIP/BCBSA</td>
<td>“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.</td>
<td>States that regulate Medicaid managed care plans may wish to broaden this definition, specifically for Medicaid network plans, to list other types of facilities, such as end-stage renal facilities, hospice, and home health agencies.</td>
</tr>
<tr>
<td>Academy of Managed Care Pharmacy (AMCP)</td>
<td>“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, pharmacy, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.</td>
<td></td>
</tr>
<tr>
<td>CHA</td>
<td>***</td>
<td>States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities, such as end-stage renal facilities, hospice, and home health agencies.</td>
</tr>
<tr>
<td>National Kidney Foundation (NKF)</td>
<td>***</td>
<td>States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities, such as end-stage renal facilities, hospice, transplant centers, and home health agencies.</td>
</tr>
<tr>
<td>PhRMA</td>
<td>“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, pharmacies (in the case of vaccination services), and rehabilitation and other therapeutic health settings.</td>
<td></td>
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<tr>
<td>Urgent Care Association of America (UCAOA)</td>
<td>“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, urgent care centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.</td>
<td></td>
</tr>
<tr>
<td>I. Health benefit plan</td>
<td>“Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.</td>
<td></td>
</tr>
<tr>
<td>CHA</td>
<td>“Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of physical and mental/behavioral health care services.</td>
<td></td>
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</tbody>
</table>
| Delta Dental Plans Association (DDPA) | (1) “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.  
(2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. |                                                                                                                |
(3) “Health benefit plan” does not include: (a) Coverage only for accident, or disability income insurance, or any combination thereof; (b) Coverage issued as a supplement to liability insurance; (c) Liability insurance, including general liability insurance and automobile liability insurance; (d) Workers’ compensation or similar insurance; (e) Automobile medical payment insurance; (f) Credit-only insurance; (g) Coverage for on-site medical clinics; and (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: (a) Limited scope dental or vision benefits; (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: (a) Coverage only for a specified disease or illness; or (b) Hospital indemnity or other fixed indemnity insurance.

(6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance: (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act; (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or (c) Similar supplemental coverage provided to cover under a group health plan.

<table>
<thead>
<tr>
<th>J. Health care professional</th>
<th>“Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate “persons.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAFP</td>
<td>“Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with their scope of practice under state law.</td>
</tr>
<tr>
<td>AMCP, National Association of Chain Drug Stores (NACDS)</td>
<td>“Health care professional” means a physician, pharmacist or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.</td>
</tr>
<tr>
<td>APA</td>
<td>“Health care professional” means a physician, including psychiatrists, or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.</td>
</tr>
<tr>
<td>CHA</td>
<td>“Health care professional” means a physician or other health, mental/behavioral care practitioner licensed, accredited or certified to perform specified physical or mental/behavioral health services consistent with state law.</td>
</tr>
<tr>
<td>K. Health care provider</td>
<td>“Health care provider” or “provider” means a health care professional, a pharmacy or a facility.</td>
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</tr>
<tr>
<td>AAP, Pharmaceutical Care Management Association (PCMA)</td>
<td>“Health care provider” or “provider” means a health care professional, a pharmacy or a facility.</td>
</tr>
<tr>
<td>AHA, AMA, NAIC Consumer representatives</td>
<td>“Health care provider” or “provider” means a health care professional, a pharmacy, a home health agency or a facility.</td>
</tr>
</tbody>
</table>
| AHIP/BCBSA | “Health care provider” or “provider” means a health care professional, a pharmacy or a facility.  
**Drafting Note:** The term “essential community provider” (ECP) is not used in this Act. However, the term is noted here to alert states that ECPs are addressed in the federal Affordable Care Act (ACA) and implementing regulations. The requirement to have a certain number or percentage of essential community providers in a provider network, or to meet the alternate ECP standard, is a requirement that a qualified health plan (QHP) certified by a health insurance exchange and offered in the individual and small group markets must satisfy in order to be offered on a health insurance exchange under federal law. |
| BIO | “Health care provider” or “provider” means a health care professional, a retail pharmacy, a specialty pharmacy or a facility.  
**Drafting Note:**  |
<p>| CHA | “Health care provider” or “provider” means a physical or mental/behavioral health care professional, a facility or a pharmacy or a facility. |
| Disability Rights Education &amp; Defense Fund (DREDF), National Health Law Program | “Health care provider” or “provider” means a health care professional, a pharmacy, a community-based organization, a peer provider or a facility. |
| L. Health care services | “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. |
| APA | “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including mental health and substance use disorders. |
| CHA | “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a physical or mental/behavioral health condition, illness, injury or disease. |</p>
<table>
<thead>
<tr>
<th>DREDF</th>
<th>“Health care services” means services and devices for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, maintenance of bodily function, or slowing or preventing the deterioration of bodily function.</th>
</tr>
</thead>
</table>
| M. Health carrier | “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.  
**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.  
**Drafting Note:** Section 2791(b)(2) of the Public Health Service Act (PHSA) defines the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” above is consistent with the definition of “health insurance issuer” in Section 2791(b)(2) of the PHSA. |
| N. Health indemnity plan | “Health indemnity plan” means a health benefit plan that is not a network plan. |
| MO DOI | “Health indemnity plan” means a health benefit plan that is not a network plan. |
| O. Intermediary | “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.  
No comments received |
<p>| P. Network | “Network” means the group of participating providers providing services to a network plan. |
| IHA | “Network” means the group or groups of participating providers providing services to a network plan. |
| O. Network plan | “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. <strong>Drafting Note:</strong> The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including accountable care plans (ACOs) and other models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act. |
| AHIP/BCBSA, AMCP | “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. <strong>Drafting Note:</strong> The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including accountable care plans (ACOs) and other models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act. |
| CHA | “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. <strong>Drafting Note:</strong> The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including innovative delivery system models (such as accountable care plans (ACOs) and other care models) of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act. |
| California Medical | “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. |
| Association (CMA) | <strong>Drafting Note:</strong> The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including accountable care plans (ACOs) and other models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, traditional indemnity plans, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act. |
| Families USA | “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. <strong>Drafting Note:</strong> The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including accountable care plans (ACOs) and other models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act. |
| R. Participating provider | “Participating provider” means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier. |
| DREDF | “Participating provider” means a provider, a community-based organization or a peer provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier. |
| S. Person | “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing. |
| No comments received |</p>
<table>
<thead>
<tr>
<th>T. Primary care professional</th>
<th>“Primary care professional” means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.</th>
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<td>No comments received</td>
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<tr>
<td>U. Telemedicine or telehealth</td>
<td>“Telemedicine” or “Telehealth” means covered benefits provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology.</td>
</tr>
<tr>
<td>AMA</td>
<td>“Telemedicine” or “Telehealth” means covered benefits provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology. <em>Telemedicine</em> means the delivery of clinical health care services by means of real time two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.</td>
</tr>
<tr>
<td>MO DOI</td>
<td>“Telemedicine” or “Telehealth” means covered benefits provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology.</td>
</tr>
<tr>
<td>Maine Bureau of Insurance</td>
<td>“Telemedicine” or “Telehealth” means covered benefits provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology.</td>
</tr>
<tr>
<td>V. To stabilize</td>
<td>“To stabilize” means with respect to an emergency medical condition, as defined in Subsection E, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in Subsection E(4), to deliver, including the placenta.</td>
</tr>
<tr>
<td>MO DOI</td>
<td>“To stabilize” means with respect to an emergency medical condition, as defined in Subsection E, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in Subsection E(4), to deliver, including the placenta.</td>
</tr>
<tr>
<td>Maine Bureau of Insurance</td>
<td>“To stabilize” means with respect to an emergency medical condition, as defined in Subsection E, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in Subsection E(4), birth with no complications resulting in a continuing emergency, to deliver, including the child and the placenta.</td>
</tr>
<tr>
<td>W. Transfer</td>
<td>“Transfer” means, for the purposes of Subsection V, the movement, including the discharge, of an individual outside a hospital’s facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who: (1) has been declared dead; or (2) leaves the facility without the permission of such person.</td>
</tr>
<tr>
<td>Maine Bureau of Insurance</td>
<td>“Transfer” means, for the purposes of Subsection V, the movement, including the discharge, of an individual outside a hospital’s facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who: (1) has been declared dead; or (2) leaves the facility without the permission of such person.</td>
</tr>
<tr>
<td>Suggested Additional Definitions</td>
<td></td>
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<tr>
<td>American Academy of Dermatology Association (AADA)</td>
<td>“Board certification” means either: (i) certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association; or (ii) requisite successful completion of postgraduate training program approved by the Accreditation Commission for Graduate Medical Education or the American Osteopathic Association that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the American Board of Medical Specialties or the American Osteopathic Association board for that training field and further successful completion of examination in that specialty or subspecialty certified. “Material change” means a change in network that could cause the coverage to fail to meet the actuarial value of a plan, due to a change in benefit design that modifies the recipient’s benefits, including but not limited to, physician network or drug coverages. “Narrow network” means health insurance plans that place limits on the doctors and hospitals available to their subscribers based solely on economic and subjective quality criteria to the detriment of patient access to needed care. “Specialist” means a physician who has successfully completed a residency or fellowship training program which is accredited by the Accreditation Council of Graduate Medical Education, the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada. “Subspecialist” means a physician whose scope of residency or fellowship training encompasses the treatments, conditions or procedures for which subspecialization is being claimed.</td>
</tr>
</tbody>
</table>
| AAFP | “Material change”?

“Broad network”?; “Narrow network”?; “Tiered network”?; “Ultra-narrow network”? (suggests defining based on percentage of hospital participation, family physician and other primary care physician percentage participation and other factors). |
| American Association on Health & Disability (AAHD), National Multiple Sclerosis Society (MS Society) | “Community-based organization” means?  
“Peer provider” means? |
|---|---|
| ACS CAN | “Specialty provider” means a provider who provides specialized services. The term can be used to describe a physician or health care professional (e.g. surgeon) as defined by the American Board of Medical Specialties list of approved medical boards. The term also can be used to describe a facility offering specialized services (e.g. cancer center).  
“Tiered provider network” or “tiered network” means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality or to otherwise incentivize covered person or provider behavior. |
| AHA | “Specialty care” means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions. Specialty care is provided by a medical professional with advanced training who may also be certified by a specialty examining board, or by facilities with trained personnel and clinical expertise to treat children or adults with complex medical conditions. Specialists generally work with primary care providers to provide coordinated and comprehensive care.  
“Tiered provider network” is a type of provider network that occurs when participating providers in a health plan’s network are further divided into sub-groupings that differentiate them on the basis of their payment from the health plan, enrollee cost-sharing levels, quality scores, access requirements, or in any combination of these or other factors established by the health plan in order to influence enrollees’ selection of providers at the time that care is needed or planned. |
| AMA | ? “Essential Health Benefits” means a set of benefits in the following categories: 1. ambulatory patient services; 2. emergency services; 3. hospitalization; 4. maternity and newborn care; 5. mental health and substance use disorder services, including behavioral health treatment; 6. prescription drugs; 7. rehabilitative and habilitative services and devices; 8. laboratory services; 9. preventive and wellness services and chronic disease management; and 10. pediatric services, including oral and vision care.  
? “Material Change” is a change in the composition or structure of a health carrier’s provider network or a change in the size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier’s network non-compliant with one or more of the network adequacy standards set forth at Section 5 of this Act or rules adopted pursuant to that section.  
? “Narrow network” means a panel of providers, within a network, that is comprised of a limited number of providers who have been selected based by a health carrier based primarily on criteria relating to cost or resource utilization or other measures determined by the carrier.  
? “Preferred provider” means a physician, hospital or other provider that has agreed to join, participate in, or become a member of a network. |
<table>
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<tr>
<th>Group</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>American Society for Dermatologic Surgery Association (ASDSA), American Society of Retina Specialists (ASRS)</td>
<td>“Specialty provider” means a physician who has successfully completed a residency or fellowship training program which is accredited by the Accreditation Council of Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada. “Subspecialty provider” means a physician whose scope of residency or fellowship training encompasses the treatments, conditions, or procedures for which sub-specialization is being claimed. “Board certification” means either: (i) certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association; or (ii) Requisite successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education or the American Osteopathic Association that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the American Board of Medical Specialties or American Osteopathic Association board for that training field and further successful completion of examination in the specialty or subspecialty certified. “Board certification” means licensed medical doctor or doctor of osteopathic medicine.</td>
</tr>
<tr>
<td>CHA</td>
<td>“Specialty Care” means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions. Specialty care is provided by a medical professional with advanced training who may also be certified by a specialty examining board, or by facilities with trained personnel and clinical expertise to treat children and adults with complex medical conditions. Specialists work closely with primary care providers to provide coordinated and comprehensive care. “Tiered network” or “tiered provider network” means a carrier’s network that identifies and groups participating providers into specific groups to which different provider reimbursement, enrollee cost-sharing, provider access requirements, or any combination thereof, apply as a means to control cost, utilization, quality or to otherwise incentivize enrollee or provider behavior.</td>
</tr>
<tr>
<td>CMA</td>
<td>“Tiered provider network” means a network of participating providers which has been divided into sub-groupings differentiated by the health plan according to enrollee cost-sharing levels, the payment to the provider, performance ratings, quality scores, or any combination of these factors, among others, established as a means to influence an enrollee’s choice of provider. “Material change” means a change in the composition or structure of a health carrier’s provider network or change in the size or demographic characteristics of the enrollee population such that the health carrier is at a significant risk for noncompliance with network adequacy standards or access to care for a substantial portion of enrollees within a service area will be affected.</td>
</tr>
<tr>
<td>NAIC Consumer representatives</td>
<td>“Specialty care” means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions. Specialty care is provided by a medical professional with advanced training who may also be certified by a specialty examining board, or by facilities with trained personnel and clinical expertise to treat children or adults with complex medical conditions. Specialists generally work with primary care providers to provide coordinated and comprehensive care.</td>
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</table>
“Tiered provider network” or “Tiered network” occurs when participating providers in a health plan’s network are further divided into sub-groupings that differentiate them on the basis of their payment from the health plan, enrollee cost-sharing levels, quality scores, access requirements, or in any combination of these or other factors established by the health plan in order to influence enrollees’ selection of providers at the time that care is needed or planned.

<table>
<thead>
<tr>
<th>National Health Law Program</th>
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<tbody>
<tr>
<td>“Tiered provider network” or “Tiered network” means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered person or provider behavior.</td>
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| National Indian Health Board (NIHB), Tribal Technical Advisory Group |
| “Indian health provider” means a facility or program that is funded in part by the federal government or a federally-recognized Tribe to serve primarily American Indians and Alaskan Natives, including the federal Indian Health Service, facilities and programs that are operated by Tribes and Tribal Organizations, and urban Indian clinics (also called “I/T/U”). |

**Section 4. Applicability and Scope**

This Act applies to all health carriers that offer network plans.

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

**AAP***

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity **should** make available to the state its current standards to demonstrate that the entity’s
standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

| ACS CAN, AHA, NAIC | *** Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance. |
| ACS CAN, AHA, NAIC, Consumer representatives, Families USA, National Health Law Program | 

| AHIP/BCBSA | This Act applies to all health carriers that offer network plans with the exception of Medicare network plans, Medicaid network plans or other benefits plans outside the commissioner’s jurisdiction. Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity or health carrier shall file or provide the state with documentation that the carrier and its networks have been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance. |

| AMA | *** Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some |
or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity and the private accrediting entity shall make its standards publicly available. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool, but should not rely on accreditation for in determining compliance with the standards required under this Act. Under such an approach, the commissioner must assure that the current accrediting entity’s standards, as well as documentation related to the state’s independent review and certification of a carrier’s network adequacy, are publicly available. Documentation that must be made publicly available would include all information that demonstrates that the accrediting entity’s standards meet or exceed the state’s requirements. The carrier that relies on the private accrediting entity for the certification of the adequacy of its networks shall file or provide the state with the required documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.
**Maine Bureau of Insurance**

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

**NCQA**

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity or health carrier shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

**Texas Medical Association (TMA)**

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity or health carrier shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.
**PhRMA**

**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

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**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 to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.

**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.

**Association of American Cancer Institutes (AACI), Alliance of Dedicated Cancer Centers (ADCC)**

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.

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**AAFP**

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible **without unreasonable delay or cost or imposing undue financial strain.** In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.

***

**AAHD**

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible **without unreasonable delay. Networks must include providers with documented experience and expertise in treating, serving and supporting those with discrete health care needs, including those with chronic**
### AAP

A. A health carrier providing a network plan shall maintain a network that includes a comprehensive range of primary, specialty and subspecialty providers and with respect to children, pediatricians, pediatric medical subspecialties and pediatric surgical specialist that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest tier as measured by required cost-sharing, without unreasonable travel or delay.**

### ACS CAN

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 without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services should be accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay.**

**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 ensuring that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

### AHA

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay.**

### AHIP/BCBSA

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay.**

### America’s Essential Hospitals (AEH)

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers, including providers that offer access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care, public health services, mental health services, and substance abuse services, to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.
| AMA | A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services be accessible through a provider in the lowest cost-sharing tier.**  

**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. |

| APA | A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers (full-time equivalents) and types of providers who are available to see patients of the particular plan to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. |

| CHA | A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers, including all types of ECPs. The network must be sufficient numbers and types of providers to assure that all primary and specialty health care services necessary to treat covered persons, children and adults will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable delays or travel.**  

**Option 1:**  
**Drafting Note:** The issue of “tiered” or “narrow networks” must be carefully considered by regulators and is addressed in this Model Act in order to prevent the creation of a health benefit plan that discriminates based on health status. Such discrimination may be caused by additional and burdensome pre-authorization or utilization review requirements to access specialty care from non-network providers or from cost-sharing requirements that deter appropriate care, for example. When a carrier chooses to use a tiered network, the lowest patient cost-sharing tier must provide “in-network” access to all types of appropriate participating providers necessary to deliver all covered primary, specialty, tertiary and quaternary health care services for children and adults under the terms of the benefit contract. Carriers that choose to offer a narrow network must ensure that the narrow network includes the full range of appropriate providers to deliver all covered services in-network. Reliance on an exceptions process, whereby patients are referred to out-of-network providers through single case agreements or other mechanisms, is not sufficient evidence of network adequacy even when benefits are provided at an “in-network” benefit level as this type of arrangement does not protect consumers from balance billing by the non-network provider. |

| APA | A. A health carrier providing a network plan shall develop and maintain a network that is sufficient in participating and appropriate providers, including all types of ECPs. The network must be sufficient numbers and types of providers to assure that all primary and specialty health care services necessary to treat covered persons, children and adults will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. |

| CHA | Option 2:  
**Drafting Note:** States **may want to** should 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 or narrow networks.” These types of 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 plan to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable delays or travel.**  

**Option 2:**  
**Drafting Note:** States may want to should 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 or narrow networks.” These types of 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 plan to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable delays or travel.**  

**Drafting Note:** States may want to should 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 or narrow networks.” These types of 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 plan to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable delays or travel.**

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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, resulting in potentially discriminatory benefit design for children and adults with serious, chronic or complex health care conditions. Regulators should pay close attention to the benefits promised to the consumer by the carrier and assure that the consumer not only has adequate information about the network design, but is able to access the full range of primary, specialty, tertiary and quaternary care from in-network participating providers. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

### CMA

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A tiered provider network shall meet these standards at the lowest cost-sharing tier of the network.***

### DREDF

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of appropriately credentialed providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **Networks must include providers with documented experience and expertise in treating, serving and supporting those with discrete health care needs, including those with chronic conditions and disabilities.***

### NAIC Consumer representatives, Physicians Advocacy Institute (PAI)

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay.***

**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 ensure that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

### Families USA

A. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. **A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay.***

**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 “value-based networks,” “narrow networks,” networks that use “reference pricing” and “tiered networks.” **TieredThese** 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. For example, 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 ensuring that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

<table>
<thead>
<tr>
<th>National Health Law Program</th>
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</table>
| **A.** A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.  

A health carrier providing a tiered network plan shall ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay. Carriers must demonstrate that their networks include providers with documented experience and expertise in treating, serving, and supporting those with discrete health care needs, including those with chronic conditions and disabilities. Carriers must demonstrate that their networks include providers willing to provide all covered services. Carriers must also demonstrate that their networks are accessible to limited English proficient individuals.|

**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 ensuring that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

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<th>Maine Bureau of Insurance</th>
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<tr>
<td><strong>A.</strong> A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay consistent with an access plan [Option 1: approved by] [Option 2: filed with] the commissioner pursuant to this section. In the case of emergency services, covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.***</td>
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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;
7. New health care service delivery system options, such as telemedicine or telehealth; and
8. 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.

### AAP, AAFP

| (2) | Primary care provider-covered person ratios **determined by using the full-time equivalent (FTE) of physician calculation?** |
| (3) | Provider-to-covered person ratio by specialty; |
| (6) | Hours of operation, **including the specific hours a physician is available to see patients.** |

### AAP

B. Sufficiency shall be determined **by the commissioner** 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;
7. **New health care service delivery system options, such as telemedicine or telehealth; and**
8. The **volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.**

(1) **Maximum travel time and distance standards to access a full time equivalent primary care physician, specialist or subspecialist, facility, and other health care providers.** Such a standard shall take into consideration the provider’s ability to accept new patients, the wait time to see the provider and hours of availability, the ability of the provider to admit the patient to an in-network hospital, and the quality measures used to include the provider in-network;

(2) **Minimum ratio of providers to covered persons for primary care physician, specialist and subspecialist services, and other health care providers.** With respect to children and with a focus on children with special health care needs (CSHCN), a health carrier must maintain a network of pediatricians as well as a complete range of pediatric medical subspecialists and pediatric surgical specialists in a given geographic area so that every child has and can maintain access to his/her medical home in a timely manner;

(3) **Minimum number of full time equivalent physicians and healthcare providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities;**

(4) **Maximum time and distance standards in miles to access full time equivalent diagnostic and ancillary services; and**

(5) **Maximum time and distance standards in miles to access general hospital services with emergency care.**

(C) The commissioner shall consider the following factors in the access standards identified in Section 5(B) of this Act:

1. In instances where care provided by a pediatrician, pediatric medical subspecialist or pediatric surgical specialist is not readily available, **network adequacy standards documenting access to appropriate pediatricians, pediatric medical subspecialists and/or pediatric surgical specialists will need to include pediatric specialty or subspecialty care provided in a geographic region beyond the**
normal confines of an existing plan network area. For example, in some areas of the country, access to pediatric specialty and subspecialty care might require travel to a neighboring or nearby state. As such, network adequacy measures must document the availability and coverage of non-emergency transport in such cases; and 

(2) Telehealth care may provide opportunities to meet the needs of enrollees, particularly in underserved areas. Network adequacy standards documenting access to care can include care provided via telehealth technologies, but should be balanced with safety, quality, licensing and certification standards, and must take place within the context of or in support of a medical home.

(D) The commissioner shall conduct or review available periodic patient and family surveys to help inform its monitoring of network adequacy and shall make the results publically available.

ACS CAN

B. [1] 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 adopted by the commissioner through rulemaking. Such requirements must include quantitative criteria and any other requirements that the commissioner deems appropriate. When developing its quantitative criteria, the commissioner must incorporate the following:

(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;
(7) New health care service delivery system options, such as telemedicine or telehealth; and
(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(a) Maximum travel time and distance standards in miles by county to access a full time equivalent primary care physician, specialist, facility, and other health care provider.
(b) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care provider.
(c) Minimum number of full time equivalent physicians and healthcare providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.
(d) Maximum time and distance standards in miles by county to access full time equivalent diagnostic and ancillary services.
(e) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(2) The commissioner shall consider the following factors in the access standards identified in Paragraph (1):

(a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, and other health care provider.
(c) Regular assessment of provider capacity, including the availability of providers to accept new patients.
(d) The breadth of hours of operation for network providers.
(e) The quality measures used to evaluate providers for network inclusion.
(f) The ability of physicians to admit patients to in-network hospitals.

(3) All requirements of the regulations to be issued under Subsections A and B shall be applied to the lowest cost-sharing tier of any tiered network.
(4) The Department shall conduct or review available periodic patient surveys to help inform its monitoring of network adequacy and shall make the results publicly available.

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<tr>
<td>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:</td>
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<th>AHA</th>
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<tr>
<td>B. (1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. Such requirements must include quantitative criteria and any other requirements that the commissioner deem appropriate. When developing its quantitative criteria, the commissioner must incorporate the following: of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:</td>
</tr>
<tr>
<td>(1) Provider-covered person ratios by specialty;</td>
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<td>(2) Primary care provider-covered person ratios;</td>
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<td>(6) Hours of operation;</td>
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<td>(7) New health care service delivery system options, such as telemedicine or telehealth; and</td>
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<tr>
<td>(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.</td>
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| (1) |
| (a) Maximum travel time and distance standards to access a full time equivalent primary care physician, specialist, facility, and other health care provider; |
| (b) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care providers; |
| (c) Minimum number and range of types of full time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities; |
| (d) Maximum time and distance standards in miles by county to access full time equivalent diagnostic and ancillary services; and |
| (e) Maximum time and distance standards in miles by county to access general hospital services with emergency care. |

| (2) |
| (a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care. |
| (b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider. |
| (c) Regular assessment of provider capacity, including the availability of providers to accepting new patients. |
| (d) The breadth of hours of operation for network providers. |
| (e) The quality measures used to evaluate providers for network inclusion. |
| (f) The degree to which in-network physicians are authorized to admit patients to or, in the case of in-network hospital-based physicians, practice at in-network hospitals. |
| (g) New health care service delivery options, such as telemedicine or telehealth. |
| (h) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. |
(3) All requirements of the regulations to be issued under Subsections A and B shall be applied to the lowest cost-sharing tier of any tiered network.

(4) The commissioner shall conduct or review available periodic patient surveys to help inform its monitoring of network adequacy and shall make the results publically available.

**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. While categorically included in this Act, the details are more likely to be established through regulation.

**AHIP/BCBSA**

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:

***

(7) New health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and ancillary providers, such as physician assistants and nurse practitioners, value-based benefit design and payment and delivery models, such as patient-centered medical homes, accountable care organizations and other ways of delivery care; and

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**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. As each state has its own unique health care delivery issues, state regulators are best positioned to determine the appropriate network adequacy review criteria that will work in their state. These can differ widely based on geographic barriers, population and provider density differences within and among the states. The elements of Subsection B are the basis in determining the standards appropriate for each state.

**AEH**

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;
(7) New health care service delivery system options, such as telemedicine or telehealth;
(8) The number and type of ECPs in the network, including the offering of good faith contracts to all ECP hospitals in each county in the
plan's service area;
(9) Provision of linguistically and culturally appropriate care and other services tailored to low-income and vulnerable populations;
(10) With regard to institutional providers, the availability of trauma care, public health services, behavioral health and substance abuse services, and wraparound services critical to vulnerable patients; and
(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

AMA B. (1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. Such requirements must include quantitative criteria and other requirements that the commissioner deems appropriate. When developing its criteria, the commissioner must incorporate the following: 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;
(7) New health care service delivery system options, such as telemedicine or telehealth; and
(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(a) Maximum travel time and distance standards in miles by county to access a full time equivalent primary care physician, specialist, facility, and other health care provider;
(b) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care provider;
(c) Minimum number and range of types of full time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
(d) Maximum time and distance standards in miles by county to access full time equivalent diagnostic and ancillary services; and
(e) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(2) The commissioner shall consider the following factors in the access standards identified in Paragraph (1):
(a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider.
(c) Regular assessment of provider capacity, including the availability of providers to accepting new patients.
(d) The breadth of hours of operation for network providers.
(e) The quality measures used to evaluate providers for network inclusion.
(f) The degree to which in-network physicians are authorized to admit patients to or, in the case of in-network hospital-based physicians, practice at in-network hospitals.
(g) New health care service delivery options, such as telemedicine or telehealth.
(h) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.
(3) All requirements of the regulations to be issued under Subsections A and B shall be applied to the lowest cost-sharing tier of any tiered network.

(4) The commissioner shall conduct or review available periodic patient surveys to help inform its monitoring of network adequacy and shall make the results publically available.

**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 and should reference numbers of providers in terms of full-time equivalents.

| ASDSA, Immune Deficiency Foundation | B. ***
---|---
| Provider-covered person ratios by specialty **and subspecialty**; ***
| (8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty **or subspecialty** care. ***

| MS Society | B. ***
---|---
| The ability of network providers to accommodate patients relying on wheelchairs or other wheeled mobility devices; ***

| APA | B. ***
---|---
| Hours each participating physician dedicates to coverage under the plan; ***

**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 and should reference numbers of providers in terms of full-time equivalents.

| CHA | 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 adopted by the commissioner through rulemaking. Such requirements must include a broad set of measureable criteria and any other requirements that the commissioner deems appropriate to assure access to all covered services by appropriate in-network providers. When developing quantitative criteria, the commissioner must incorporate the following, without relying on a single metric alone to avoid a false assessment of adequacy. Factors to consider include, but are not limited to:
Drafting Note: Instead of In addition to 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. It is important to note that quantitative standards do not diminish the need for regulators to individually assess networks that may employ unique techniques to ensure access to care that may fall outside the established objective requirements. For instance, there may not be specific specialty care available within required time and distance standards. However, if the insurer has arranged for access to that specialized care as an in-network provider outside the geographic region, the regulator would still consider approval of the network. In addition, regulators should incorporate the use of quality measurement, as well as patient feedback through regular consumer surveys and consumer complaints, in the evaluation of network adequacy. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

Consumers Union 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:

- Maximum allowable wait times for an appointment with a primary care physician, specialist, and other health care provider, taking into account the urgency of care” [see similar current consumer-suggested factor for consideration Sec. 5(B)(2)(b)]
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<td>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:</td>
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<tr>
<td>(9) Percentage of network primary care and specialist providers have established structural accessibility, and offer accessible examination/diagnostic equipment, and programmatic accessibility;</td>
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<td>(10) The percentage of network primary care and specialist providers who can be reached within a reasonable time solely via public transportation; and</td>
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<tr>
<td>(11) The percentage of network primary care and specialist providers who offer sign language interpretation, alternative formats to print communication, and/or threshold language translation and interpretation.</td>
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</tbody>
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<tr>
<th>NAIC Consumer representatives, National Health Law Program, PAI</th>
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<tr>
<td>B. (1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. Such requirements must include quantitative criteria and any other requirements that the commissioner deem appropriate. When developing its quantitative criteria, the commissioner must incorporate the following: of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:</td>
</tr>
<tr>
<td>(1) Provider-covered person ratios by specialty;</td>
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<td>(2) Primary care provider-covered person ratios;</td>
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<tr>
<td>(3) Geographic accessibility;</td>
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<td>(4) Geographic population dispersion;</td>
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<td>(5) Waiting times for visits with participating providers;</td>
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<td>(6) Hours of operation;</td>
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<tr>
<td>(7) New health care service delivery system options, such as telemedicine or telehealth; and</td>
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<tr>
<td>(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.</td>
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<tr>
<td>(a) Maximum travel time and distance standards in miles by county to access a full time equivalent primary care physician, specialist, facility, and other health care provider;</td>
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<tr>
<td>(b) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care providers;</td>
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<tr>
<td>(c) Minimum number and range of types of full time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities;</td>
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<tr>
<td>(d) Maximum time and distance standards in miles by county to access full time equivalent diagnostic and ancillary services; and</td>
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<tr>
<td>(e) Maximum time and distance standards in miles by county to access general hospital services with emergency care.</td>
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<tr>
<td>(2) The commissioner shall consider the following factors in the access standards identified in Paragraph (1):</td>
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<tr>
<td>(a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care,</td>
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<tr>
<td>(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider,</td>
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<tr>
<td>(c) Regular assessment of provider capacity, including the availability of providers to accepting new patients,</td>
</tr>
<tr>
<td>(d) The breadth of hours of operation for network providers,</td>
</tr>
<tr>
<td>(e) The quality measures used to evaluate providers for network inclusion.</td>
</tr>
</tbody>
</table>
(f) The degree to which in-network physicians are authorized to admit patients to or, in the case of in-network hospital-based physicians, practice at in-network hospitals.
(g) New health care service delivery options, such as telemedicine or telehealth.
(h) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(3) All requirements of the regulations to be issued under Subsections A and B shall be applied to the lowest cost-sharing tier of any tiered network.

(4) The commissioner shall conduct or review available periodic patient surveys to help inform its monitoring of network adequacy and shall make the results publically available.

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Families USA

B. (1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. Such requirements must include quantitative criteria and any other requirements that the commissioner deem appropriate. When developing its quantitative criteria, the commissioner must establish the following: of this section, and may be established by reference to any reasonable criteria used by the carrier, 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 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.

(a) Maximum travel time and distance standards in miles to access a full-time equivalent primary care physician, specialist, facility, and other health care provider; and
(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider.

(2) The commissioner shall consider the following factors in the access standards identified in Paragraph (1):

- Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care providers;
- Minimum number and range of types of full time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- Regular assessment of provider capacity, including the availability of providers to accepting new patients;
- The breadth of hours of operation for network providers to ensure access during non-business hours for covered persons who must get care during these times due to work schedules or other reasons;
- The quality measures used to evaluate providers for network inclusion;
- The availability of in-network providers at in-network hospitals; and
- New health care service delivery options, such as telemedicine or telehealth.

**Drafting Note:** States may want to include some of the factors under Paragraph (2) as mandatory factors for inclusion under Paragraph...
(1) instead, depending on the state’s main network adequacy concerns.

(3) All requirements of the regulations to be issued under Subsections A and B shall be applied to the lowest cost-sharing tier of any tiered network.

(4) The commissioner shall conduct or review available periodic patient surveys to help inform its monitoring of network adequacy and shall make the results publicly available.

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**UCAOA**

B. ****

? The availability of health care providers to deliver after-hours and same-day care, which may include, but should not be limited to, emergency departments of hospitals;

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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.

**AACI**

(Insert new) 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).

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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 or does not have a participating provider available to provide the service without unreasonable travel or delay; and/or

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

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 or subspecialty 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.

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.

The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list: (i) all such requests; (ii) the name of the covered person involved; (iii) the name and address of the provider making the request; (iv) whether the request was approved or denied; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

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, including in instances where a covered person’s request to access an out-of-network provider using the alternative process is denied.

The health carrier shall ensure that these processes are documented and made publically available.
(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 or subspecialty with the professional training and expertise and experience 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 and experience 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, including by counting the covered person’s cost-sharing toward the maximum out-of-pocket limit.

(4)(a) The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

(b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list: (i) all such requests; (ii) the name of the covered person involved; (iii) the name and address of the provider making the request; (iv) whether the request or was approved or denied; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

(4)(5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s request to assess an out-of-network provider using the alternate process is denied by the carrier.

Drafting Note: States should be aware that it is intended that the process for accessing out-of-network providers established in subsection C be used as infrequently as possible and that it not be used by carriers as a substitute for maintaining an adequate network for all covered services. States should establish a process for monitoring consider how often the alternate process is being used as a potential indicator of an inadequate network.
| ADCC | 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: *** |
| AHA | 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 and at no greater out-of-pocket cost to the covered person, 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 or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay; and/or
(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(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 or subspecialty with the professional training and expertise and experience 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 and experience 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, including by counting the covered person’s cost-sharing toward the maximum out-of-pocket limit.

(4) (a) The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.
(b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list: (i) all such requests; (ii) the name of the covered person involved; (iii) the name and address of the provider making the request; (iv) whether the request was approved or denied; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

(4)(5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s
request to assess an out-of-network provider using the alternate process is denied by the carrier.

**Drafting Note:** It is intended that the process for accessing out-of-network providers established in subsection C be used as infrequently as possible and that it not be used by carriers as a substitute for maintaining an adequate network for all covered services. States should consider monitoring how often the alternate process is being used as a potential indicator of an inadequate network.

### AHIP/BCBSA

C. ***

(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 internal and external appeals processes.

**Drafting Note:** States that seek to protect covered persons from additional charges by establishing hold-harmless provisions, which would permit providers to charge whatever they want and require the plan to cover the difference, would undermine incentives for providers to participate in networks, therefore posing serious implications for network adequacy. Such provisions would create disincentives to contracting with health plans, and serious issues of access and affordability. To address this, states could consider limiting out-of-network payment to a benchmark, such as Medicare, and a no-balance-billing requirement on those out-of-network providers to accept that payment, if states establish a mandatory hold-harmless provision in these situations.

### AMA

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 or it does not have a 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 or subspecialty with the professional training, and expertise and experience 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 and experience 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. The health carrier shall ensure that the covered person's financial responsibilities are not greater than if the service had been provided by an in-network provider pursuant to Paragraph (2), and shall include the covered person's cost-sharing toward the maximum out-of-pocket limit.

(4) For the processes required under Paragraphs (1) and (2), a covered person and the requesting provider shall be notified of a decision to approve or decline the request within seven (7) calendar days of receipt of the request. However, if the covered person's life, health or ability to regain or maintain optimal function is in jeopardy, as indicated by the requesting provider, the health carrier...
must notify the covered person and requesting provider of approval or denial within 24 hours of receipt of the request. Denials will be subject to expedited carrier review and external review, if necessary.

(5) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This document must include a log subject to review at the discretion of the commissioner to be updated on no less than a monthly basis. The frequency with which the processes described in Paragraphs (1) and (2) are used may be used as a potential indicator of failure to comply with the requirements of this Act.

[4][6] Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

**Drafting Note:** States should be aware that it is intended that the process for accessing out-of-network providers established in this section be used as infrequently as possible and that they not be used by carriers as a substitute for maintaining an adequate network as required by this Act.

| Cancer Leadership Council | C. ***
|---------------------------|---
| (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 or knowledge of relevant treatment guidelines or standards of care 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.

| APA | C. (1) ***
|----|---
| (b) The health carrier has an insufficient number or type of participating provider within a reasonable distance available to provide the covered benefit to the covered person in a reasonable time. | *(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 and health carrier shall be responsible for any payment owed the non-network provider.*
| (2) ***
| | (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 or distance.
| | (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 and health carrier shall be responsible for any payment owed the non-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.
| | *(5) A health carrier shall disclose on a quarterly basis any geographic area where it does not have adequate in-network coverage in a specialty area as determined by the number of out of network claims received in the prior quarter for that specialty in that area.*
### IHA

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 **such that the covered person incurs no greater out-of-pocket expenses than had that person used an in-network 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.

### CHA

C. (1) **If a health carrier** shall have a process to assure that a covered person obtains a covered benefit **has an insufficient number or type of participating provider to provide a covered benefit**, the health carrier shall have a well-documented process to assure that a covered person obtains covered services from a non-participating network provider at no greater cost or administrative burden to the covered person than if the benefit were obtained from a participating provider. In addition, the health carrier shall provide payment 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 an otherwise sufficient network, as determined by the commissioner, but **in a highly usual or rare situation** has determined that it does not have a type of appropriate participating provider available to provide the covered benefit to the covered person; and/or
- (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) in the rare instances 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 an appropriate network provider of the required specialty with the professional training, and expertise and experience to treat or provide health care services for the condition or disease;
  - (ii) Cannot provide reasonable access to an appropriate network provider with the professional training, and expertise and experience 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-participating provider pursuant to Paragraph (2) as if the services were provided by a network provider, **including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit**.

(4) **Use of non-network providers may not be a substitute for establishing an adequate network of appropriate providers to deliver primary, specialty, tertiary and quaternary care for children and adults. A health carrier should utilize this option only for unanticipated and extraordinary health care services.**

[4][5] Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, **including in instances where a covered person's request to access an out-of-network provider through these alternate processes is denied by the carrier.**
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| **DREDF** | 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 *with the same timeliness and effectiveness as that provided to other covered persons*; and  
***
(b) 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 *or physical or programmatic accessibility*; 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 *and appropriate physical and programmatic accessibility* 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.  
***
(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 *or subspecialty* with the professional training and expertise *and experience* 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 *and experience* 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, *including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit*. |
| **MO DOI** | C. ***  
(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. |
| **NAIC Consumer representatives, National Health Law Program** | 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 *or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay*; and  
(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person *without unreasonable travel or delay*.  

(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 *or subspecialty* with the professional training and expertise *and experience* 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 *and experience* 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, *including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit*. |
(4) (a) The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

(b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list: (i) all such requests; (ii) the name of the covered person involved; (iii) the name and address of the provider making the request; (iv) whether the request was approved or denied; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

(4)(5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s request to assess an out-of-network provider using the alternate process is denied by the carrier.

Drafting Note: States should be aware that it is intended that the process for accessing out-of-network providers established in subsection C be used as infrequently as possible and that it not be used by carriers as a substitute for maintaining an adequate network for all covered services. States should consider monitoring how often the alternate process is being used as a potential indicator of an inadequate network.

Families USA

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 or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay; 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 requires medically necessary services that are included as covered benefits under the plan contract; and

(b) The health carrier:

(i) Does not have a network provider of the required specialty or subspecialty with the professional training and expertise and experience to treat or provide the necessary health care services for the condition or disease; or

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

(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, including by counting the covered person’s cost-sharing toward the maximum out-of-pocket limit and preventing covered persons from exposure to balance billing from non-network providers.

(4) (a) The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

(b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list: (i) all such requests; (ii) the name of the covered person involved; (iii) the name and address of the provider making the request; (iv) whether the request was approved or denied; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

(4)(5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s request to assess an out-of-network provider using the alternate process is denied by the carrier.

(6) Health carriers must provide covered persons of their rights described under Paragraphs (1) and (2), including by prominently describing these rights on their provider directories.

Drafting Note: States should be aware that it is intended that the process for accessing out-of-network providers established in subsection C be used as infrequently as possible and that it not be used by carriers as a substitute for maintaining an adequate network for all covered services. States should consider monitoring how often the alternate process is being used as a potential indicator of an inadequate network.
(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person.

C. (1) When a covered service is not available through a preferred provider or there is an insufficient number or type of participating provider available to provide a covered service:

(a) A health carrier:

(i) Shall ensure that co-insurance requirements are applied at the in-network percentage level;

(ii) Shall ensure that copayment and deductible requirements are applied as in-network coverage; and

(iii) May be required to pay billed charges to ensure network access; or

(b) A health carrier shall make arrangements acceptable to the commissioner.

Shriver Center

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 without unreasonable delay.

PhRMA

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, disclose and 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. This includes counting the covered person’s cost-sharing for such services towards the maximum out-of-pocket limit applicable to in-network services under the plan.

(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 and external claims grievance and appeals processes, including in instances where a covered person’s request to access an out-of-network provider pursuant to the process described in Paragraph (2) is denied by the carrier.
D. (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.

| AAP | DF. (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. Drafting Note: States should be aware that it is intended that the process for accessing out-of-network providers established in this subsection be used as infrequently as possible and that it cannot be used by carriers as a substitute for maintaining an adequate network for all covered services. States must monitor how often the alternate process is being used as a potential indicator of an inadequate network. G. A health carrier shall ensure that all essential community providers are included in network plans, especially children’s hospitals. |
| AHIP/BCBSA | D. (1) A health carrier shall establish and maintain adequate arrangements to ensure reasonable access of participating providers to located near 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 license of its participating providers to furnish all contracted covered benefits to covered persons. |
| APA | D. *** (3) A health carrier shall provide and publish quarterly reports by physician, by plan the number of claims the provider submitted in the prior quarter. The health carrier also shall report and publish the number of in-network and out-of-network claims paid by each physician specialty on a quarterly basis. |
| DREDF | D.*** (2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, compliance with applicable federal and state disability accessibility laws, regulations and legal authority of its participating providers to furnish all contracted covered benefits to covered persons. |
| Maine Bureau of Insurance | D. *** (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 covered benefits to covered persons. |
| **Maryland Insurance Administration (MIA)** | D. (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. |
| **National Health Law Program** | D. ***
(2) A health carrier shall monitor, on an ongoing basis, the ability, willingness, clinical capacity, financial capability and legal authority of its participating providers to furnish all contracted covered benefits to covered persons. |
| **Stakeholder Group (reps BIO and Association of State and Territorial Health Officials)** | D. (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.

(3) Community providers, such as health departments, pharmacies, and school-based clinics, can act as safety net providers to improve access to certain preventive services, including vaccinations. Health carriers should offer in-network status to such community providers in order to ensure reasonable and adequate access to preventive care for covered persons. |

| **E. 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.

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.

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

(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.

AAP

EH. 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 purpose of this subsection, information is [proprietary, 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 secret] 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) (a) 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.
(b) For purposes of this section, “material change” is a change in the composition of a health carrier’s provider network or a change in size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier’s network non-compliant with one or more of the network adequacy standards set forth in this section or rules adopted pursuant to this section.

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.

ACS CAN

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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.

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(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 purpose of this subsection, information is [proprietary, 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 as a change in the composition of a health carrier’s provider network (including any changes to tiering structure, if applicable) and/or any change that renders the health carrier’s network non-compliant with one or more of the network adequacy standards set forth in this section or any rules adopted or promulgated pursuant to this section.
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.

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**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.

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**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 for review, but not require that the insurance commissioner take any action on the plan. This is
Option 2 of Paragraph (1) below. Other states may prefer that a carrier file the access plan with the commissioner for prior approval. Other states may prefer that a health carrier not file the access plan with the commissioner and instead maintain the access 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.

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.

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 be [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.

Drafting Note: States should be aware that the access plan is considered a regulatory filing. If the state makes these regulatory filings publicly available, the protections afforded under the state’s open records laws should be used 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 that such information should not be made public. 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. 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. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier’s competitors to obtain valuable business information. If the state treats the filing as available for public access, the health carrier shall make the access plan information available upon request, absent [proprietary, competitive or trade secret] information.
(3)F. 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 to an existing access plan.

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

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.

AEH

E. 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.

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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.

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AMA

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(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.

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(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 purpose of this subsection, information is [proprietary, 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.
E. Option 1. Prior Approval of Access Plan

(1) Beginning [insert effective date], an health carrier shall submit to the commissioner for approval prior to or at no later than 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.

***

E. Option 2. Filing of Access Plan

(1) Beginning [insert effective date], an 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.

***

(3) (a) The carrier shall prepare an access plan prior to offering a new network plan. The access plan may incorporate by reference all or the relevant part of the carrier’s existing access plan for one or more of its other network plans.

(b) The carrier, 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 new or updated access plan.

***

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.

E. ***

? A health carrier network shall ensure that for anesthesiology, radiology, pathology, emergency room physicians and hospitalists that there are sufficient numbers of participating physicians at each hospital or facility for the delivery of network services.

? A health carrier is required to provide notice to covered persons of a substantial decrease in the availability of participating anesthesiologists, hospitalists, radiologists, pathologists, emergency medicine physicians, at a participating facility. A decrease is substantial if the contract between the health carrier and any facility-based physician group that comprises 75 percent or more of the participating physicians for that specialty at the participating facility terminates or the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred physicians for that specialty at the facility terminates.

***

(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 purpose of this subsection, information is [proprietary, 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.

F. The access plan shall describe or contain at least the following:
(1) The health carrier’s network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards;
(2) The health carrier’s procedures for making and authorizing referrals within and outside its network, if applicable;
(3) 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;
(4) 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;
(5) 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;
(6) The health carrier’s methods for assessing the health care needs of covered persons and their satisfaction with services;
(7) 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 benefit, if applicable, and its procedures for providing and approving emergency and specialty care;
(8) 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;
(9) The health carrier’s process for enabling covered persons to change primary care professionals;
(10) 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.

AADA

F. ***

(4) 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;
(5) The health carrier’s process for determining how it excludes providers from its network even though the provider meets the carrier’s criteria for inclusion in its network;
| AAFP | F. ***
(4) 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;
(5) The health carrier’s specific performance, quality and outcome methodology and metrics used in selecting and terminating physicians from networks in the access plan; *** |

| American Academy of Ophthalmology (Academy) | F. ***
(4) The health carrier’s process for identifying, developing and implementing quality standards for providers;
(5) The health carrier’s methods for ongoing assessment and monitoring of adequacy and sufficiency within all tiers of the provider network in order to assure that the needs of covered persons within the provider network are met; *** |

| AAP | F. The access plan shall describe or contain at least the following: ***
(3) 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, with specific details of children’s access to pediatricians, pediatric medical subspecialties and surgical specialists; ***
(11) The health carrier’s system for appropriately informing providers of their network status on any plan in which they are included in-network. Carriers must inform physicians of the marketplace networks to which they are added; and (11)(12) Any other information required by the commissioner to determine compliance with the provisions of this Act. |

| ACS CAN | F. The access plan shall describe or contain at least the following: ***
(4) The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network (including information about the breadth of the network and the criteria used to select and/or tier providers), which must be made available through the health carrier’s on-line and in-print provider directories; ***
(9) The health carrier’s process for enabling covered persons to change primary care professionals, if applicable; *** |

| AHA, NAIC Consumer representatives, Families USA, National Health Law Program | F. The access plan shall describe or contain at least the following: ***
(4) The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network (including information about the breadth of the network and how it selects and/or tiers providers), which must be made available through the health carrier’s on-line and in-print provider directories; ***
(9) The health carrier’s process for enabling covered persons to change primary care professionals, if applicable; ***
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 appropriate and available 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. |
### AHIP/BCBSA

F. The access plan shall describe or contain at least the following:

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<td>(4)</td>
<td>The health carrier’s <strong>description of the</strong> 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;</td>
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<td><strong>Drafting Note:</strong> A health carrier may utilize the same provider network for more than one network plan.</td>
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<td>(7)</td>
<td>The health carrier’s method of informing covered persons of the plan’s services and features and any referral or prior approval processes, if applicable, 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 benefit, if applicable, and its procedures for providing and approving emergency and specialty care;</td>
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<td><strong>Drafting Note:</strong> 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 narrower network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.</td>
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<td>(9)</td>
<td>The health carrier’s process for enabling covered persons to change primary care professionals, <strong>if applicable</strong>;</td>
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<td><strong>Drafting Note:</strong></td>
<td>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 narrower network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.</td>
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### AEH

F. The access plan shall describe or contain at least the following:

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<td>(5)</td>
<td>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, and low-income individuals affected by homelessness, unemployment, or other circumstances that require special care;</td>
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<td><strong>Drafting Note:</strong> 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 narrower network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.</td>
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<td>(9)</td>
<td>The health carrier’s process for enabling covered persons to change primary care professionals, <strong>if applicable</strong>;</td>
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<td>(10)</td>
<td>The health carrier’s methods for ensuring provision of essential health benefits in accordance with legal requirements;</td>
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<td>(11)</td>
<td>The health carrier’s methods for selecting providers for networks that are offered as “high-performance,” “high-value,” or other label indicating that providers in such networks are selectively chosen;</td>
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### AMA

F. The access plan shall describe or contain at least the following:

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<td>(4)</td>
<td>The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network, <strong>including information about the breadth of the network and how it selects or tiers providers</strong>, which must be made available through the health carrier’s on-line and in-print provider directories;</td>
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<td>(9)</td>
<td>The health carrier’s process for enabling covered persons to change primary care professionals, <strong>if applicable</strong>;</td>
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<td>The health carrier’s methods for ensuring provision of essential health benefits in accordance with legal requirements;</td>
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<td>(11)</td>
<td>The health carrier’s methods for selecting providers for networks that are offered as “high-performance,” “high-value,” or other label indicating that providers in such networks are selectively chosen;</td>
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### ASRS

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<td>(2) The health carrier’s methods for assessing and monitoring, on an on-going basis, the sufficiency of specialty and subspecialty providers (including those without Medicare and other payer-recognized specialty designation) in the plan network to meet the health care needs of populations that enroll in network plans;</td>
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<td><strong>Drafting Note:</strong> States may want to consider requiring a health carrier to assess and monitor the sufficiency of specialty and subspecialty providers by reviewing claims history and maintaining a panel of physicians who have historically billed for covered specialty services.</td>
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### CHA

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<td>(2) The health carrier’s procedures for making and authorizing referrals within and outside its network, if applicable. <strong>This includes the health carrier’s process for referrals to appropriate and age-specific specialty care for children and adults with serious, chronic or complex health conditions, including pre-authorization or utilization review requirements that use appropriate clinical measures and do not create additional barriers to access or discriminate based on health status. The Plan should demonstrate that out-of-network referrals do not substitute for adequate access to appropriate in-network health care professionals and facilities;</strong></td>
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<td>(2) How the health carrier’s network provides reasonable access to a sufficient number and type of ECPs, including eligible children’s hospitals that treat low-income and medically underserved children with serious, complex or chronic health conditions;</td>
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<tr>
<td>(4) The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network, including information about the breadth of the network and how it selects/tiers providers, which must be made available through the health carrier’s on-line and in-print provider directories;</td>
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<tr>
<td>(5) The health carrier’s efforts to address the needs of covered persons who may face barriers to access to care, including but not limited to, children with serious, chronic or complex medical conditions, individuals with limited English proficiency and illiteracy, individuals with diverse cultural and ethnic backgrounds, and individuals with physical and mental disabilities;</td>
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<td>(8) The health carrier’s system for ensuring the coordination and continuity of care for covered persons, children and adults with complex or chronic health conditions, including assurances that they will be referred to appropriate specialty physicians and facilities in the event of a contract termination, carrier insolvency or other event affecting plan operations, for covered persons using. The carrier’s care coordination and continuity system should include a specific transition plan for these children, address how care is coordinated for children and adults, including the use of ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;</td>
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<td><strong>Drafting Note:</strong> 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-appropriate and available quality of care standards and health outcomes for certain types of network plans, such as HMOs and tiered or narrow network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.</td>
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### CMA

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<th>F. The access plan shall describe or contain at least the following:</th>
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<td>(2) The health carrier’s inclusion and exclusion criteria for selecting participating providers and any methodologies used in the selection of professionals and facilities for inclusion in the provider network; and</td>
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<td>(2) The health carrier’s criteria and any methodologies used in tiering or publicly designating participating providers with a label</td>
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indicating performance, value, quality, cost, or any combination thereof.

### DREDF
F. The access plan shall describe or contain at least the following:

(5) The health carrier’s efforts for monitoring and assuring on an ongoing basis the sufficiency of the network 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, or who have other personal characteristics that are associated with health care disparities;

(7) 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, any right of new members to continuity of care, a statement of services offered, including those services offered through the preventative benefit, if applicable, and its procedures for providing and approving emergency and specialty care;

(8) The health carrier’s system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons receiving Long-Term Services and Supports, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

### MIA
F. The access plan shall describe or contain at least the following:

(10) The health carrier’s proposed plan for providing continuity of care informing covered persons 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

### NIHB
F. The access plan shall describe or contain at least the following:

(2) The health carrier’s procedures for making and authorizing referrals within and outside its network, if applicable, and it plans for coordinating referrals with Indian health facilities, if applicable;

### NCQA
F. The access plan shall describe or contain at least the following:

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

### PhRMA
F. The access plan shall describe or contain at least the following:

(4) The health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network (including information about how the carrier selects and/or tiers providers), which must be made available through the health carrier’s on-line and in-print provider directories;

(?) Information on specific quality or cost-management techniques applicable to the carrier’s network of providers, such as quality measures, treatment pathways or protocols, or provider incentive arrangements that seek to manage the cost of care;
(7) 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 and appeals 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 benefit, if applicable, and its procedures for providing and approving emergency and specialty care;

***

**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.

### UCAOA

F. The access plan shall describe or contain at least the following:

***

(7) 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 benefit, if applicable, and its procedures for providing and approving emergency, urgent and specialty care;

(?) The health carrier’s process for monitoring and assuring on an ongoing basis the sufficiency of the network, including, but not exclusively, emergency departments of hospitals, to meet the need for after-hours and same-day care for non-life, limb or organ threatening conditions;

***

### Suggested Additional Subsections

#### ACS CAN

**?.** A health carrier shall ensure that its networks meet, at a minimum, the essential community provider requirements that apply to qualified health plans under federal and state law, regulations or guidance.

#### ADCC

**?.** 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.

**?.** 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
| **AMA, NAIC Consumer representatives** | A health carrier shall ensure at a minimum that its networks meet, at a minimum, the essential community provider requirements that apply to qualified health plans under federal and state law, regulations or guidance. |
| **Families USA** | A health carrier shall ensure at a minimum that its networks meet, at a minimum, the essential community provider requirements that apply to qualified health plans under federal and state law, regulations or guidance. |
| **Drafting Note:** Although this Act does not provide specific language regarding essential community provider standards, inclusion of such providers is mandatory for meeting network adequacy standards under the Affordable Care Act. States with federally facilitated marketplaces must meet specific federally prescribed essential community provider standards, and other states may have or should consider enacting specific standards to ensure compliance with the essential community provider provision of the Affordable Care Act. |
| **NACDS** | (A) A managed care organization (MCO), or contracted pharmacy benefit manager (PBM), shall not mandate that a covered individual use a specific retail pharmacy, mail order pharmacy, specialty pharmacy or other pharmacy or entity if the MCO or PBM has an ownership interest in such pharmacy, practice site, or entity or that the pharmacy, practice site or entity has ownership interest in the MCO or PBM. Nor can the MCO or PBM provide incentives to beneficiaries to encourage the use of a specific pharmacy if only applicable to a MCO or PBM pharmacy.  
(B) A MCO or PBM may not require that a pharmacist or retail pharmacy participate in a network managed by such MCO or PBM as a condition for the retail pharmacy to participate in another network managed by the same MCO or PBM.  
(C) A MCO or PBM may not exclude an otherwise qualified pharmacist or retail pharmacy from participation in a particular network provided that the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the MCO or PBM, and meets all applicable federal and state licensure and permit requirements and has not been excluded from participation in any Federal or State program.  
(D) A MCO or PBM may not automatically enroll or disenroll a retail pharmacy in a contract or modify an existing agreement without written agreement of the pharmacist or retail pharmacy.  
(E) If a MCO or PBM establishes a discount card network, the MCO or PBM shall not require participation in the discount card network by a pharmacy in exchange for participation in the broader retail network. The MCO or PBM shall allow a pharmacy to opt-out of the discount card network and choose to only participate in the MCO’s or PBM’s funded retail network.  
(F) A MCO or PBM must have a contracted pharmacy network consisting of retail pharmacies sufficient to ensure that the following requirements are satisfied. |

| 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. |

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. |
(1) At least 90 percent of health plan beneficiaries, on average, in urban areas served by the MCO or PBM live within 2 miles of a network pharmacy that is a retail pharmacy.

(2) At least 90 percent of health plan beneficiaries, on average, in suburban areas served by the MCO or PBM live within 5 miles of a network pharmacy that is a retail pharmacy.

(3) At least 70 percent of health plan beneficiaries, on average, in rural areas served by the MCO or PBM live within 15 miles of a network pharmacy that is a retail pharmacy.

Maine Bureau of Insurance

In evaluating the reasonableness of carrier’s access plan, the commissioner shall consider the nature and extent of any differential incentives under the network plan influencing the covered person’s choice between participating providers, including but not limited to tiering, profiling and reference pricing, and the impact of those incentives upon fair and adequate access to services by covered persons.

Hospital Based Physicians Caucus of the American Medical Association (AMA)

In order to ensure adequacy, accessibility and quality, a health carrier must have an ongoing plan for providing network adequacy for its covered persons that includes a process to routinely monitor and assess access to physician specialist services in emergency room care, anesthesia, radiology, hospitalist care and pathology/laboratory services. The network adequacy plan for these physician specialists shall be consistent with accepted medical standards of care, and any applicable standards issued by the Department, in providing covered persons with timely access and utilization for maintaining quality of care.

If the department determines that a plan is inadequate for physician specialist services in emergency room care, anesthesia, hospitalist care, radiology and/or pathology/laboratory services the plan shall be responsible for paying out-of-network physicians the reasonable and customary value for out of network services and at no greater out-of-pocket expense to the patient as would be the case for an in-network physician service. This provision shall not be construed to establish a basis for any implied contract or contract of adhesion between a non-participating physician and a health plan.

Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a network plan shall satisfy all the requirements contained in this section.

No comments received

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

ASDSA

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis, with no less than ninety (90) days advance notice of any material change, of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:
“Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier’s covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.”

C. (1) Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater.

(2) After the period for which premium has been paid, covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the earlier of: (a) The effective date of new health benefit plan coverage; or (b) their discharge from the inpatient facility because their continued confinement in the inpatient facility is no longer medically necessary; or (c) the assets of the plan are exhausted and payment of claims by the state’s guaranty fund is not available.
C. (1) Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, *the provider’s obligation to provide* covered benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. *Without balance billing will continue until the earlier of*:;

(2) After the period for which premium has been paid, covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the earlier of: (a) The effective date of new health benefit plan coverage; or (b) their discharge from the inpatient facility because their continued confinement in the inpatient facility is no longer medically necessary.

(1) The termination of the covered person’s coverage under the network health plan, including any extension of coverage provided under the contract terms or applicable law for covered persons who are in active treatment or totally disabled; or

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in active treatment, would have terminated if the carrier or intermediary had remained in operation.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by Subsections B and C of this section.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

No comments received

F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection of providers by the health carrier and its intermediaries with which it contracts.  
(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3) Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; 

(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or

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<th>Maine Bureau of Insurance</th>
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<td><strong>C.</strong> Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, <em>the provider’s obligation to provide</em> covered benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. <em>Without balance billing will continue until the earlier of</em>:;</td>
<td><strong>D.</strong> The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by Subsections B and C of this section.</td>
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<td><em>(2)</em> After the period for which premium has been paid, covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the earlier of: (a) The effective date of new health benefit plan coverage; or (b) their discharge from the inpatient facility because their continued confinement in the inpatient facility is no longer medically necessary. (1) The termination of the covered person’s coverage under the network health plan, including any extension of coverage provided under the contract terms or applicable law for covered persons who are in active treatment or totally disabled; or (2) The date the contract between the carrier and the provider, including any required extension for covered persons in active treatment, would have terminated if the carrier or intermediary had remained in operation.</td>
<td><strong>E.</strong> In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.</td>
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<td><strong>No comments received</strong></td>
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<td><strong>(2) (a)</strong> The standards shall be used in determining the selection of providers by the health carrier and its intermediaries with which it contracts. (b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].</td>
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(c) That fails to take into account provider performance on quality metrics and patient outcomes.

(4) Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider’s specialty or on the type of patient contained in the provider’s practice may discourage a person unwilling to change providers in the course of treatment. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier’s network to meet all the carrier’s requirements for participation.

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<tr>
<th>American Association for Marriage and Family Therapy (AAMFT), American Association of Nurse Anesthetists (AANA), American Association of Naturopathic Physicians (AANP), American College of Nurse-Midwives (ACNM)</th>
<th>F. ***</th>
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<td>(5) (a) A health carrier shall not discriminate with respect to participation under the plan or coverage against any provider that is acting within the scope of that provider’s license or certification under applicable state law. This provision does not require that a health carrier contract with any provider willing to abide by the terms and conditions for participation established by the carrier.</td>
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<td>(b) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.</td>
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<td>(2) (a) The standards shall be used in determining the selection or tiering of providers by the health carrier and its intermediaries with which it contracts.</td>
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<td>(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].</td>
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<td>(3) Selection or tiering criteria shall not be established in a manner:</td>
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| AHIP/BCBSA | F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional specialty.  
***  
(3) Selection criteria shall not be established in a manner:  
***  
(c) That fails to is solely based on provider charges and does not take into account applicable provider performance on quality criteria or metrics and patient outcomes, to the extent the health carrier implements such programs. |
| AEH | F. ***  
(3) Selection criteria shall not be established in a manner:  
(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers, reimbursing providers at lower rates, or placing providers in less favorable tiers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;  
(b) That would exclude providers, reimburse providers at lower rates, or place providers in less favorable tiers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or  
(c) That fails to take into account provider performance on quality metrics and patient outcomes that are appropriately adjusted for clinical complexity and patient socio-demographic characteristics.  
*** |
| American Nurses Association (ANA) | F. ***  
(5) A health carrier shall contract with a sufficient number of each type of provider licensed to provide specific covered health care services or benefits. The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.  
*** |
| American Optometric Association (AOA) | F. ***  
(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ contract with specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.  
*** |
| AMA | F. ***  
(2) (a) The standards shall be used in determining the selection or tiering of providers by the health carrier and its intermediaries with which it contracts.  
(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].  
(3) Selection criteria shall not be established in a manner:  
***  
(c) That fails to take into account provider performance on quality metrics and patient outcomes as a major and essential component of provider selection criteria. |
| **ASDSA** | F. ***  
(3) Selection criteria shall not be established in a manner:  
(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;  
(b) That would exclude providers because they treat, or specialize or subspecialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or  
(c) That fails to take into account provider performance on quality metrics and patient outcomes.  *** |
| **ASRS** | F. ***  
(3) Selection criteria shall not be established in a manner:  ***  
(d) That fails to use appropriate peer comparisons, including at the specialty and subspecialty levels of services provided and billed, when assessing individual provider quality and resource use.  *** |
| **BIO** | F. ***  
(3) Selection criteria shall not be established in a manner:  
(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;  
(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or  
(c) That fails to take into account provider performance on quality metrics and patient outcomes.  
**Drafting Note:** Any metrics of quality-of-care and patient outcomes against which provider performance is judged must: (1) be specific to the type of care provided; (2) meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment; and (3) be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.  *** |
| **CHA** | F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers, and each health care professional specialty and specialty facilities, such as children’s pediatric specialty hospitals, free-standing cancer centers, transplantation facilities, and other unique and specialized providers appropriate for the treatment of children and adults with serious, chronic or complex health conditions.  
(2) (a) The standards shall be used in determining the selection or tiering of providers by the health carrier and its intermediaries with which it contracts.  
(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].  
(3) Selection or tiering criteria shall not be established in a manner:  
(a) That would allow a health carrier to discriminate against high-risk populations by excluding or tiering providers because they are
located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;

(2) That fails to include primary and specialty health care professionals and facilities that have the appropriate clinical expertise, experience, training, equipment and staff to deliver medically necessary health care services. In addition to general licensure standards, the carrier should select providers with the capability and experience necessary to deliver age-appropriate care for children and adults;

(b) That would exclude providers because they treat or specialize in treating populations either children or adults who presenting a risk of higher than average claims, losses or health care services utilization due to complex or chronic health conditions; or

(c) That fails to take into account provider performance on appropriate, available and age-relevant quality metrics and patient outcomes.

***

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider’s specialty or on the type of patient contained in the provider’s practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. In addition, states should be aware that certain providers, notwithstanding the scope of their license, limit their practice to either children or adults. Any evaluation of network adequacy should include an analysis of the availability and capability of providers to deliver age and medically appropriate treatment.

This subsection does not prevent health carriers from requiring all providers that participate in the carrier’s network to meet all the carrier’s requirements for participation.

DREDF

F.***

(3) Selection criteria shall not be established in a manner:

***

(c) That fails to take into account provider performance on quality metrics and patient outcomes unless there is a dearth of established or appropriate quality metrics relevant to the provider’s treatment specialty.

***

Maine Bureau of Insurance

F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection of providers by the health carrier and its intermediaries with which it contracts.

(b) The health shall be responsible for the development of and compliance with standards for the selection, and if applicable, the tiering of facilities, primary care professionals and each health care professional specialty, which shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3)(2) Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services
(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or
(c) That fails to take into account provider performance on quality metrics and patient outcomes.

(4) Paragraph (3) shall not be construed to require a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed by or on behalf of the carrier in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

### NCQA

F. ***

(3) Selection criteria shall not be established in a manner:

(c) That fails to take into account provider performance on quality, patient experience metrics and patient outcomes metrics, where appropriate and feasible.

### WHA

F. ***

(3) Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or

(c) That fails to take into account provider performance on quality metrics and patient outcomes.

### G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner.

Academy

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. The health carrier also shall make its standards publicly available.

ACS CAN, AHA, NAIC Consumer representatives, Families USA, National Health Law Program

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner and available to the public on its website.
| AHIP/BCBSA | G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. |
| AMA, CMA | G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner, and the health carrier shall make the standards available to the public on its website. Any material change made to the standards for selecting and tiering participating providers throughout the plan year shall be submitted to the commissioner for review and approval prior to implementation. |
| ASRS | G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner and subsequently make those standards available to providers and consumers. |
| Maine Bureau of Insurance | G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. |

H. A health carrier shall notify participating providers of the providers’ responsibilities with respect to the health carrier’s applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeal procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements and any applicable federal or state programs.

No comments received

I. A health carrier shall not offer an inducement to a provider to provide less than medically necessary services to a covered person.

ACS CAN, NAIC Consumer representatives, National Health Law Program | I. A health carrier shall not offer an inducement or penalty to a provider to provide less than medically necessary services to a covered person. |

AHA | I. A health carrier shall not offer an inducement to or penalize a provider to provide less than medically necessary services to a covered person. |

AMA | I. A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to furnish to provide less than medically necessary services to a covered person. |

J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier’s position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier.
**Drafting Note:** States should be aware that the term “participating provider” is meant to include providers who may not be in the typical physician office setting or hospital setting, such as patient care coordinators.

| **AHIP/BCBSA** | J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier’s position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier.  

**Drafting Note:** States should be aware that the term “participating provider” is meant to include licensed providers acting within the scope of licensure who may not be in the typical physician office setting or hospital setting, and may include licensed, accredited or certified staff operating under the supervision of a participating provider, such as patient care coordinators. |
| --- | --- |
| **CHA** | J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier’s position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier.  

**Drafting Note:** States should be aware that the term “participating provider” is meant to include providers who may not be in the typical physician office setting or hospital setting, such as some patient care coordinators. |
| **Families USA** | J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier’s position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier, or available under state or federal law.  

***K. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.*** |
| **DREDF** | K. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to both the confidentiality of medical or health records and the covered person’s right to effective communication of medical or health records. |
| **L.** (1) **(a)** A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.  

**Drafting Note:** In addition to without cause contract terminations, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements. |
(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(c) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(3) (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.
Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

AADA

L. (1) (a) A health carrier and participating provider shall provide at least ninety (90) days written notice to each other before terminating the contract without cause. The health carrier shall mail any notice of network termination or a change in network status to the office(s) at which the physician is listed as practicing.

(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis in the past one (1) year or in the time the patient has been with the insurer, whichever is shorter, by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(2) ***

(b) Whenever a provider’s contract is terminated without cause during the benefit year, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less, with the provider for the duration of the benefit year.

***

AAFP

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.

****

(b) The health carrier shall make a good faith effort to provide written notice of a termination within ninety (90) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. (Note comments seem to suggest defining “regular basis” and the possibility of excluding healthy individuals who see their primary care doctor yearly or every two years.)

AAP

L.

***

(2) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

(iii) “Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has limited duration;

(iv) “Terminal illness” means an incurable or irreversible condition that has a high probability of causing death within one year or less; and

(iv) “Special circumstance” means a condition in which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special
circumstance include a covered person with a disability, a mental health condition, or a substance use disorder; acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy; or a person who has prior authorization for a procedure or surgery by a provider who subsequently leaves the network.

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.

(e) In the event that a provider’s contract is terminated without cause and the treating physicians or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.

(f) In the event that a treating physician or health care provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the covered person to continue care with the treating provider until the course of treatment ends or for up to 90 days, whichever is less.

(3) (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b)(a) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(e)(b) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).
(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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<td>L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.</td>
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Drafting Note: In addition to without cause contract terminations, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(c) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(d) In instances where a provider does not notify the health carrier of their termination, the health carrier is responsible for making a good faith effort to notify covered persons being seen by the provider on a regular basis within thirty (30) days, after learning of and confirming the provider’s termination.

(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

(b) (i) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever
is less.

(ii) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for active treatment in-network if: (I) The health carrier agrees that a condition for which ongoing treatment is being provided is part of a short-term agreement for enrollees undergoing active treatment; and (II) The contract termination was not “for cause.”

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

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Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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(c) Where a contract termination involves a primary care professional or specialty provider, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. (ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). “Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and has limited duration; (iii) “Special circumstance” means a condition in which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, a mental health condition, or a substance use disorder; an individual who is currently undergoing active cancer treatment, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy; or a person who has prior authorization for a procedure or surgery by a provider who subsequently leaves the network; and (iv) “Terminal illness” means an incurable or irreversible condition that has a high probability of causing death within one year or less.

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, twelve (12) months, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.
(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.

(e) In the event that a provider’s contract is terminated without cause and the treating physician or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.

(f) In the event that a treating physician or health care provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the covered person to continue care with the treating provider until the course of treatment ends or for up to 90 days, whichever is less.

(g) A health carrier shall allow any enrollee described in paragraph (2)(a)(i)-(iv) to be able to obtain a second opinion from an out-of-network provider if no alternative in-network provider is available, qualified, or within a reasonable distance. In such instances, the enrollee’s cost-sharing for accessing the out-of-network provider should be no higher than the enrollee would pay if the provider were included in-network. If the first and second opinions are in conflict, the carrier should be required to cover a third opinion if requested by the enrollee.

(3) (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance meets one of the conditions laid out in Paragraph (2) if the treating physician or health care provider does the following:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) (b) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of time laid out for one of the conditions in Paragraph (2), if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or
provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

**Drafting Note:** States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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**AHA**

L. (1)***(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(c) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days until the end of the coverage year, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.

(e) In the event that a provider’s contract is terminated without cause and the treating physician or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.

(f) In the event that a treating physician or health care provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the covered person to continue care with the treating provider until the course of treatment ends or 60 days, whichever is less.

(3) (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or
condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who meets one of the conditions stipulated in Paragraph (2) has a special circumstance if the treating physician or health care provider does the following:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement rate negotiated with from the health carrier for that patient as provided under the carrier’s provider contract; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate if for the duration of time stipulated for one of the conditions under paragraph (2):

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.
phase of the condition).
(b) Whenever a provider's contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.
(c) In the event that a provider's contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(3)(a) For purposes of this paragraph:
(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following:
(i) Identifies a special circumstance with respect to the covered person;
(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;
(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and
(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate if:
(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and
(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.
Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

(2) A health carrier shall have in place a continuity of care provision as required by [insert state continuity of care provision].

Drafting Note: Health plans already support transitional care policies and procedures that result in continuity of care for covered persons undergoing active courses of treatment, such as radiation therapy or chemotherapy, for a serious or terminal illness; and mothers in their second or third trimester of pregnancy, to include at least six weeks post-partum care. For a new enrollee transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursements during the transition period, and for existing covered persons of a plan whose provider is no longer in the plan's network - at in-network reimbursements during the transition period. When considering continuity of care requirements, states also should consider provisions which prohibit providers from balance-billing covered persons during these transition periods or otherwise charging those covered persons amounts beyond their in-network cost sharing obligation.

AMA

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) ninety (90) days written notice to each other before terminating the contract without cause.

(b) When a participating provider is reassigned to a higher cost-sharing tier during the patient’s plan year, the patient may continue seeing the provider at the original cost-sharing level until the end of the covered person’s contract year.

Drafting Note: In addition to without cause contract terminations, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b)(c) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(e)(d) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) (i) For purposes of this paragraph: (i) “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. (ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). “Acute medical condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and has limited duration; (iii) “Life threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; and (iv) “Special circumstance” means a condition in which the treating physician or health care provider believes that discontinuing care by
the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition, or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(3) (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b)(c) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following: meets one of the conditions outlined in Paragraph (2) and the physician or provider:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement from the health carrier for that patient covered person as provided under the carrier’s provider contract between the physician or the provider; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the
Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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<td>(b) Whenever a provider’s contract is terminated without</td>
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<td>cause, the health carrier shall allow affected covered</td>
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<td>treatment to continue such treatment until it is completed</td>
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<td>or for up to ninety (90) days one year, whichever is less.</td>
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<td>(c) In the event that a provider’s contract is terminated</td>
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<td>without cause and the provider treats pregnant covered</td>
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<td>persons, the health carrier shall allow affected covered</td>
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<td>persons in their second or third trimester of pregnancy to</td>
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| continue care with the provider through
the postpartum period.
(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.
(e) In the event that a provider’s contract is terminated without cause and the treating physician or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.
(f) In the event that a treating physician or health care provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the covered person to continue care with the treating provider until the course of treatment ends or for up to 90 days, whichever is less.

(3) (a) For purposes of this paragraph:
(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance meets one of the conditions laid out in Paragraph (2) if the treating physician or health care provider does the following:
(i) Identifies a special circumstance with respect to the covered person;
(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;
(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and
(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(e)(b) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of time laid out for one of the conditions in Paragraph (2), if:
(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and
(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the
tacting physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

**Drafting Note:** States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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<th>Families USA</th>
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<td>(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.</td>
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<tr>
<td>(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.</td>
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<td>(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). “Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has limited duration;</td>
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<tr>
<td>(iii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, a mental health condition, or a substance use disorder, or a covered person who has received prior authorization for a procedure or surgery by a provider who subsequently leaves the network; and</td>
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<td>(iv) “Terminal illness” means an incurable or irreversible condition that has a high probability of causing death within one year or less.</td>
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<td>(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, twelve (12) months, whichever is less.</td>
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<tr>
<td>(c) In the event that a provider’s contract is terminated without cause, the provider treats pregnant covered persons in their second or third trimester of pregnancy who are pregnant to continue care with the provider through the postpartum period.</td>
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<td>(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.</td>
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<td>(e) In the event that a provider’s contract is terminated without cause and the treating physician or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.</td>
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</table>
| (f) In the event a patient with an acute or chronic medical condition, pregnancy, terminal illness or a special circumstance enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the newly enrolled person to continue care with the treating provider. Care for acute or chronic conditions should until the course of treatment ends or for up to 90 days, whichever is less. In the case of pregnancy, coverage should last through the postpartum period. Care for
(3) (a) For purposes of this paragraph:
(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.
(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following:
(i) Identifies a special circumstance with respect to the covered person;
(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;
(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract to in-network providers for similar services in the same or similar geographic area unless the carrier and the provider mutually agree on a different rate; and
(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.
(c)(b) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of time laid out for one of the conditions in Paragraph (2), if:
(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and
(ii) The contract termination was not “for cause.”
(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.
(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be in-network or a participating provider is listed as accepting new patients.
1. (a) A health carrier **and/or a** participating provider shall provide at least sixty (60) days written notice to **each other** before terminating the contract without cause.

**Drafting Note:** In addition to without cause contract terminations, **with respect to tiered network plans**, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

***

3. (a) For purposes of this paragraph:

(i) “Life-threatening” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(b) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or the provider providing for medically necessary treatment at the time of termination to a covered person who has a special circumstance if the treating physician or health care provider does the following:

(i) Identifies a special circumstance with respect to the covered person;

(ii) Requests that the covered person be permitted to continue treatment under the physician’s or provider’s care;

(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided under the carrier’s provider contract; and

(iv) Agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate if:

(i) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of:

(i) The termination of the covered person’s coverage under the network plan; or

(ii) The next plan renewal date, if the covered person had notice of the provider contract termination before renewing coverage; or

(iii) The end of the course of treatment ends.
(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery, **as long as coverage is still in force.**

**Drafting Note:** States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.

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<th>Shriver Center</th>
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<td>(2) (a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. (ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).</td>
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<td>(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.</td>
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<td>(ii) The contract termination was not “for cause.”</td>
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<td>(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery, <strong>as long as coverage is still in force.</strong></td>
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<td>provider for ongoing treatment of a covered person ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends. (e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery. (f) If a health carrier agrees to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate pursuant to this paragraph, a covered person’s cost-sharing for services by such provider, pursuant to such an agreement, shall count toward the covered person’s maximum out-of-pocket limit applicable to in-network benefits.</td>
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<td>M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier. Drafting Note: In order to assure continued provider participation, a state may wish to restrict the right of a health carrier to assign or delegate its contract with a provider without prior written notice to the provider.</td>
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<td>N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person’s enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions. No comments received</td>
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<td>O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers’ obligations, if any, to notify covered persons of their personal financial obligations for non-covered services. No comments received</td>
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<td>P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare. No comments received</td>
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Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not an individual is covered by the carrier.

**AMA**

Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not an individual is covered by the carrier. _Any positive eligibility determinations made by the health carrier using the established mechanism are binding on the carrier._

**R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.**

No comments received

**S. A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.**

No comments received

**T. A health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions at the time the contract is executed and of any material changes in the contract.**

**Maine Bureau of Insurance**

_T. A health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions at the time the contract is executed and of any material changes in the contract. If the contract signed by the provider incorporates other documents by reference, those documents, and any material changes to those documents while the contract is in force, shall not be binding on the provider until the provider has been given reasonable notice of the terms of those documents or changes._

**Suggested Additional Subsections**

**AAP**

？ A health carrier shall appropriately inform providers of their network status on any plan in which they are included in-network.

**American Chiropractic Association (ACA)**

？ A health carrier shall establish a mechanism to ensure that its network access and adequacy procedures and standards fully comply with the Providers’ Non-Discrimination in Health Care requirements under Section 2706(a) of the Public Health Service Act and applicable provisions of state law.

**ACS CAN, NAIC Consumer representatives, Families USA, National Health Law Program**

？ A health carrier shall ensure via contract with a facility that is a network provider that a covered person will not be subject to balance billing for health care services provided in that facility by an out-of-network health care professional employed by or under contract with the facility.
| American Podiatric Medical Association (APMA) | ? A contract between a health carrier and a provider shall not contact providers or other terms that conflict with the carrier’s obligations set forth in 42 U.S.C. 300gg-5(a), which prohibits discrimination with respect to participation or coverage against health care providers acting within the scope of their licensure or certification. |
| ASRS | ? A health carrier may not remove a provider of services from a network plan during the middle of a policy or contract year unless the carrier has cause to remove such provider.  
**Drafting Note:** Add examples of “cause” for removal, such as loss of licensure or conviction of fraud and/or abuse, as well as what may not be considered “cause” for removal, such as provider economic profiling and provider choice of drug/therapy. |
| APA | ? A health carrier that uses automatically renewing contracts with its providers shall provide notice to the provider three (3) weeks in advance of the notice of termination period that the contract is about to renew and failure to terminate by the contractual deadline will result in contract renewal. |
| Consumers Union | ? In no event shall a non-participating provider collect or attempt to collect from a covered person the difference between the provider’s charge and the health carrier’s allowed amount when the covered health care service is subject to Section 5C(2) of this Act or when health care services were rendered in an in-network facility.  
? The carrier shall certify to the department that the information provided in the provider directory is consistent with the information required under other provisions of the Act, including the carrier’s access plan. The carrier shall assure that other information reported to the department is consistent with the information provided to enrollees, potential enrollees and the department pursuant to this section. |
| DREDF | ? A health carrier shall notify participating providers of the provider’s responsibilities with respect to compliance with federal and state civil rights and disability accessibility laws such as the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and the Affordable Care Act. |

**Section 7. Disclosure and Notice Requirements**

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital.

**Drafting Note:** States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide...
Adequate and reasonable access for covered persons to covered benefits related to hospital-based providers who are not in the same network as the in-network hospital.

**AAP**

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. **Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount that covered person would be required to pay for out-of-network services.**

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. **Such disclosure shall include an estimate of the approximate charges that may be billed to the covered person for services provided by a non-participating provider.***

**ACS CAN**

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. **Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).**

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. **Such disclosure shall include an estimate of the approximate charges that may be billed to the covered person for services provided by a nonparticipating provider.**

C. Health carriers providing written notice and disclosure provided under this section shall notify enrollees of any options available to them to obtain access to services through an in-network provider.

**Drafting Note:** States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to hospital-based providers who are not in the same network as the in-network hospital. **States should actively monitor the extent to which carriers are issuing written disclosures and notices and take this information into account when determining the adequacy of a plan’s network.**
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<td><strong>AHA</strong></td>
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<td><strong>AHIP/BCBSA</strong></td>
<td>A. A health carrier for each of its network plans, a health carrier shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital. This written disclosure or notice would explain that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital. This written disclosure or notice would confirm that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. *** Drafting Note: States may wish to consider applying disclosure and notice requirements to hospitals as well as health carriers. That may necessitate that states develop appropriate laws and regulations to provide for disclosure and notice requirements that apply to hospitals. State insurance departments may need to coordinate with other state agencies, specifically those agencies with regulatory jurisdiction for hospitals, to develop and apply such laws and regulations.</td>
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<tr>
<td><strong>NAIC Consumer representatives, National Health Law Program</strong></td>
<td>A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services). B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. Such disclosure shall include an estimate of the approximate charges that may be billed to the covered person for services provided by a nonparticipating provider. ***</td>
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</table>
### Families USA

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services and a description of what the consumer will be responsible for paying if care is delivered by an out-of-network provider, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. Such disclosure shall include an estimate of the approximate charges that may be billed to the covered person for services provided by a nonparticipating provider.

**Drafting Note:** States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to hospital-based providers who are not in the same network as the in-network hospital. States may wish to enact standards to address these issues.

### Maine Bureau of Insurance

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital, if applicable, that there is the possibility that the covered person could be treated by a provider that is not in the same carrier’s network as the hospital and that the covered person could then be responsible for cost-sharing at nonparticipating levels and for balance billing by the non-participating provider.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and, if applicable, informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital.

***

### WHA

**Section 7. Disclosure and Notice Requirements**

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written
Disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital.

**Drafting Note:** States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to hospital-based providers who are not in the same network as the in-network hospital.

### Section 8. Provider Directories

A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C.

(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

<table>
<thead>
<tr>
<th>AAFP</th>
<th>A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. For purposes of this section “current” means?</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>A. (1) <strong>(a)</strong> A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. <strong>(b)</strong> In making a directory available online, the carrier shall do so in a manner that: (i) makes clear which providers are included in-network in a given health benefit plan; and (ii) does not require a covered person or a prospective covered person to log in or enter a policy number in order to access the applicable provider directory. <strong>(2)</strong> The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities. <strong>(3)</strong> A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person. <strong>(4)</strong> For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory, the following general information: <strong>(a)</strong> The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is coverage for services provided by out-of-network providers; <strong>(b)</strong> The methodology used, if any, for determining the payment amount for out-of-network services and the covered person’s liability for additional costs; <strong>(c)</strong> The breadth of the network;</td>
</tr>
</tbody>
</table>
(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier; 
(e) The carrier’s process for allowing covered persons to use out-of-network providers with in-network cost-sharing in situations where a suitable in-network provider is not available on a timely basis; and 
(f) The email address and phone number that covered persons or the public can use solely to directly notify the plan when provider directory information is inaccurate.

ACAP

(2) The health carrier shall update each network plan provider directory at least monthly after making a good faith effort to verify changes and shall offer the provider directory in a manner to accommodate individuals with limited-English language proficiency or disabilities.

ACS CAN, AHA, NAIC Consumer representatives

A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. In making a directory available online, the carrier shall do so in a manner that:
(a) Makes it clear what provider directory applies to which network plan to the maximum extent possible; and
(b) Does not require a covered person or prospective covered person to log in or enter a policy number in order to access the applicable provider directory.

(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory, the following general information:
(a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;
(b) The methodology used, if any, for determining the payment amount for out-of-network services and the covered person’s liability for additional costs;
(c) The breadth of the network;
(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;
(e) The carrier’s process for allowing covered persons to use out-of-network providers with in-network cost-sharing in situations where a suitable in-network provider is not available on a timely basis; and
(f) The email address and phone number that covered persons or the public can use solely to directly notify the plan when provider directory information is inaccurate.

Families USA, National Health Law Program

A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. In making a directory available online, the carrier shall do so in a manner that:
(a) Makes it clear what provider directory applies to which network plan to the maximum extent possible; and
(b) Does not require a covered person or prospective covered person to log in or enter a policy number in order to access the
(2) The health carrier shall update each network plan provider directory at least monthly every fifteen (15) days and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory, the following general information:

(a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;
(b) The methodology used, if any, for determining the payment amount for out-of-network services and the covered person’s liability for additional costs;
(c) The breadth of the network;
(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;
(e) The carrier’s process for allowing covered persons to use out-of-network providers with in-network cost-sharing in situations where a suitable in-network provider is not available on a timely basis; and
(f) The email address and phone number that covered persons or the public can use solely to directly notify the plan when provider directory information is inaccurate, along with an indication that plans will investigate reports from the public received through this email address and modify directories (such as removing providers no longer in-network) accordingly within fifteen (15) days.

Drafting Note: For oversight purposes, states may want carriers to report annually on the number of inaccuracy reports received, the timeliness of the carriers’ responses, and the corrective actions taken. States could make these reports publicly available on regulator websites.

**AHIP/BCBSA**

A. ***

(2) The health carrier shall update each network plan provider directory at least monthly within thirty (30) calendar days of receiving new information from providers and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

***

**AMA**

A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. In making a directory available online, the carrier shall do so in a manner that: (i) clearly indicates which provider directory applies to which network plan; and (b) does not place any barriers to allowing any individual from accessing the directory.

***

**American Telemedicine Association (ATA)**

A. ***

(4) The health carrier shall provide information in the provider directory on where to access the plan’s services and features, including but not limited to its process for choosing and changing providers, available interpretative and language assistance services, the plan’s referral and prior authorization procedures, services offered through the preventive care benefit and access to telemedicine, if
applicable, and its procedures for providing and approving emergency and specialty care.

<table>
<thead>
<tr>
<th>APA</th>
<th>A.***</th>
</tr>
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<tbody>
<tr>
<td>(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities. <strong>The health carrier must take affirmative action to ensure that providers listed in the directory are actively submitting claims and that all information provided is correct.</strong>*</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Consumers Union</th>
<th>A. ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) The health carrier shall update each network plan provider directory at least <strong>monthly</strong>weekly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities. ***</td>
<td></td>
</tr>
<tr>
<td>(? ) Clear and conspicuous notice of which, if any, participating hospitals have no participating physicians or other providers in specific specialties, including but not limited to emergency services, or few such providers according to state-established minimums.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DREDF</th>
<th>A. ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner <strong>that assures effective communication to accommodate</strong> individuals with limited-English language proficiency or disabilities, and <strong>accommodates their privacy and independence.</strong></td>
<td></td>
</tr>
<tr>
<td>(3) A health carrier shall provide a <strong>print</strong> copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Maine Bureau of Insurance</th>
<th>A. ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner <strong>disabilities or</strong> limited-English language proficiency or <strong>disabilities.</strong>*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. The health carrier shall make available in print the following provider directory information for each network plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) For health care professionals: <strong>disabilities or</strong></td>
</tr>
<tr>
<td>(a) Name;</td>
</tr>
<tr>
<td>(b) Gender;</td>
</tr>
<tr>
<td>(c) Contact information;</td>
</tr>
<tr>
<td>(d) Specialty; and</td>
</tr>
<tr>
<td>(e) Whether accepting new patients.</td>
</tr>
<tr>
<td>(2) For hospitals:</td>
</tr>
<tr>
<td>(a) Hospital name;</td>
</tr>
<tr>
<td>(b) Hospital location and telephone number; and</td>
</tr>
<tr>
<td>(c) Hospital accreditation status; and</td>
</tr>
<tr>
<td>(3) Except hospitals, other facilities by type:</td>
</tr>
<tr>
<td>(a) Facility name;</td>
</tr>
<tr>
<td>(b) Facility type;</td>
</tr>
<tr>
<td>(c) Procedures performed; and</td>
</tr>
<tr>
<td>(d) Facility location and telephone number.</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
</tbody>
</table>
| **AADA, AAFP** | B. (1) *** *(d) and subspecialties:*  
 | *** |
| **AAP, NAIC Consumer representatives, Families USA, National Health Law Program** | B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Gender;  
(c) Contact information;  
(d) Specialty;  
(e) Network tier to which the professional is assigned, if applicable; and  
(f) Whether accepting new patients.  
(2) For hospitals:  
(a) Hospital name;  
(b) Hospital location and telephone number; and  
(c) Hospital accreditation status; and  
(d) Network tier to which the hospital is assigned, if applicable; and  
(3) Except hospitals, other facilities by type:  
(a) Facility name;  
(b) Facility type;  
(c) Procedures performed; and  
(d) Network tier to which the facility is assigned, if applicable; and  
(e) Facility location and telephone number.  

**AARP** | B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Gender;  
(c) Contact information;  
(d) Specialty; and  
(e) Languages spoken by the health care professional or clinical staff;  
(f) Whether accepting new patients; and  
(g) The website address for the online provider directory and a list by category of the additional information that is available on the online provider directory.  

**ACS CAN** | B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Gender;
| AHA | B. The health carrier shall make available in print the following provider directory information for each network plan:
|     | (1) For health care professionals:
|     | (a) Name;  
|     | (b) Gender;  
|     | (c) Contact information;  
|     | (d) Specialty;  
|     | (e) Network tier to which the professional is assigned, if applicable; and  
|     | (e)[f] Whether accepting new patients.  
|     | (2) For hospitals:
|     | (a) Hospital name;  
|     | (b) Hospital location and telephone number; and  
|     | (c) Hospital accreditation status; and  
|     | (d) Network tier to which the hospital is assigned, if applicable; and  
|     | (3) Except hospitals, other facilities by type:
|     | (a) Facility name;  
|     | (b) Facility type;  
|     | (c) Procedures performed; and  
|     | (d) Network tier to which the facility is assigned, if applicable; and  
|     | (d)[e] Facility location and telephone number.  

| AHIP/BCBSA | B. The health carrier shall make available electronically or in print, upon request, the following provider directory information for each network plan to the extent the information is provided to the health carrier by its providers:
|      | (3) Except hospitals, other facilities by type:
| AMA | B. The health carrier shall make available in print and online the following provider directory information for each network plan:  
(1) For each network:  
(a) The type of plan (HMO, PPO, EPO, etc.) and the patient cost-sharing responsibilities (deductibles, co-pays, premiums, etc.);  
(b) Whether there is out-of-network coverage, and the methodology used to determine payment amounts for out-of-network services, if applicable;  
(c) The standards used to select or tier participating providers and the cost-sharing differentials that may result from using a non-participating provider or a provider in a higher cost-sharing tiers; and  
(d) The email addresses and phone numbers individuals may use to report inaccuracies to the provider directories to the plans.  
(2)(2) For health care professionals:  
(a) Name;  
(b) Gender;  
(c) Contact information;  
(d) Specialty and subspecialty, if applicable and indication of whether the provider may be chosen as a primary care provider;  
(e) Network tier to which the provider is assigned, if applicable; and  
(f) Whether accepting new patients.  
(2)(3) For hospitals:  
(a) Hospital name and type (e.g. general acute care, children’s cancer, rehab, etc.);  
(b) Hospital location and telephone number;  
(c) Network tier to which the hospital is assigned; and  
(d) Hospital accreditation status; and  
(3)(4) Except hospitals, other facilities by type:  
(a) Facility name;  
(b) Facility type;  
(c) Procedures performed;  
(d) Network tier to which the facility is assigned, if applicable; and  
(e) Facility location and telephone number. |

| ASDSA | B. ***  
(1) For health care professionals:  
***  
(d) Specialty and subspecialty, if applicable;  
*** |

| APA | B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Facility type;  
(c) Procedures Types of services performed; and  
(d) Facility location and telephone number. |
(b) Gender;  
(c) Contact information;  
(d) Specialty;  
(e) Health plans accepted; and  
(f) Whether accepting new patients.  

**CHA**  
B. The health carrier shall make available in print the following provider directory information for each network plan:  
***  
(2) For hospitals by type (i.e. acute, rehabilitation, children’s, cancer):  
(a) Hospital name;  
(b) Hospital location and telephone number; and  
(c) Hospital accreditation status; and  

**DREDF**  
B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Gender;  
(c) Contact information;  
(d) Specialty; and  
(e) Whether accepting new patients for each tiered network in which they participate.  
***  

**ERIC H, Banterings**  
B. The health carrier shall make available in print the following provider directory information for each network plan:  
(1) For health care professionals:  
(a) Name;  
(b) Gender;  
(c) Contact information;  
(d) Specialty; and  
(e) Gender of support staff; and  
(f) Provide same gender care for; and  
(g) Whether accepting new patients.  
(2) For hospitals:  
(a) Hospital name;  
(b) Hospital location and telephone number; and  
(c) Gender of support staff;  
(d) Provide same gender care for; and  
(e) Hospital accreditation status; and  
(3) Except hospitals, other facilities by type:  
(a) Facility name;  
(b) Facility type;  
(c) Procedures performed;  
(d) Gender of support staff;
| **Maine Bureau of Insurance** | (e) Provide same gender care for; and  
<table>
<thead>
<tr>
<th></th>
<th>(d)(f) Facility location and telephone number.</th>
</tr>
</thead>
</table>
|                             | B. ***  
|                             | (3) **Except** Facilities other than hospitals, **other facilities** by type:  
|                             | (a) Facility name;  
|                             | (b) Facility type;  
|                             | (c) Procedures performed; and  
|                             | (d) Facility location and telephone number. |
| **NCQA**                    | B. The health carrier shall make available in print the following provider directory information for each network plan:  
|                             | (1) For health care professionals:  
|                             | (a) Name;  
|                             | (b) Gender;  
|                             | (c) Contact information; and  
|                             | (d) Specialty; and  
|                             | (e) Whether accepting new patients.  
|                             | ***  
| **C. For the online provider directories, for each network plan, a health carrier shall include:**  
|                             | (1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:  
|                             | (a) Hospital affiliations;  
|                             | (b) Medical group affiliations;  
|                             | (c) Board certification(s);  
|                             | (d) Languages spoken by the health care professional or clinical staff; and  
|                             | (e) Office location(s);  
|                             | (2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:  
|                             | (a) Hospital name; and  
|                             | (b) Hospital location; and  
|                             | (3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:  
|                             | (a) Facility name;  
|                             | (b) Facility type;  
|                             | (c) Procedures performed; and  
|                             | (d) Facility location.  

**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still
intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

### AADA

| C. (1) ***(d) Subspecialties; 
| *** |

### AAFP

C. (1) ***(d) Subspecialties; 
***

D. A health carrier develop an automated verification process to contact providers listed in its provider directories as in-network for its health benefit plan(s) who have not submitted claims with the past [x] months to determine if a provider is still in-network.

**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and closely monitoring consumer complaints.

### ACAP

C. For the online provider directories, for each network plan, a health carrier shall include:

(1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:
(a) Hospital affiliations in the health carrier’s network;
(b) Medical group affiliations in the health carrier’s network;
(c) Board certification(s);
(d) Languages spoken by the health care professional or clinical staff; and
(e) Office location(s);
***

**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months for primary care providers and twelve months for specialists or some other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to assess: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

### AHA

***

(3) Except hospitals, for other facilities or agencies, the following information with search functions for specific data types and instructions for searching for the following information:
<table>
<thead>
<tr>
<th>Entity</th>
<th>Text</th>
</tr>
</thead>
</table>
| **(a)** Facility or agency name;  
(b) Facility or agency type;  
(c) Procedures performed; and  
(d) Facility or agency location.  

**AHIP/BCBSA**  
C. For the online provider directories **only**, for each network plan, the health carrier shall include:  
***  
(3) ***  
(c) ProceduresTypes of services performed;  
***  
Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints requiring health carriers to establish a process for updating and assuring the accuracy in the directories, and monitoring consumer complaints related to provider directories.  

| **AMA** | C. For the online provider directories, for each network plan, a health carrier shall include the information required under Subsection B and additionally:  

(1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:  
(a) Hospital affiliations;  
(b) Medical group affiliations;  
(c) Board certification(s);  
(d) Languages spoken by the health care professional or clinical staff; and  
(e) Office location(s);  

***  

| **ASDSA** | C. For the online provider directories, for each network plan, a health carrier shall include:  

(1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:  
(a) Hospital affiliations;  
(b) Medical group affiliations;  
(c) Board certification(s) and sub-specialization(s), if applicable;  
(d) Languages spoken by the health care professional or clinical staff; and  
(e) Office location(s); and  
(f) Physician office hours at each office location;  

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### D. If a patient has made a decision to participation in a network plan based on provider directory information that is inaccurate or incomplete, the patient should be permitted to terminate or make changes to his or her plan without penalty.

### Cancer Leadership Council

<table>
<thead>
<tr>
<th>C. (1)**</th>
<th>(d) Affiliation, if any, with cancer centers;</th>
</tr>
</thead>
</table>

### CHA

<table>
<thead>
<tr>
<th>C.</th>
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| (2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information: |
| --- | --- |
| (a) Hospital name; |
| (b) Hospital type; and |
| (b) Hospital location; and |

### CMA

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**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) adopting processes and procedures for state-ordered direct testing of networks, such as in response to consumer complaint trends or to evaluate the efficacy of a corrective action plan; 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to assess: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

### DREDF

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<tr>
<th>C.</th>
<th>For the online provider directories, for each network plan, a health carrier shall include:</th>
</tr>
</thead>
</table>

| (1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as: |
| --- | --- |
| (a) Hospital affiliations; |
| (b) Medical group affiliations; |
| (c) Board certification(s); |
| (d) Languages spoken by the health care professional or clinical staff; and |
| (e) Structural accessibility, presence of accessible exam and diagnostic equipment, and availability of programmatic accessibility; and |
| (f) Office location(s); |

### ERIC H, Banterings

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<tr>
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| --- | --- |
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| (b) Medical group affiliations; |
| (c) Board certification(s); |
| (d) Languages spoken by the health care professional or clinical staff; |
(e) Gender of support staff;  
(f) Provide same gender care for; and  
(g) Office location(s);  

(2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:  
(a) Hospital name; and  
(b) Hospital location;  
(c) Gender of support staff; and  
(d) Provide same gender care for; and  

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:  
(a) Facility name;  
(b) Facility type;  
(c) Procedures performed; and  
(d) Facility location;  
(e) Gender of support staff; and  
(f) Provide same gender care for.  

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<table>
<thead>
<tr>
<th>Families USA</th>
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<tbody>
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(c) Board certification(s);  
(d) Languages spoken by the health care professional or clinical staff; and  
(e) Office location(s);  

(2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:  
(a) Hospital name; and  
(b) Hospital location; and  

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:  
(a) Facility name;  
(b) Facility type;  
(c) Procedures performed; and  
(d) Facility location.  
|
Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly every 15 days, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network. Based on the provider’s response, the carrier must update the directory accordingly. If the provider does not respond within 30 days, the carrier must attempt contact again, and if the provider does not respond within another 30 days, the carrier must remove the provider’s information from the directory; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to assess: a) whether their provider contact information is correct, b) whether the providers are really in the plan’s network; and c) whether they are taking new patients. If any of the information listed in the directory is found to be inaccurate based on the audit findings, the directory must be updated within one month of the date in which the specific inaccuracy is noted; and 3) closely monitoring consumer complaints.

NCQA

C. For the online provider directories, for each network plan, a health carrier shall include:

1. The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:
   a. Hospital affiliations;
   b. Medical group affiliations;
   c. Board certification(s);
   d. Languages spoken by the health care professional or clinical staff; and
   e. Office location(s); and
   f. Whether accepting new patients.

***

4. For the pieces of information about the health care professionals and hospitals referenced in Paragraphs (1) through (3), health carriers shall make available through their directories the source of that information and any limitations, if applicable.

Consumers Union

C. (1) *** (f) Whether the provider is currently accepting new patients;

***

Suggested new subsections

AADA

D. A health carrier shall permit an individual to disenroll and enroll in another health benefit plan of the carrier if the individual enrolled in the health benefit plan based on inaccurate information in the health carrier’s provider directory.

Academy

D. In addition to requiring updating each provider directory at least monthly, to maintain the accuracy of the directory information, a health carrier shall: (1) develop and maintain an automated verification process to contact providers listed as in-network that have not submitted claims within the past six (6) months, or other timeframe as determined by the commissioner, to determine if the provider intends to be in-network; (2) develop and maintain an internal audit process to audit the information in a provider directory and modify the directory based on the results of the audit to correct information concerning a provider’s contact information, whether the
**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

<table>
<thead>
<tr>
<th>AAP, ACS CAN, AHA, NAIC Consumer representatives, Families USA, National Health Law Program</th>
<th>D. In any instance in which a covered person receives covered benefits from a non-participating provider due to a material inaccuracy in the provider directory indicating that the provider is a participating provider, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider.</th>
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<tr>
<td>APA</td>
<td>D. The health carrier shall confirm the availability of the physicians tested in the directory by providing and publishing quarterly reports by provider, by plan or the number of claims the provider submitted in the prior quarter. The health also shall report and publish the number of in-network and out-of-network claims submitted by physician specialty on a quarterly basis.</td>
</tr>
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</table>
| PAI | D. Submission of contracted provider data to regulators. Health carriers must submit participating provider information to the commissioner in prescribed electronic format at a regular interval, no less than weekly. In addition to the information included in the provider directories, this should include valid email addresses for every physician/provider listed in the directory to facilitate direct testing via electronic means, such as enabling a state software program to generate a randomized verification sample. E. Enforcement. (1) The commissioner shall adopt, through rulemaking, regulations that establish a process for oversight for health carrier compliance with the standards set for in Sections 8A-C and shall include specific penalties for failure to ensure accuracy in the information required in these sections. In adopting rules to ensure compliance, the commissioner shall consider the following mechanisms including but not limited to: (a) Regular internal audits with findings submitted to the commissioner; (b) External audits to certify accuracy, or on an ad hoc basis as the result of complaint trends or a failed verification sample; (c) Mechanisms for “secret shopping” and spot-checking by state regulators or contracted entities to identify inaccuracies and/or potential access problem areas; (d) A closely monitored consumer complaint process to trigger state review and publicly report on complaint volume and trends, among other things. Such a process should also be accompanied by a consumer education campaign to ensure that consumers understand that access issues should be reported; (e) A mechanism for comparing the submitted contracted provider data against the universal provider data source (UPD); and (f) Automated verification if a physician or health care provider hasn’t submitted claims for a plan’s beneficiaries within six (6) months or other time frame as identified by the state. (2) The commissioner shall adopt penalties for noncompliance with directory accuracy standards. In the event that a patient relies on
an inaccurate listing in a provider directory, the health carrier shall hold the beneficiary harmless for any additional expenses incurred.

**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers, in some manner, such as through an automated verification process, contact providers listed as in network who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; 2) a requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

### Section 9. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

No comments received

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.

No comments received

B. A health carrier’s statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

No comments received

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier’s covered persons.

No comments received

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

No comments received

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

No comments received
F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

No comments received

G. An intermediary shall allow the commissioner access to the intermediary’s books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.

No comments received

H. A health carrier shall have the right, in the event of the intermediary’s insolvency, to require the assignment to the health carrier of the provisions of a provider’s contract addressing the provider's obligation to furnish covered services.

AMA

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider’s contract addressing the provider’s obligation to furnish covered services. *If the health carrier requires assignment, the health carrier shall remain obligated to pay the provider for providing covered services under the same terms and conditions as the intermediary prior to the insolvency.*

I. Notwithstanding any other provision of this section, the health carrier shall retain full responsibility for the intermediary’s compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

AHIP/BCBSA

I. Notwithstanding any other provision of this section, the health carrier shall retain full responsibility for the intermediary's compliance with the requirements of this Act.

*Drafting Note:* States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

AMA

I. Notwithstanding any other provision of this section, the health carrier shall retain full responsibility for the intermediary’s compliance with the requirements of this Act, *as well as full legal responsibility for any other entity’s compliance with this Act’s requirements.*

Suggested Additional Subsections

None suggested
**Section 10. Filing Requirements and State Administration**

**A. Beginning [insert effective date], a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.**

**Drafting Note:** States may want to review their open records laws to determine whether the sample contract forms filed under Subsection A are considered public information.

<table>
<thead>
<tr>
<th>Maine Bureau of Insurance</th>
<th>A. Beginning [insert effective date]. At the time it files its access plan, a health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.</th>
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**B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner for [filing] [approval within [cite period of time in the form approval statute]] within [x] days prior to use.**

**Drafting Note:** Subsection B provides an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file with the commissioner any material changes to a contract for prior approval. A state should choose which option is appropriate for the state.

**Drafting Note:** States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person’s access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

| AHIP/BCBSA | ***
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<tr>
<td></td>
<td><strong>Drafting Note:</strong> States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person’s access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.</td>
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<tr>
<th>AEH</th>
<th>B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner for [filing] [approval within [cite period of time in the form approval statute]] within [x] days prior to use.</th>
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<td><strong>Drafting Note:</strong> Subsection B provides an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file with the commissioner any material changes to a contract for prior approval. A state should choose which option is appropriate for the state. ***</td>
</tr>
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</table>
B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner within at least [cite period of time in the form approval statute] - within [x] days prior to use.

**Drafting Note:** Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file with the commissioner any contracts and material changes to a contract for prior approval. A state should choose which option is appropriate for the state.

**Drafting Note:** States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person's access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

**Families USA**

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) ten (10) days prior written notice from the commissioner.

**Suggested Additional Subsections**

None suggested

**Section 11. Contracting**

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

No comments received
<table>
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<tr>
<th>B. All contracts shall be in writing and subject to review.</th>
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<tr>
<td>No comments received</td>
</tr>
<tr>
<td>C. All contracts shall comply with applicable requirements of the law and applicable regulations.</td>
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<tr>
<td>No comments received</td>
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**Section 12. Enforcement**

**A.** If the commissioner determines that a health carrier has not contracted with sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier’s network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner’s other enforcement powers to obtain the health carrier’s compliance with this Act.

**Drafting Note:** The reference to requiring the health carrier to modify the access plan instead of instituting a corrective action is to reflect the idea that sometimes the network changes through no fault of the health carrier and in those instances, the commissioner may require the health carrier to modify the access plan to bring the health carrier into compliance with the network adequacy requirements of this Act.

**Drafting Note:** State insurance regulators may use a variety of tools and/or methods to determine a health carrier’s ongoing compliance with the provisions of this Act and whether the health carrier’s provider network is sufficient and provides covered persons with reasonable access to covered benefits. Such tools and/or methods include consumer surveys, reviewing and tracking consumer complaints and data collection on the use of out-of-network benefits.

| No comments received |

**B.** The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

| NACDS   | B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination. |

**Section 13. Regulations**

**The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].**

| No comments received |
### Section 14. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

No comments received

### Section 15. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

No comments received

### Section 16. Effective Date

This Act shall be effective [insert date].

Maine Bureau of Insurance

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date]

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

No comments received

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

No comments received

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

No comments received

### Suggested Additional Sections

Maine Bureau of Insurance

D. **Option 1**

For states with access-plan requirements comparable to or exceeding pre-2015 Model. No later than twelve (12) months after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans
consistent with Section 5 of this Act, as amended, for all in-force network plans.

**Option 2**
For states without access-plan requirements comparable to pre-2015 Model. No later than twelve (12) months after [insert effective date of Act or amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.

**Suggested Additional Sections to Model**

| WHA | Recommend new section to require insurers to demonstrate a good faith effort to contract with providers before being granted any exception to network adequacy standards. |