2015 Spring National Meeting
Phoenix, Arizona

NETWORK ADEQUACY MODEL REVIEW (B) SUBGROUP

Sunday, March 29, 2015
11:30 a.m. – 1:00 p.m.
Phoenix Convention Center North—Room 124—Street Level

ROLL CALL

J.P. Wieske, Chair Wisconsin
Rebecca Horne/Bruce Hinze California
Peg Brown Colorado
Molly White/Mary Mealer Missouri
Christina Goe Montana
Martin Swanson Nebraska
Kim Everett Nevada
Terry Seaton New Mexico
Gayle Woods Oregon
Linda Johnson Rhode Island
Chlora Lindley-Myers Tennessee
Molly Nollette/Jennifer Kreitler Washington

AGENDA

1. Consider Adoption of its March 19, March 12, March 2 and Feb. 23 Minutes—J.P. Wieske (WI)

2. Discuss Comments Received on Draft Revisions to Managed Care Plan Network Adequacy Model Act (#74) —J.P. Wieske (WI)

3. Discuss Any Other Matters Brought Before the Subgroup—J.P. Wieske (WI)

4. Adjournment

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Agenda Item #1

Consider Adoption of its March 19, March 12, March 2 and Feb. 23 Minutes
Network Adequacy Model Review (B) Subgroup
Conference Call
March 19, 2015

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call March 19, 2015. The following Subgroup members participated: J.P. Wieske, Chair (WI); Bruce Hinze and Rebecca Horne (CA); Peg Brown (CO); Molly White (MO); Christina Goe (MT); Martin Swanson (NE); Terry Seaton (NM); Gayle Woods (OR); Linda Johnson (RI); Lorrie Brouse (TN); and Jennifer Kreitler (WA). Also participating was: Robert Wake (ME).

1. Discussed Comments Received on Model #74, Section 3—Definitions

The Subgroup continued its discussion of the comments received on the Managed Care Plan Network Adequacy Model Act (#74) section-by-section using the chart developed by NAIC staff beginning with the definition of “health benefit plan” in Section 3—Definitions.

a. Health Benefit Plan

Mr. Wieske said the Children’s Hospital Association (CHA) suggests adding the words “physical and mental/behavioral” to the definition of “health benefit plan” for consistency with its previous suggested revisions. He said he could understand adding this reference to other definitions, but he was not sure it was appropriate to add it to this definition. Mr. Wieske expressed concern that including these references would further distinguish between physical and mental illness, which seems to be counter to the goals of the federal Mental Health Parity Act (MHPA) when it was enacted in 1996. Beth Berendt (Berendt and Associates, LLC) said the CHA believes this revision is necessary to ensure mental health services are covered like physical illnesses. Mr. Seaton suggested that this revision would be more appropriate for the definition of “health care services.” Mr. Wieske expressed support for Mr. Seaton’s suggestion. He said that if “health care services” was revised to include “physical and mental/behavioral,” then, perhaps, it would not be necessary to add that same language to other definitions. Stephanie Mohl (American Heart Association—AHA) expressed support for CHA’s suggested revision. After additional discussion, the Subgroup agreed to accept the CHA’s suggestion.

The Subgroup next discussed the Delta Dental Plans Association’s (DDPA) suggestion to add language to the definition exempting certain types of coverage, including limited scope dental or vision plan benefits, from being considered a health benefit plan. Chris Petersen (Morris, Manning & Martin LLP) said that, although the DDPA believes network adequacy standards for dental plans are important, it is suggesting this revision to exempt dental plans from the provisions of Model #74 because the model’s network adequacy standards appear to be focused on comprehensive major medical coverage. He said the DDPA believes that the NAIC should develop a new NAIC model to address dental plan network adequacy standards. Ms. Goe expressed opposition to the DDPA’s suggested revision. She said dental plan coverage is an essential health benefit. Ms. Goe also said she did not want to exclude dental plans from Model #74 based on the possibility of developing another NAIC model for dental plans. Other Subgroup members agreed.

Mr. Swanson asked if the federal Center for Consumer Information and Insurance Oversight (CCIIO) had special network adequacy standards for dental plans. Claire McAndrew (Families USA) said the final “2016 Letter to Issuers in the Federally-facilitated Marketplaces,” which was issued Feb. 20, includes a chapter, Chapter 3: Stand-Alone Dental Plans: 2016 Approach, which describes the process of what standards issuers must satisfy to receive certification to offer a stand-alone dental plan in a federally facilitated marketplace.

After discussion, the Subgroup agreed to defer the discussion of the DDPA’s suggested revision until another conference call. Mr. Wieske said during that discussion, the Subgroup would consider: 1) alternative exemption language in the Uniform Health Carrier External Review Model Act (#76), as suggested by NAIC staff; 2) additional suggested revisions to be offered by the DDPA that would highlight specific provisions in Model #74 that should not apply to dental plans; and 3) Ms. Goe’s suggestion to add a drafting note to the definition to alert the states to the possibility of exempting certain types of coverages, such as dental plan coverage, from the network adequacy standards in Model #74. Robert Holden (Stateside Associates) reminded the Subgroup that vision plans should be included in the discussion. The Subgroup agreed.
b. **Health Care Professional**

The Subgroup next discussed the American Academy of Family Physicians’ (AAFP) suggestion to add “their scope of practice” to the definition of “health care professional.” The Subgroup agreed to accept the suggested language.

The Subgroup next discussed the Academy of Managed Care Pharmacy (AMCP) and the National Association of Chain Drug Stores’ (NACDS) suggestion to add “pharmacist” to the definition of “health care professional.” Mr. Wieske said adding pharmacist appeared to be redundant because a pharmacist is a health care practitioner. He also noted the American Psychiatric Association’s (APA) suggestion to add “psychiatrist.” After discussion, the Subgroup did not accept either suggested revision because they were redundant, and as such, unnecessary.

Mr. Wieske pointed out the CHA’s suggestion to add “mental/behavioral” and “physical or mental/behavioral” to the definition of “health care professional.” The Subgroup agreed to add only the second suggested revision because it believed the first suggested revision was unnecessary if the second suggested revision was accepted.

c. **Health Care Provider**

The Subgroup next discussed the comments received on the definition of “health care provider.” Wendy Chill (American Academy of Pediatrics—AAP) said the AAP suggests removing the reference to “pharmacy” because of scope of practice issues. Jessica Mazer (Pharmaceutical Care Management Association—PCMA) said the PCMA suggests deleting reference to “pharmacy” because Model #74 is focused on provider networks not pharmacy networks. She also noted that consumers can obtain prescription drugs in a multitude of ways, not just through a retail pharmacy. Ms. Mazer explained that ensuring that consumers can obtain pharmaceutical services raises different access issues than other types of services. Elayda Saizajem (Pharmaceutical Research and Manufacturers of America—PhRMA) said PhRMA would like to retain the reference to “pharmacy” in the definition to ensure access to vaccination services.

Mr. Wake said the Subgroup should focus on access and any network issues that would impact consumers from obtaining the prescription drugs they need. Ms. Goe agreed. She also said the reference to “pharmacy” should not be removed from the definition until the access issue is resolved. Ms. Mazer said that if the Subgroup retains the reference to “pharmacy” in the definition, the PCMA believes certain provisions in Model #74 should not apply to pharmacies. She said the PCMA would submit another comment letter specifically highlighting those provisions.

Joan Gardner (Blue Cross and Blue Shield Association—BCBSA) explained that one of the reasons the BCBSA and America’s Health Insurance Plans (AHIP) suggested in their joint comment letter to delete the reference to “pharmacy” was because of the wide array of delivery methodologies available to consumers to obtain pharmaceutical services. Candy Gallaher (AHIP) suggested adding a drafting note to the definition of “health care provider” to alert the states that there are other delivery methodologies available to consider other than a retail pharmacy—such as hospitals, providers and mail order—in assessing network adequacy. Mr. Wieske asked Ms. Gallaher to draft the drafting note and submit it to the Subgroup for its consideration.

Kristin Viswanathan (Biotechnology Industry Organization—BIO) pointed out BIO’s suggestion to revise the definition of “health care provider” to further define the type of pharmacy to be included in the definition. The Subgroup decided to defer discussion on this suggested revision until later when it discusses the PCMA’s (and any other stakeholder’s) suggested revisions to exclude pharmacies from specified provisions in Model #74.

The Subgroup next discussed the CHA’s suggestion to add “physical or mental/behavioral” to the definition. Mr. Wieske asked if this revision was necessary. Ms. Goe expressed support for accepting the suggested revision particularly as to stand-alone treatment centers. Ms. Berendt said it was necessary in order to have it apply to facilities. Mr. Wieske suggested adding the CHA’s suggested revision to the definition of “facility” instead of this definition. After discussion, the Subgroup agreed to his suggestion.
Ms. White suggested that the Subgroup needs to ensure there is consistency in the language “physical or mental/behavioral” and “physical or mental behavioral.” The Subgroup agreed and, after discussion, decided to discuss this in more detail at its upcoming meeting during the Spring National Meeting. The Subgroup also agreed to discuss the other suggested revisions to the definition offered by the American Hospital Association (AHA), the American Medical Association (AMA), the NAIC consumer representatives, the Disability Rights Education & Defense Fund (DREDF) and the National Health Law Program.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call March 12, 2015. The following Subgroup members participated: J.P. Wieske, Chair (WI); Bruce Hinze and Rebecca Horne (CA); Peg Brown (CO); Molly White (MO); Christina Goe (MT); Martin Swanson (NE); Viara Ianakieva (NM); Cliff King (NV); Gayle Woods (OR); Linda Johnson (RI); Chlora Lindley-Myers (TN); and Jennifer Kreitler (WA).

1. Discussed Follow-up Language from its March 2 Conference Call

Mr. Wieske said that, prior to the call, NAIC staff had distributed language for the Subgroup’s consideration concerning proposed revisions to Section 1—Title and Section 2—Purpose (Attachment 1) based on the discussion during the Subgroup’s March 2 conference call. Beth Berendt (Berendt and Associates, LLC) requested that the Subgroup defer discussion of the proposed revisions to Section 1—Title until the Children’s Hospital Association (CHA) could discuss the language further. She said that, as currently drafted, the CHA could not support the proposed revisions. After discussion, the Subgroup agreed to defer discussion of both proposed revisions until the Subgroup’s meeting at the Spring National Meeting.

2. Discussed Comments Received Section 3—Definitions

The Subgroup continued its discussion of the comments received on Managed Care Plan Network Adequacy Model Act (#74) section-by-section using the chart developed by NAIC staff beginning with the definition of “emergency medical condition” in Section 3—Definitions.

a. Emergency Medical Condition

Daniel Blaney-Koen (American Medical Association—AMA) said the AMA suggests substituting the word “fetus” for “unborn child.” He said this suggested revision reflects more accurate clinical terminology. Ms. Brown expressed concern with the proposed change because of its deviation from the how the term is defined in federal regulations. Mr. Wieske agreed. Ms. Goe said Montana had a similar issue in enacting its external review law, but made the change. She said it is a state-by-state decision. After discussion, the Subgroup agreed to revise the definition to include brackets around both terms allowing each state to choose whichever term is deemed to be more appropriate.

The Subgroup next discussed the CHA’s suggestion to add the words “physical or mental” in order to encompass the idea that “physical” health is not the only relevant factor in defining whether an individual’s condition is a medical emergency. Mr. Hinze expressed concern about whether this suggested revision should be made throughout the definition. After discussion, the Subgroup decided to accept the CHA’s suggested revision, but, after it completes its review of the comments, the Subgroup will consider whether a definition of “health” should be added to Model #74 to reflect that “health” could include both physical and mental health.

The Subgroup next discussed the American Psychiatric Association’s (APA) suggestion to add “a threat to the individual’s safety or the safety of others” as an additional condition to be considered an “emergency medical condition.” Ms. Brown said she believed this was already covered in the definition. After discussion, the Subgroup agreed to accept the APA’s suggested revision for now and revisit its decision later.

Mr. Wieske said the Shriver Center and the Wisconsin Hospital Association (WHA) have similar suggested revisions to delete the phrase “sudden and, at the time unexpected onset of.” Joanne Alig (WHA) said WHA suggests deleting the phrase because it is not in the term, as defined in the federal Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. She said WHA also believes that the phrase is narrowing. Jolie Matthews (NAIC) agreed, but said she included the phrase based on the Subgroup’s previous discussion of the term. After discussion, the Subgroup agreed to accept the WHA’s suggested revision.
b. Emergency Services

The Subgroup next discussed the definition of “emergency services.” Mr. Wieske pointed out the CHA’s suggested revisions to add a reference to “mental health,” similar to what it had suggested for the definition of “emergency medical condition.” The Subgroup agreed to add the CHA’s suggested language. Ms. White expressed concern that the definition appeared to be focused on hospital emergency rooms, even though emergency services can be provided outside a hospital-setting. Ms. Goe agreed. She said that, although the definition is derived from the federal definition for this term, it appears to be narrower than some state definitions, which are broader and, as such, more consumer protective. Candy Gallaher (America’s Health Insurance Plans—AHIP) said she interprets the reference to “ancillary services” in the definition to apply to other types of services such as transportation services. She urged the Subgroup to adopt this definition rather than deviate from it because this is a model act. Stephanie Mohl (American Heart Association—AHA) agreed with Ms. White that the definition should not be so focused on hospital-based emergency services.

Mr. Wieske suggested adding drafting note to the definition noting that the definition is the federal definition for the term and that some states have adopted a broader definition based on the original definition in Model #74. He said the states could consider which definition to include. Ms. Goe said she is not opposed to adding a drafting note, but believes it is important to add that each state will need to evaluate which definition is appropriate. After discussion, the Subgroup agreed to add the drafting note. The Subgroup requested NAIC staff to develop language, in consultation with Ms. Goe, for the drafting note for the Subgroup’s consideration at the Spring National Meeting.

c. Essential Community Provider (ECP)

The Subgroup next discussed the comments received on the definition of “essential community provider.” Mr. Wieske said the American Cancer Society Cancer Action Network (ACS CAN) suggests deleting the drafting note for the term. Anna Howard (ACS CAN) said ACS CAN suggests deleting the drafting note in order to avoid any confusion that the federal Affordable Care Act’s (ACA) provider network requirements related to the inclusion of ECPs applies to all health benefit plans, not just qualified health plans (QHPs). Ms. Mohl said the NAIC consumer representatives had suggested revising the definition to more accurately reflect the federal definition for the term. She noted, however, that the recently issued “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule,” as published in the Federal Register, Feb. 27, 2015, included a revised definition for ECP. She suggested that the definition be revised to reflect the revision. Ms. Brown said it is important that the states are aware that they may define the term broader than the federal definition for the term. Ms. Goe agreed.

Mr. Wieske directed the Subgroup’s attention to AHIP’s and the Blue Cross and Blue Shield Association’s (BCBSA) suggestion to delete the definition and move the drafting note to the definition of “health care provider.” Ms. Gallaher said AHIP and the BCBSA are making that suggestion because they believe that QHPs should be the only plans required to include ECPs in their provider networks, in accordance with the ACA. Ms. Mohl noted that a number of states have required all health benefit plans, not just QHPs, to include ECPs in their provider networks. As such, she believes the definition of ECP should remain in Model #74. Ms. Berendt noted that Washington made the ECP provider network requirement only applicable to QHPs, but included this requirement in its market-wide network adequacy rules. After discussion, the Subgroup decided to defer the discussion of the comments on the definition of ECP until it finishes its review of any substantive provisions that could include the term.

d. Facility

Mr. Wieske said the American Academy of Family Physicians (AAFP) suggests adding a reference to “outpatient and solo or group practitioner offices” to the definition of “facility.” After discussion, the Subgroup rejected AAFP’s suggested revision because such offices did not fit within the meaning of the definition.

Mr. Wieske said the ACS CAN suggests adding oncology facilities to the term. He said he interprets the reference in the definition to “treatment centers” as including oncology facilities and, as such, the ACS CAN’s suggestion was unnecessary. Mr. Wieske also noted that if oncology facilities were added, this could lead to a whole laundry list of similar facilities being added. The Subgroup agreed and rejected ACS CAN’s suggested revision. The Subgroup next discussed the AHIP and BCBSA suggested revision to the drafting note. After discussion, the Subgroup agreed to revise the drafting note to state: “Drafting Note: States that regulate Medicaid managed care plans may wish to broaden this definition.”
The Subgroup next discussed the Academy of Managed Care Pharmacy’s (AMCP) suggestion to add the term “pharmacy” to the definition as a type of facility. The Subgroup discussed whether a “pharmacy” is a facility or whether network adequacy requirements actually apply to a “pharmacist” as a provider. After additional discussion of these issues, the Subgroup decided to defer making any changes until it can resolve the broader issue of pharmacies as part of network adequacy requirements.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call March 2, 2015. The following Subgroup members participated: J.P. Wieske, Chair (WI); Bruce Hinze and Rebecca Horne (CA); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Terry Seaton (NM); Gayle Woods (OR); Linda Johnson (RI); and Molly Nollette and Jennifer Kreitler (WA). Also participating were: Bob Wake (ME); and Molly White (MO).

1. **Discussed Comments Received on Model #74**

Mr. Wieske said that, as discussed during the Subgroup’s Feb. 23 conference call, the Subgroup will begin its review of the comments received on *Managed Care Plan Network Adequacy Model Act (#74)* section-by-section using the chart developed by NAIC staff section-by-section.

a. **Section 1—Title**

Mr. Wieske said the Children’s Hospital Association (CHA) suggests adding a drafting note to Section 1—Title alerting states to consider adopting the network adequacy standards in Model #74 for Medicaid managed care plans in order to provide standardization between the commercial market and Medicaid because many consumers will transition between coverage under commercial insured plans and Medicaid managed care plans. Jan Kaplan (CHA) noted that the CHA’s suggestion is only a suggestion, not a requirement. Mr. Wieske expressed concern with including the drafting note because not all states regulate Medicaid managed care plans in the same manner. In addition, in many states, state insurance regulators do not regulate such plans. Some Subgroup members expressed support for Mr. Wieske’s comments, while some Subgroup members expressed limited support for CHA’s suggestion.

Claire McAndrew (Families USA) noted that some states have network adequacy standards already in place for Medicaid managed care plans. Candy Gallaher (America’s Health Insurance Plans—AHIP) expressed opposition to adding a drafting note. She said the revisions to Model #74 should be focused narrowly on insured plans. The model should not include drafting notes referring to other types of plans, such as Medicaid managed care plans. Beth Berendt (Berendt and Associates, LLC) said the CHA’s suggested drafting note is meant to raise legislative awareness of the possibility of standardizing network adequacy requirements between commercial insured plans and Medicaid managed care plans and how these plans work together. After additional discussion, Mr. Wieske suggested that he and NAIC staff work to develop more general language for a drafting note for the Subgroup’s consideration during its next conference call March 12. The Subgroup agreed to his suggestion.

b. **Section 2—Purpose**

The Subgroup next discussed Section 2—Purpose. Mr. Wieske said the American Academy of Family Physicians’ (AAFP) suggestion to add language to Section 2B(2) to require network plans to have and maintain up-to-date clinician listings seemed duplicative of other provisions in Model #74, particularly Section 8—Provider Directories. The Subgroup agreed and decided not to accept the AAFP’s suggested language.

The Subgroup next discussed the AHIP and Blue Cross and Blue Shield Association’s (BCBSA) suggestion to delete the words “publicly available” in Section 2B(2). Mr. Wieske said he assumed that the AHIP and BCBSA are making this suggestion because not all provisions in the access plan are publicly available. Ms. Gallaher agreed with Mr. Wieske’s comment. Stephanie Mohl (American Heart Association—AHA) expressed opposition to deleting the language because it is assumed that the access plan provisions are public unless it is determined that a provision is proprietary, competitive or a trade secret. Daniel Blaney-Koen (American Medical Association—AMA) and Molly Collins Offner (American Hospital Association—AHA) expressed support for Ms. Mohl’s comments. Joan Gardner (BCBSA) expressed support for Ms. Gallaher’s comments. Mr. Wake suggested that it is the health carrier, not the network plan that should be required to have and maintain an access plan. After discussion, the Subgroup decided to request that NAIC staff work with the Subgroup chair to develop language for this provision that reflects the discussion for the Subgroup’s consideration during its next conference call March 12.
The Subgroup next discussed the AMA’s suggestion to delete the word “quality” from Section 2B. Mr. Blaney-Koen said the AMA suggests deleting “quality” because assuring the adequacy, accessibility, transparency and quality of health care services offered under a network plan is something to aspire to, but is beyond the purpose of Model #74. Ms. Goe said that an argument could be made that some network designs, such as value-based networks or tiered networks, are designed using quality ratings. Mr. Wake said that, although he could understand the AMA’s perspective, the word “quality” has been in Model #74 since its adoption in 1996 and removing it could be perceived negatively. Ms. Mohl agreed with Mr. Wake’s comments. After additional discussion, the Subgroup decided to leave the language unchanged.

Bill McAndrew (Illinois Hospital Association— IHA) said the IHA suggests revising Section 2B(1) to reflect that health carriers are responsible for adhering to the requirements in the written agreements under which participating providers will provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Mr. Wieske said he interprets Section 2B(1) as referring to the provisions in Section 6— Requirements for Health Carriers and Participating Providers. The Subgroup agreed with Mr. Wieske’s interpretation and agreed to leave the provision unchanged.

The Subgroup next discussed Ms. White’s suggested revisions to Section 2B(2). After discussion, Ms. White agreed to leave the provision unchanged. The Subgroup next discussed Mr. Wake’s suggestion to revise Section 2B(2) to require network plans “to maintain and follow” access plans consistent with Section 5 of this Act. After discussion, the Subgroup agreed to accept Mr. Wake’s suggested revision and incorporate it into the changes based on the AHIP and BCBSA’s suggested changes the Subgroup had already agreed to make to Section 2B(2).

c. Section 3— Definitions

Turning to the Section 3— Definitions, the Subgroup noted the Biotechnology Industry Organization’s (BIO) suggestion to delete the definition of “balance billing” in Section 3A because the term is not used in the proposed revisions to Model #74. Ms. Goe said the definition should not be deleted at this time. She suggested that it be flagged for re-review after the Subgroup finishes its review of the comments. The Subgroup agreed to her suggestion. Ms. White pointed out her suggestion to delete the reference to “non-participating” in the definition because in some cases, it could be a participating provider that balance bills a covered person even though they are contractually prohibited from billing covered persons. Mr. Wake agreed.

Mr. Wieske said balance billing could occur in at least two situations. One situation Ms. White already explained. The other situation is when an out-of-network provider may balance bill. Ms. Gallaher pointed out another situation where a participating provider may balance bill a covered person. She said this situation occurs when a participating provider provides non-covered services to a covered person. Ms. Gallaher explained that because the hold harmless clause does not apply to non-covered services, health carriers do not prohibit participating providers from balancing billing a covered person in this situation as long as the provider discloses to the covered person that it is a non-covered service for which they may be balanced billed. After discussion, the Subgroup agreed to delete the reference to “non-participating” and re-review the definition later.

Mr. Wieske said no comments were received on the definitions of “commissioner,” “covered benefits” or “covered person.” He said the Subgroup would continue its discussion of the comments beginning with the definition of “emergency medical condition.”

2. Discussed Next Steps

Mr. Wieske said the Subgroup would meet March 12 via conference call to continue its discussion of the comments. He also said the Subgroup would be meeting at the Spring National Meeting. Ms. Berendt asked if the Subgroup would be meeting once or twice a week. Mr. Wieske said that because the Subgroup has until the Summer National Meeting to complete its work, he anticipates holding weekly conference calls. However, the Subgroup could begin meeting twice a week if it becomes necessary in order to complete its work by the Summer National Meeting.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Network Adequacy Model Review (B) Subgroup
Conference Call
February 23, 2015

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Feb. 23, 2015. The following Subgroup members participated: J.P. Wieske, Chair (WI); Rebecca Horne and Bruce Hinze (CA); Peg Brown (CO); Martin Swanson (NE); Linda Johnson (RI); and Molly Nollette and Jennifer Kreitler (WA).

1. **Adopted its 2014 Fall National Meeting Minutes**

Jolie Matthews (NAIC) explained that Jan Kaplan (Children’s Hospital Association—CHA) had submitted suggested corrections to the Subgroup’s 2014 Fall National Meeting minutes. She said Ms. Kaplan requests that the reference on page 4 of the minutes to Chad Moore as “Dr. Moore” be corrected to “Mr. Moore” because he is not a medical doctor. Ms. Kaplan also requests that her remarks on page 4 of the minutes regarding the grouping of pediatric hospitals for purposes of being considered essential community providers be clarified. Ms. Matthews suggested that the Task Force adopt Ms. Kaplan’s suggested corrections. Mr. Swanson made a motion, seconded by Mr. Hinze, to adopt the Subgroup’s 2014 Fall National Meeting minutes, as revised (Attachment 2-A). The motion passed unanimously.

2. **Discussed Work Plan for Revising Managed Care Plan Network Adequacy Model Act (#74)**

Mr. Wieske said the Subgroup received more than 100 comment letters in response to its request for comments on the initial draft of proposed revisions to the *Managed Care Network Adequacy Model Act* (#74). He said NAIC staff had compiled a chart reflecting the suggested changes to the initial draft based on the comment letters. Mr. Wieske suggested that the Subgroup hold weekly conference calls to review the suggested changes section-by-section. He said the goal is for the Subgroup to complete its work by the Summer National Meeting in order to have a draft ready for the Regulatory Framework (B) Task Force’s and the Health Insurance and Managed Care (B) Committee’s consideration at that meeting. Mr. Swanson and Mr. Hinze expressed support for Mr. Wieske’s suggestion.

Guenther Ruch (GHR Consulting LLC) asked if it was anticipated that the full NAIC membership would adopt the proposed revisions to Model #74 at the Fall National Meeting. Mr. Wieske confirmed that was his intention. However, he noted that there is the possibility that the full NAIC membership could adopt the proposed revisions during an interim conference call after the Fall National Meeting. After additional discussion, the Subgroup agreed to Mr. Wieske’s suggestion to begin holding weekly conference calls, beginning March 2, to review the comments.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.
Agenda Item #2

Discuss Comments Received on Draft Revisions to

Managed Care Plan Network Adequacy Model Act (#74)
Comments are being requested on this draft by Jan. 12, 2014. The revisions to this draft reflect changes made from the existing model. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

MANAGED CARE HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Managed Care 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.

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 managed care network plan by:

(1) establishing requirements for written agreements between health carriers offering managed care network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services 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.

NOTE TO SUBGROUP: SUBGROUP AGREED TO RETURN TO THIS SECTION TO CONSIDER POSSIBLE ADDITIONAL REVISIONS.
Drafting Note: In states that regulate prepaid health services, this model Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to enrollee covered persons.

Section 3. Definitions

For purposes of this Act:

A. “Closed plan” means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

A. “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” 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.

C. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

D. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

E. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health medical condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

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.

E. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health medical condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

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.

E. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health medical condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

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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.

E. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health medical condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.
“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 PHSA 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.

“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 therapeutically 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.

“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.

“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.”

“Health care provider” or “provider” means a health care professional, a pharmacy or a facility.

**NOTE TO SUBGROUP:** SUBGROUP DEFERRED MAKING A DECISION ON WHETHER TO ADD “PHARMACY” TO THIS DEFINITION UNTIL IT COULD DETERMINE HOW AND IN WHAT MANNER A “PHARMACY” OR “PHARMACIST” IS TO BE REFLECTED IN PROVIDER NETWORKS.

“Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

“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.

“Health indemnity plan” means a health benefit plan that is not a managed care network plan.

**NOTE TO SUBGROUP:** THE SUBGROUP DECIDED TO RETAIN THE DEFINITION OF “HEALTH INDEMNITY PLAN” FOR POSSIBLE INCLUSION IN SECTION 4. THE SUBGROUP ALSO DEFERRED DECIDING WHETHER TO RENAME THE TERM AS “NON-NETWORK PLAN.”

“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.
“Managed care 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.

**Drafting Note:** The definition of “managed care 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. 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.

“Network” means the group of participating providers providing services to a managed care 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.

**Drafting Note:** 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 organizations (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 difference between in-network and out-of-network cost-sharing or 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.

NOTE TO SUBGROUP: THE DRAFTING NOTE ABOVE IS FOR THE MOST PART EXISTING LANGUAGE. SHOULD IT BE RETAINED, DELETED OR REVISED FURTHER?

“Open plan” means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

“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.

“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.

“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.

“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.

“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 of the condition 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.

W. “Transfer” means, for 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 any such person.

GENERAL NOTE: DURING ITS DISCUSSIONS ON REVISIONS TO THIS SECTION, THE SUBGROUP CONSIDERED INCLUDING AND DEFINING THE TERMS “ANCILLARY SERVICES,” “PREFERRED PROVIDER,” “PROVIDER CONTRACT,” “SERVICE AREA,” AND “TIERED PROVIDER NETWORK.” THESE TERMS ARE NOT INCLUDED IN THIS REVISED SECTION BECAUSE EITHER THEY WERE NOT USED IN THE SUBSTANTIVE PROVISIONS OF THE REVISED MODEL ACT OR DID NOT NEED TO BE DEFINED. HOWEVER, ANYONE MAY SUBMIT ADDITIONAL COMMENTS ON WHETHER THESE TERMS SHOULD BE INCLUDED AND DEFINED.

Section 4. Applicability and Scope

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

Drafting Note: States may wish to 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 shall consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity shall make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. States may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements would then be deemed to have met 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.

Section 5. Network Adequacy

A. A health carrier providing a managed care 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.

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

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

B. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:
(1) Provider-covered person ratios by specialty;
(2) Primary care provider-covered person ratios;
(3) Geographic accessibility;
(4) Geographic population dispersion;
(5) Waiting times for appointments 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.

C. (1) In any case where a health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall have a process to ensure that a covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or make other arrangements acceptable to the commissioner when:

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

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

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

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

(b) The health carrier:

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

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

(3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider.
(4) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal claims grievance and appeals processes.

D. (2)(1) A health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity 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)(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.

BE. Option 1. Prior Approval of Access Plan

(1) Beginning [insert effective date], a health carrier shall file with 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 managed care networks that 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. 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. 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 interested person upon request.

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

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

(3) The carrier shall prepare an access plan prior to offering a new managed care 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 whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

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

**Drafting Note:** Different states will set different requirements for the access plan. This model requires a health carrier to file the plan with the insurance commissioner but does not require the commissioner to take action on the plan. Some states may want to require the commissioner’s approval of access plans; other states may prefer that a health carrier not file the access plan with the commissioner but instead maintain the plan on file at the 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.

**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.

**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 managed care 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 care 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;
Section 6. Requirements for Health Carriers and Participating Providers

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

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.

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 services 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.

NOTE TO SUBGROUP: THE SUBGROUP DECIDED TO INCLUDE (2)(a) AND (b), BUT ALSO LEFT OPEN THE POSSIBILITY OF ADDING A THIRD PARAMETER RELATED TO THE EXAUSTION OF THE CARRIER’S ASSETS OR NO GUARANTY FUND COVERAGE.
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 services 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.

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

   (2) (a) The standards shall be used in determining the selection of health care providers by the health carrier, and its intermediaries and any provider networks 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 avoid 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.

   (2)(4) Paragraphs (1)(a) and (1)(b)(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.

   (3)(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 or types of 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 or types of providers acting within the scope of their license or certification under applicable state law than are necessary to maintain an adequate 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 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. 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.

G. A health carrier shall make its selection standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner.
Drafting Note: The disclosure of a health carrier’s selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law. The NAIC is considering developing such a model.

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 appeals 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.

I. A health carrier shall not offer an inducement under the managed care plan to a provider 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.

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.

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 fifteen (15) working thirty (30) 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.

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.

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.

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.

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.

Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.

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

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

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.

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.
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.

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.

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.

2. For hospitals:
   a. Hospital name;
   b. Hospital location and telephone number; and
   c. Hospital accreditation status; and

3. Except hospitals, other facilities by type:
   a. Facility name;
   b. Facility type;
   c. Procedures performed; and
   d. Facility location and telephone number.

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.

**Section 79. Intermediaries**

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

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

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.

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.

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.

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.

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.

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.

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.
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.

Section 810. 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.

B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute 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. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.

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.

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.

Section 911. 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.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state’s current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 1012. Enforcement

A. If the commissioner determines that a health carrier has not contracted with enough a 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.

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

**Section 4413. 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].

**Section 4214. Penalties**

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

**Section 4315. 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.

**Section 4416. Effective Date**

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.

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.

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].
Section 1. Title

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

### Proposed Revisions

Assume proposed revisions are adopted.

Jan 12, 2015 Comment Deadline

Suggested revisions to Draft dated Nov 12, 2014

Managed care plan network adequacy model act (FR4)
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<th><strong>American Medical Association (AMA)</strong></th>
<th><strong>Missouri Hospital Association (MHA)</strong></th>
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| 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 | (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. | (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. |

**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.

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<td>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 of a state, the term “commissioner” appears. If the jurisdiction of any regulation involves a state agency other than the insurance department of a state, add language referencing that agency to ensure the appropriate coordination of responsibilities.</td>
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### Covered Person

“Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

### 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.

### Emergency Medical Condition

“Emergency medical condition” means the sudden and unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to 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 an other hospital before delivery; or
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“Commissioner” means the insurance commissioner of this state.

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IHA

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Drafting Note: The term "emergency services" is not used in this section to alert states that having a certain number or percentage of emergency services within the capability of the medical staff and facilities of a hospital to stabilize the patient 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

"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 PHSA and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that standard.

Drafting Note: The term "essential community provider" is not used 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

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ACS CAN

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NAIC Consumer Representatives

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American Cancer Society Cancer Action Network (ACS CAN)

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American Hospital Association (AHA)

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Essential community providers (ECPs) have long played a significant role in providing care to low-income and often medically underserved populations, including children and adults with serious, complex and chronic conditions, through state Medicaid programs. A few states, such as Minnesota, have historically had ECP requirements for fully insured plans. Currently, states must verify that carriers have an adequate number and type of ECPs in a provider network in order for a QHP to be offered on a health insurance exchange under the ACA and implementing regulations. Hence, essential community provider (ECP) means in a state that is providing health care services or a health care setting, including but not limited to hospitals and other health care settings, that is used to provide health care to the target population.

Facility means an institution providing health care services or a health care setting, including but not limited to hospitals and other health care settings.

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<th><strong>Facility</strong></th>
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<td><strong>© 2015</strong> National Association of Insurance Commissioners</td>
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(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 health services, or any combination thereof.

(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); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

**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.”
"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.

"Health care provider" or "provider" means a health care professional, a pharmacy, a home health agency or a facility.

Drafting Note: "Health care provider" or "provider" means a health care professional, a pharmacy, a specialty pharmacy or a facility.

"Health care provider" or "provider" means a health care professional, a pharmacy, a community-based organization, a peer provider or a facility.

"Health care provider" or "provider" means a physical or mental/behavioral health care professional, a pharmacy, a community-based organization, a peer provider or a facility.

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"Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

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<th>Term</th>
<th>Definition</th>
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<td>Health care services</td>
<td>means services and devices for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease; maintaining or restoring of bodily function;</td>
</tr>
<tr>
<td>Network</td>
<td>means the group or groups of participating providers providing services under a network plan;</td>
</tr>
<tr>
<td>Health carrier</td>
<td>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.</td>
</tr>
<tr>
<td>Intermediary</td>
<td>means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers on behalf of a network.</td>
</tr>
<tr>
<td>Health indemnity plan</td>
<td>means a health benefit plan that is not a network plan.</td>
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**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. 

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<th>California Medical</th>
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<td>&quot;Network plan&quot; 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.</td>
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**Drafting Note:** 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 other care delivery system models (e.g., accountable care plans (ACOs) and other care delivery system models). Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that are specified by regulations. The standards could include minimum 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 the 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**

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CHA

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Families USA

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"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.

No comments received.

<table>
<thead>
<tr>
<th>Insurance</th>
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<th>MO DOI</th>
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<td>&quot;Telemedicine&quot; means covered benefits medical services 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>
<td>&quot;Telemedicine&quot; means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications.</td>
<td>&quot;Telemedicine or &quot;Telehealth&quot; 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>
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<td>&quot;To stabilize&quot; means with respect to an emergency medical condition, as defined in Subsection E, to provide such medical treatment 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 the facility, or, with respect to an emergency medical condition described in Subsection E(4), to deliver, including the placenta.</td>
<td>&quot;To stabilize&quot; 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.</td>
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AMA 

MO DOI
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 hospital without the permission of such person.

Suggested Additional Definitions

<table>
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<tr>
<th>American Academy of Dermatology Association (AADA)</th>
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| **Board certification** means either: (i) certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association board for that specialty or subspecialty; or (ii) requisite successful completion of a residency or fellowship training program approved by the Accreditation Council of Graduate Medical Education, the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada.

**Specialty** means a physician who has successfully completed a residency or fellowship training program which is accredited by the American Board of Medical Specialties or the American Osteopathic Association, followed by prerequisite certification by the American Board of Medical Specialties or the American Osteopathic Association and further successful completion of an examination in that specialty or subspecialty.

**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 coverage.

**Narrow network** means health insurance plans that place limited access to their subscribers based on economic and subjective quality criteria to the detriment of patient access to needed care.

**Tiered network** means a network that discriminates on the basis of the doctors and hospitals available to their subscribers based on the decision of the payer, or is in some other manner limited to the access to needed care.

**Ultra-narrow network** suggests defining based on percentage of hospital participation, family physician and other primary care physician participation, network participation and other factors.

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**Specialty** means a physician who has successfully completed a residency or fellowship training program which is accredited by the American Board of Ophthalmology, followed by prerequisite certification by the American Board of Medical Specialties or the American Osteopathic Association and further successful completion of an examination in that specialty or subspecialty.

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**Narrow network** means health insurance plans that place limited access to their subscribers based on economic and subjective quality criteria to the detriment of patient access to needed care.

**Tiered network** means a network that discriminates on the basis of the doctors and hospitals available to their subscribers based on the decision of the payer, or is in some other manner limited to the access to needed care.

**Ultra-narrow network** suggests defining based on percentage of hospital participation, family physician and other primary care physician participation, and other factors.

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**Ultra-narrow network** suggests defining based on percentage of hospital participation, family physician and other primary care physician participation, and other factors.
The term “Preferred provider” means a physician, hospital or other provider that has agreed to join, participate in, or become a member of a network. A network is a panel of providers, within a network, that is comprised of a limited number of providers who have been selected based by the carrier based primarily on criteria relating to cost or resource utilization or other measures determined by the carrier.

The term “Narrow network” means a panel of providers, within a network, that is comprised of a limited number of providers who have been selected based on criteria relating to cost or resource utilization or other measures determined by the carrier.

The term “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).

The term “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 or to otherwise incentivize covered person or provider behavior.

The term “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. Specialty care generally works with primary care providers to provide coordinated and comprehensive care.

The term “Preferred 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 any combination of these or other factors established by the health plan in order to influence enrollees’ selection of providers at the time of care is needed or planned.

The term “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; 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.

The term “Material change” is a change in the composition of structure of a health carrier’s provider network or a material change in the size of the population served by a health carrier’s provider network. A material change is an act of the health carrier that affects the quality of care, is likely to affect the availability or cost of a service, or affects the ability of enrollees to access the services of covered person.

The term “Narrow network” means a panel of providers, within a network, that is comprised of a limited number of providers who have been selected based on criteria relating to cost or resource utilization or other measures determined by the health carrier.
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<td>Material change</td>
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<td>Subspecialty provider</td>
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“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 network adequacy, and includes networks that are operated by tribes and tribal organizations, and urban Indian centers (also called “I/T/U”).

“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 Alaska 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”).

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 meet 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 by 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 provide the state with documentation that a network plan has been accredited under this Act. Under such an approach, the accrediting entity 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.
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States should periodically review a health carrier’s private certification and eligibility for deemed compliance. Under this Act, the state’s regulatory authority is not diminished by, nor should it be confused with, any accreditation by a private accrediting entity. A health carrier’s private certification should never exceed the state’s regulatory authority. An accrediting entity’s standards should never exceed the state’s regulatory standards. States should continuously assess their private accreditation programs and adjust them as necessary. States should ensure that their own standards are met or exceeded by any and all standards of a private accrediting entity. The state’s regulatory authority should never be diminished by, nor should it be confused with, any accreditation by a private accrediting entity.

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**Section 5. Network Adequacy**

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 and supporting those with discrete health care needs, including those with chronic conditions.

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 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.

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**Definitions:**
- **Network:** A set of providers that are included in a health carrier’s network and that are subject to the health carrier’s cost-sharing or other payment arrangements. A network may include primary care providers, specialists, facilities, and other providers that are included in the health carrier’s network. The term “network” does not include health carrier’s cost-sharing or other payment arrangements.
- **Network sufficiency:** The availability of a sufficient number and type of providers, facilities, and services that are included in the health carrier’s network and that are subject to the health carrier’s cost-sharing or other payment arrangements.
- **Unreasonable delay:** A delay that is unreasonable in number or type of providers, facilities, or services that are included in the health carrier’s network and that are subject to the health carrier’s cost-sharing or other payment arrangements.

**Conditions and Disabilities:** In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.
AMA

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 are accessible through a provider in the lowest cost-sharing tier.

Drafting Note: States may want to consider the adequacy of provider networks, particularly the types and numbers of providers available, and to develop standards and requirements that ensure provider networks are sufficient to meet the needs of covered persons.

CHA

A health carrier providing a network plan shall develop and maintain a network that is sufficient in numbers and types of 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 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: 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, providers of certain cost-sharing requirements that deter appropriate care. For example, when a carrier chooses to use a tiered network, the lowest 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 insufficient to address the requirement that a provider is available to see patients of the particular plan.

APA

A health carrier providing a network plan shall develop and maintain a network that is sufficient in numbers and types of 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 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.

Drafting Note: States may want to consider the adequacy of provider networks, particularly the types and numbers of providers available, and to develop standards and requirements that ensure provider networks are sufficient to meet the needs of covered persons.
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 pay close attention to ensure that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay. States should ensure that all covered services are accessible through a provider in the lowest cost-sharing tier without unreasonable travel or delay. The network may be designed such that not all covered services are provided in every tier. 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. In the case of emergency services, covered all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered all services to covered persons will be accessible without unreasonable travel or delay. A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that covered persons will 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. Networks must include providers with documented experience and expertise in treating, serving and supporting those with discrete health care needs. Consumers should have access to network providers in the lowest cost-sharing tier. The lowest cost-sharing tier shall be available to covered persons at all times. Provider 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. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.
The volume of technological and specialty services available to serve the needs of covered persons requiring technological or specialty care.

New health care service delivery system options, such as telemedicine or telehealth, and

New hours of operation.

Waiting times for visits with participating providers.

Geographic accessibility.

Provider-coordinated service restrictions.

Provider-coordinated service triggers by specialty.

The carrier, including但不限于:

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.

Maine Bureau of Insurance

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.

Drafting Note: States may want to pay particular attention to network sufficiency, marketing and disclosure issues that may arise with respect to 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 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.

National Health Law Program

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 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 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.

Program

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.
The commissioner shall consider the following factors in the access standards described in Section 5:

1. Provider-to-covered person ratios by specialty.
2. Geographic accessibility.
4. Waiting times for visits with participating providers.
5. Hours of operation.
6. New health care service delivery systems, such as telemedicine or telehealth.
7. The volume of technologically advanced or specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

The commissioner shall not require that the standard be used to determine access to network access to a specific provider, but shall include the following language in the access standards:

"Provider-to-covered person ratios by specialty shall be determined by using the full-time equivalent (FTE) of provider calculation."

Drafting Note: Instead of the general standards provided in subsection b, 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 been either mandated or required in other states. Some states have also required that such standards be incorporated into the provider’s specific network access standard.
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- emergent 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 provisions for telehealth services, 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. 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 the quantitative criteria, the commissioner must incorporate the following:

1. All requirements of the regulations to be issued under subsections A and B shall be applied to the lowest cost-sharing tier of any network.

2. All requirements of the regulations to be issued under subsections A and B shall be applied to the lowest cost-sharing tier of any network.

3. The commissioner shall consider the following factors in the access standards described in Paragraph (1):

   a. Maximum travel time and distance standards in miles to access a full time equivalent primary care physician, specialist, and other health care providers.
   b. Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care providers.
   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 physical or mental disabilities.
   d. Maximum time and distance standards in miles to access full time equivalent primary care physician, specialist, and other health care providers.
   e. Maximum time and distance standards in miles to access general hospital services with emergency care.

4. The commissioner must incorporate the following:

   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 ability of physicians to admit patients to in-network hospitals.
   f. The ability of physicians to provide prudential treatments.
   g. The ability of physicians to provide services to patients within their normal confines of an existing plan network area. For example, in some areas of the country, access to pediatric care in 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-emergent transport in such cases; and

   h. The ability of physicians to provide services to patients within their normal confines of an existing plan network area. For example, in some areas of the country, access to pediatric care in 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-emergent transport in such cases; and

5. 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.
(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.

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 options, such as telemedicine or telehealth;
(8) The volume of technological and specialty services available to serve the needs of covered persons receiving technological training.

(c) Maximum travel time and distance standards to access a full-time equivalent primary care physician, specialist, and other health care providers.

(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) The breadth of hours of operation for network providers.
(c) The quality measures used to evaluate providers for network inclusion.
(d) The ability to measure the performance of network providers.
(e) The ability to measure the performance of network physicians, providers, and other health care providers.
(f) Minimum number of approved full-time equivalent primary care physicians, specialists, and other health care providers.
(g) Provider covered person ratios by specialty.
(h) The degree to which in-network physicians are authorized to admit patients to in the case of in-network hospital-based care.

(3) The commissioner shall make the results publicly available.

ACCC

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;
(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 law. However, in many cases, these standards are more likely to be included in regulations. As each state has unique health care delivery issues, the regulations are best positioned to determine the appropriate network adequacy standards that work within and among the states. The elements of Subsection B are the basis in determining the standards applicable for each state.

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 law. However, in many cases, these standards are more likely to be included in regulations. As each state has unique health care delivery issues, the regulations are best positioned to determine the appropriate network adequacy standards applicable for each state.

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 law. However, in many cases, these standards are more likely to be included in regulations. As each state has unique health care delivery issues, the regulations are best positioned to determine the appropriate network adequacy standards applicable for each state.
(8) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(9) The ability to maintain in-network physicians in specialty areas such as cardiology or orthopedics and other health care services.

(10) Provision of in-network and culturally appropriate care and other services tailored to low-income and vulnerable populations.

Plan's service area:

(1) The existence of an in-network provider who will perform a service or is necessary to the provision of the service, and may be established by reference to any reasonable and appropriate referral network established by the commissioner.

(2) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(3) The degree to which in-network physicians are authorized to admit patients to or in the case of in-network hospital-based providers, to access full-time equivalent primary care physicians.

(4) The availability of trauma care, public health services, behavioral health and substance abuse services.

(5) The availability of language and culturally appropriate care and other services tailored to low-income and vulnerable populations.
B. Sufficiently shall be determined in accordance with the requirements of this section, and may be established by reference to any

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<tbody>
<tr>
<td><strong>(3)</strong> 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.</td>
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<tr>
<td><strong>(4)</strong> 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.</td>
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**B. *** Provider-covered person ratios by specialty and subspecialty;***

- The ability of network providers to accommodate patients relying on wheelchairs or other wheeled mobility devices.

- The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty, or subspecialty care.

**B. *** Provider-covered person ratios by specialty and subspecialty;***

- The number of providers in terms of full-time equivalents.

- The number of providers in terms of full-time equivalents.

**B. *** Provider-covered person ratios by specialty and subspecialty;***

- The number of providers in terms of full-time equivalents.
(1) Provider-covered person ratios by specialty;
(2) Primary care provider-covered person ratios;
(3) Geographic accessibility, with appropriate adjustments for geographic differences and for the regionalization of specialty care to assure access to all covered services;
(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, diagnostics or ancillary services.

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:

- Minimum appropriate providers available to meet the needs of children and adults with serious, chronic or complex health conditions or physical and mental disabilities, patients with limited English proficiency, and diverse cultural and ethnic backgrounds;
- Patient feedback, as well as carrier documentation of network access, particularly for children and adults with serious, chronic or complex health conditions.

Consumers Union

### Drafting Note

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, maximum travel distance to providers, and maximum waiting times to obtain an appointment with a primary care provider. However, in many cases, these standards could be incorporated into a law. It is important to note that quantitative standards do not diminish the need for regulators to individually assess networks. It is also possible for a specific area (such as a rural or urban area, metropolitan or non-metropolitan area) to have a minimum number of providers within a specialty. However, the need for regulators to individually assess networks that may employ unique techniques to ensure access to care that may not otherwise be provided could also be included. Providers may develop specific quality standards to ensure adequate access that may fall outside the established objective requirements. For instance, if an insurer has arranged for access to 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 surveys, into their evaluation of network adequacy.
D. The degree to which in-network physicians are authorized to admit patients to, or, in the case of hospital-based physicians, practice at in-network hospitals. [see current consumer-suggested factor for consideration Sec. 5(B)(2)(f)]

DREDF

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:

(9) Percentage of network primary care and specialist providers have established structural accessibility, and offer accessible examination/diagnostic equipment, and programmatic accessibility;

(10) The percentage of network primary care and specialist providers who can be reached within a reasonable time solely via public transportation;

(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.

NAIC Consumer representatives, National Health Law Program

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:

(a) Maximum travel time and distance standards in miles by county to access a full-time equivalent primary care physician, specialist, or other health care provider;

(b) Maximum travel time and distance standards in miles by county to access a full-time equivalent primary care physician, specialist, or other health care provider;

(c) Maximum travel time and distance standards in miles by county to access a full-time equivalent primary care physician, specialist, or other health care provider;

(d) Maximum travel time and distance standards in miles by county to access a full-time equivalent primary care physician, specialist, or other health care provider;

(e) Maximum travel time and distance standards in miles by county to access a full-time equivalent primary care physician, specialist, or other health care provider;

(f) The volume of telemedical and specialty services available to serve the needs of covered persons receiving telemedical 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 and 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 hospital-based physicians, practice at in-network hospitals. 

DREDF

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:

(9) Percentage of network primary care and specialist providers have established structural accessibility, and offer accessible examination/diagnostic equipment, and programmatic accessibility;

(10) The percentage of network primary care and specialist providers who can be reached within a reasonable time solely via public transportation;

(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.

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:

(9) Percentage of network primary care and specialist providers have established structural accessibility, and offer accessible examination/diagnostic equipment, and programmatic accessibility;

(10) The percentage of network primary care and specialist providers who can be reached within a reasonable time solely via public transportation;

(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.

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The degree to which in-network physicians are authorized to admit patients to, or, in the case of hospital-based physicians, practice at in-network hospitals. [see current consumer-suggested factor for consideration Sec. 5(B)(2)(f)]
### Families USA

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<tr>
<th>Paragraph Note: States may want to include some of the factors under Paragraph (f) as mandatory factors for inclusion under Paragraph (f).</th>
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<tr>
<td>(g) 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.</td>
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<tr>
<td>(h) New health care service delivery options, such as telemedicine or telehealth.</td>
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<tr>
<td>(i) 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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Families USA

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<tr>
<th>(1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking.</th>
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<tr>
<td>(1) The commissioner shall consider the following factors in the access standards developed in Paragraph (f):</td>
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<tr>
<td>(a) Maximum allowable travel times for appointment with a primary care physician, specialist, or other health care provider; and</td>
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<tr>
<td>(b) The availability of in-network providers at in-network hospitals.</td>
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Families USA

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<tr>
<th>(2) 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.</th>
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<tr>
<td>(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 network.</td>
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Families USA

<table>
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<th>(a) The availability of in-network providers at in-network hospitals.</th>
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<td>(b) 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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<td>(c) New health care service delivery options, such as telemedicine or telehealth.</td>
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Families USA
(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.

(5) 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:

(6) The health carrier 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, as designated by the National Cancer Institute, shall be included in the provider network. Provider networks shall also include at least one Affordability Care Act-designated cancer center or cancer center that is a member of the Association of American Cancer Institutes (AACI). Provider networks shall also include at least one essential community provider. Provider networks shall also include at least one provider providing primary care at a health care center that is a member of the Association of American Cancer Institutes (AACI).

(7) The health carrier 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, as designated by the National Cancer Institute, shall be included in the provider network. Provider networks shall also include at least one Affordability Care Act-designated cancer center or cancer center that is a member of the Association of American Cancer Institutes (AACI). Provider networks shall also include at least one provider providing primary care at a health care center that is a member of the Association of American Cancer Institutes (AACI).
(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, including specialists and subspecialists, available to provide the covered benefit to the covered person or it does not have a type of participating provider available on a non-network level of benefits.

(b) The health carrier has an insufficient number or type of participating provider available on a non-network level of benefits.

(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 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;

(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 or medical services;

(ii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care services or medical services 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 obtaining a covered benefit from a non-network provider or from exercising the rights and remedies available under applicable state or federal law.

(5) 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-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.

(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) The process described in Paragraphs (1) and (2) must ensure that requests to obtain a covered benefit from a non-network 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 provider of a covered person within twenty-four (24) hours of receipt of the request. The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-network provider.

(5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state law, 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.

Potential indicators of an inadequate network:

- The health carrier should establish a process for monitoring and measuring the availability of participating providers and for ensuring that the process is being used in a fair and equitable manner.
- The health carrier should regularly review the availability of participating providers and report any significant changes to the commissioner.
- The health carrier should consider factors such as the number of participating providers, their location, and their specialties when making decisions about network adequacy.
- The health carrier should ensure that the process for accessing out-of-network providers is transparent and that covered persons have access to information about their network status.

The health carrier may also consider providing education and training to covered persons about their network status and the process for accessing out-of-network providers.
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:

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<th>Paragraph</th>
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<tr>
<td>(1)</td>
<td>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:</td>
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<td></td>
<td>(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; or</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
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(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:

<table>
<thead>
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<tbody>
<tr>
<td>(a)</td>
<td>The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and</td>
</tr>
<tr>
<td>(b)</td>
<td>The health carrier does not have a network provider of the required specialty or subspecialty with the professional training and experience to treat or provide health care services for the condition or disease; or</td>
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<tr>
<td></td>
<td>The health carrier cannot provide reasonable access to a network provider with the professional training and experience to treat or provide health care services for the condition or disease without unreasonable delay.</td>
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(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) 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 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. |

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 costs exceed the maximum out-of-pocket limit. |

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<th>Table</th>
<th>Description</th>
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<tr>
<td>1</td>
<td>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:</td>
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<tr>
<td>2</td>
<td>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; or</td>
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<tr>
<td>3</td>
<td>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.</td>
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(4) 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 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. |

(5) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider pursuant to Paragraph (2) when:

<table>
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<th>Subparagraph</th>
<th>Description</th>
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<tr>
<td>(a)</td>
<td>The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and</td>
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<tr>
<td>(b)</td>
<td>The health carrier does not have a network provider of the required specialty or subspecialty with the professional training and experience to treat or provide health care services for the condition or disease; or</td>
</tr>
<tr>
<td></td>
<td>The health carrier cannot provide reasonable access to a network provider with the professional training and experience to treat or provide health care services for the condition or disease without unreasonable delay.</td>
</tr>
</tbody>
</table>
(4) For the process required under Paragraphs (1) and (2), a covered person and the requesting provider shall be notified of a decision to approve or deny the request within seven (7) calendar days of receipt of the request. However, if the covered provider is required to approve the request as a result of a decision to use out-of-network providers, or if the covered provider is required to use out-of-network providers to provide the covered benefit, the covered provider shall be notified of a decision to approve or deny the request within seven (7) calendar days of receipt of the request.

(5) The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person. The health carrier shall provide the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit.

(6) The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit. The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit. The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit. The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit. The health carrier shall provide the covered person with a covered benefit equal to the covered benefit to the covered person if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit.

(7) A covered person has the right to appeal a covered benefit decision made by the health carrier. The health carrier shall notify the covered person of their right to appeal the decision, and shall provide the covered person with a process to appeal the decision. The health carrier shall provide the covered person with a process to appeal the decision if the covered benefit to the covered person is not greater than the covered benefit to a non-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 benefit as an in-network benefit.
A health carrier shall 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 and external review, if necessary.

A health carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. The process for accessing out-of-network providers established in this section shall be used as infrequently as possible and shall not be used by carriers as a substitute for maintaining an adequate network as required by this Act.

The health carrier shall treat the covered services as if the services were provided by a network provider and shall be responsible for any payment owed the non-network provider.

The health carrier shall also be responsible for any payment owed the non-network provider.

Cancer Leadership Council

(2) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-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 within a reasonable distance; or

(ii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care 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 they were provided by a network provider and the 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 grievances 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.

(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 claims grievances and appeals processes.
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.

(2) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider 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, expertise, and experience to treat or provide health care services for the condition or disease; or
(ii) Cannot provide reasonable access to an appropriate network provider with the professional training, expertise, and experience to treat or provide health care services for the condition or disease without unreasonable delay.

(3) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider pursuant to Paragraph (2) as an 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 covered services.

(a) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider, including by covering the covered person's cost-sharing toward the maximum out-of-pocket limit.

(b) The health carrier shall ensure that the services were provided by a network provider, indicating by the covered person's cost-sharing toward the maximum out-of-pocket limit.

(c) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(5) Nothing in this section affects a covered person's right to exercise 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 out-of-pocket expenses exceed the level of benefits provided by the health carrier.

A covered person shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a non-network provider, including by covering the covered person's cost-sharing toward the maximum out-of-pocket limit.

(b) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider 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, expertise, and experience to treat or provide health care services for the condition or disease; or
(ii) Cannot provide reasonable access to an appropriate network provider with the professional training, expertise, and experience to treat or provide health care services for the condition or disease without unreasonable delay.

(3) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider pursuant to Paragraph (2) as an 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 covered services.

(a) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-network provider, including by covering the covered person's cost-sharing toward the maximum out-of-pocket limit.

(b) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(c) The health carrier shall ensure that the services were provided by a network provider, indicating by the covered person's cost-sharing toward the maximum out-of-pocket limit.

(d) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(e) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(f) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(g) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(h) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(i) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(j) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(k) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(l) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(m) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(n) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

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(x) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(y) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.

(z) The health carrier shall provide the covered person with a copy of the covered person's financial responsibility for the covered benefit provided from a non-network provider.
(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 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 covered person is diagnosed with a condition or disease that requires specialized health care services or medical services.

(2) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-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 participating provider of the required specialty or subspecialty with the professional training and expertise and experience to treat of provide health care services; 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 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.

(c) 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-network provider pursuant to Paragraph (2) as if the services were provided by a network provider.
(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 health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating 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; and
(v) the relevant authorization number, if the request was approved.

(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 assess an out-of-network provider using the alternate process is denied by the carrier.

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 an insufficient number of type of participating provider available to provide the covered benefit or it does not have a type of participating provider available to provide the covered benefit without unreasonable travel or delay; and

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

(2) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-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 requires medically necessary services that are included as covered benefits under the plan and includes, but is not limited to, services of medical services.

(b) The health carrier:

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

(ii) Cannot provide reasonable access to a network provider with the professional training and experience to treat or provide the necessary health care services within a reasonable amount of 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 part of the delivery and payment of the covered benefit is through a non-network provider.
C. (1) A health carrier shall have a process to assure that a covered person obtaining a covered benefit at an in-network level of benefits from a non-participating provider is provided the covered benefit without the assistance of one or more non-participating providers.

C. (2) The health carrier shall routinely monitor how often the alternative process is being used and the indicators of need for using the alternative process.

C. (3) 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 where:

C. (3)(a) The health carrier has an insufficient number of types of participating providers available to provide the covered benefit in the event of a non-participating provider.

C. (3)(b) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.

C. (3)(c) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.

C. (3)(d) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.

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 and external claims grievance and appeals processes, including in instances where a covered person’s request to obtain a covered benefit from a non-participating provider is denied by the carrier.

C. (5) 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 if not used by carriers as a substitute for maintaining an adequate network of in-network providers, states should consider monitoring how often the alternative process is being used and the indicators of need for using the alternative process.

Maine Bureau of Insurance

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 where:

C. (1)(a) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.

C. (1)(b) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.

C. (1)(c) No qualified participating provider is available to provide the covered benefit in the event of a non-participating provider.

C. (1)(d) The health carrier has determined that it does not have a type of participating provider available to provide the covered benefit in the event of a non-participating provider.
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 Paragraph (2) is denied by the carrier.

The maximum out-of-pocket limit applicable to in-network services under the plan is $5,000.

(a) The health carrier shall treat the covered person’s covered benefit as if it were covered through a network provider pursuant to Paragraph (2) as if it were covered through a network provider.

(b) The health carrier shall ensure that a covered person’s covered benefit is available to the health carrier.

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

(1) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
(2) The health carrier has a sufficient network, but has determined that it does not have a participating provider available to provide the covered benefit.

(d) 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 with the professional training and expertise to treat or provide health care services.

The 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:

(1) 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;

(2) 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 with the professional training and expertise to treat or provide health care services.

(3) 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 with the professional training and expertise to treat or provide health care services.

(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 Paragraph (2) is denied by the carrier.

The maximum out-of-pocket limit applicable to in-network services under the plan is $5,000.

(a) The health carrier shall treat the covered person’s covered benefit as if it were covered through a network provider.

(b) The health carrier shall ensure that a covered person’s covered benefit is available to the health carrier.

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

(1) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
(2) The health carrier has a sufficient network, but has determined that it does not have a participating provider available to provide the covered benefit.

(d) 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.

The 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:

(1) 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;

(2) 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 with the professional training and expertise to treat or provide health care services.

(3) 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 with the professional training and expertise to treat or provide health care services.

(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 Paragraph (2) is denied by the carrier.
(2) 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. The business of covered persons in determining whether the health carrier has complied with this provision is the commissioner’s role, not the business of covered persons. States should be aware that the health carrier has complied with this provision when the commissioner’s review of data on claims filed by covered persons (including the type and number of claim submissions by each provider specialty) indicate that the proportion of in-network and out-of-network claims paid to each provider specialty is consistent with the proportion of in-network and out-of-network provider submissions by each provider specialty. The commissioner shall review the data on claims filed by covered persons on a quarterly basis.

G. A health carrier shall ensure that all essential community providers are included in network plans, especially children’s hospitals.

AHIP/BCBSA

D. (3) A health carrier shall provide and publish quarterly reports by physician specialty to the commissioner on the number of out-of-network and in-network claims paid, and the number of claims the provider submitted in the prior quarter.

APA

DREF

D. ***

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.
Insureds 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.

Drafting Note: States will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to file the access plan with the insurance commissioner. In access plan meeting the requirements of this Act for each of the network plans the carrier offers in this state.

E. Option 1. Prior Approval of Access Plan

Prior to or at the time it files a newly offered network plan, a health carrier shall submit to 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.

Drafting Note: States will establish different requirements for the access plan. Option 2 of Paragraph (1) below, Option 2 of Paragraph (1) above requires a health carrier to file the access plan with the insurance commissioner. But not 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 to the insurance commissioner for prior approval.

Option 2. Filing of Access Plan

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.

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 that the insurance commissioner take action on the plan. Some states may want the commissioner to approve the access plan.
Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Option 1: Prior Approval of Access Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Beginning [insert effective date], a health carrier shall file with the commissioner, in a manner and form defined by 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 should be aware that the requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act.</td>
</tr>
<tr>
<td></td>
<td>Beginning [insert effective date], a health carrier shall file with the commissioner, in a manner and form defined by 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 should be aware that the requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act.</td>
</tr>
</tbody>
</table>
Option 1: Prior Approval of Access Plan

(1) Beginning [insert effective date], a health carrier shall submit to the commissioner a network plan, in a manner and form determined by the commissioner, an access plan meeting the requirements of this Act.

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 to 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 an updated 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 the commissioner's approval of a new network 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.
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 may want to consider defining, in paragraph (2) above, a change in the access plan.

(2) The carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner or any material change in the access plan.

(3) The carrier shall prepare and file an access plan prior to offering a new network plan, and shall notify the commissioner of any material change in the access plan.

Drafting Note: States may want to consider defining, in paragraph (3) above, a change in the access plan.

(4) The 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 plan, 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 (4) above is to make the access plan public. States should not permit the entire plan to be deemed proprietary, competitive or trade secret information and should not make the entire plan public based on information received from the health carrier supporting its request. States should review their open records laws in determining whether a particular provision, if any, of the 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. States should also 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.

(5) The carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change in the access plan.

Drafting Note: States may want to consider defining, in paragraph (5) above, a change in the access plan.

(6) The commissioner shall issue an order approving the access plan.

Drafting Note: States may want to consider defining, in paragraph (6) above, a change in the access plan.
### Option 1. Prior Approval of Access Plan

1. **Beginning [insert effective date]**, a health carrier shall submit to the insurance commissioner an access plan meeting the requirements of this Act to the insurance commissioner for prior approval prior to or at the time of filing a newly offered network plan.

**Drafting Note:** States will establish different requirements for the access plan. Some states may adopt a prior approval of the access plan that is separate from, but part of, the prior approval of the network plan the carrier offers in this state. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as applicable, the information one time.

2. **Option 2 of Paragraph (1) above requires a health carrier to submit an access plan to the insurance commissioner.** Some states may want to require the insurance commissioner to approve the access plan. Other states may prefer that a health carrier not submit the access plan to the insurance commissioner but, instead, maintain the plan on file at the health carrier’s place of business and make it accessible to the insurance commissioner upon request or at any other time.

**Drafting Note:** States will establish different requirements for the access plan. Some states may require that the insurance commissioner approve the access plan.

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### Option 2. Filing of Access Plan

1. **Beginning [insert effective date]**, a health carrier shall file with the insurance commissioner an access plan meeting the requirements of this Act.

**Drafting Note:** States will establish different requirements for the access plan. Option 2 of Paragraph (1) above requires a health carrier to file an access plan with the insurance commissioner. Some 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 or any changes to tiering structure (if applicable), and/or any change that renders the health carrier’s provider network non-compliant with one or more of the network adequacy standards set forth in this section of the Act.

**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 or any changes to tiering structure (if applicable) and/or any change that renders the health carrier’s provider network non-compliant with one or more of the network adequacy standards set forth in this section of the Act.
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 carrier not file the access plan with the commissioner but, 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 plan 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 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 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 to use in some other context.

In drafting the health carrier’s comments on other business information

(3) The health carrier may request the commissioner or sections of the access plan to be opened to public access.

Drafting Note: States may also specify an agency other than the insurance department to receive or approve access plans.
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 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.

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

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 the insurance commissioner to take action on the plan. This is Option 2 of Paragraph (1).

Drafting Note: States will establish different requirements for the access plan.

E. Option 1—Prior Approval of Access Plan

(1) Beginning [insert effective date], a health carrier shall submit to the commissioner a new network plan. The health carrier shall include in the notice to the commissioner an access plan. Option 1 of Paragraph (1) above requires a health carrier to 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.

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

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 the insurance commissioner to take action on the plan. This is Option 2 of Paragraph (1).

Drafting Note: States will establish different requirements for the access plan.

...
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) above. Some states may also specify an agency other than the insurance department as the appropriate agency to receive the access plan.

(2) 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 access plan all network plans offered by the carrier.

Drafting Note: States should consider defining "material change" for purposes of Paragraph (3) above.

(3) The carrier shall include 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 access plan all network plans offered by the carrier.

Drafting Note: States may want to consider defining "proprietary," "competitive," or "trade secret" for purposes of Paragraph (2) above.

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 treated as "proprietary," "competitive," or "trade secret" 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 of the plan may be required to be made public. States should also consider adopting a uniform public records law to define what information is considered "proprietary," "competitive," or "trade secret."
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 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.

***

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 should be aware that the intent of Paragraph (2) above is that the access plan be considered public information.

Drafting Note: States should be aware that the health carrier’s competitive or trade secret information is [proprietary, competitive or trade secret] if revealing the information would cause the health carrier’s competitors to obtain valuable business information.

(2) 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 available [proprietary, competitive or trade secret], complete or trade secret information that shall not be made public. The health carrier shall submit the information to the commissioner in a manner and form defined by rule of the commissioner.

***

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.

Drafting Note: States should be aware that the health carrier’s competitive or trade secret information is [proprietary, competitive or trade secret] if revealing the information would cause the health carrier’s competitors to obtain valuable business information.

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***

Drafting Note: States should be aware that the intent of Paragraph (2) above is that the access plan be considered public information.
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 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 online and in-print provider directories.

3. The health carrier’s process for making available to persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

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 online 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

Drafting Note: States may want to consider requiring that an access plan include information on the health carrier’s efforts to ensure that participating providers meet reasonable 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.

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 process for enabling covered persons to change primary care professionals.

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

9. The health carrier’s system for ensuring that its participating providers meet its quality of care and health outcome standards.

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.

11. Any other information required by the commissioner to determine compliance with the provisions of this act.

Drafting Note: States may want to consider including information on the health carrier’s efforts to ensure that participating providers meet reasonable 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.
<table>
<thead>
<tr>
<th><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 provider directories are comprehensive, clearly understood and regularly updated, with emphasis on the breadth of the network and how it selects and rates providers, which must be made available through the health carrier’s on-line and in-print provider directories.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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 rates providers), which must be made available through the health carrier’s on-line and in-print provider directories.</strong></td>
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<tr>
<td><strong>The health carrier’s process for identifying, developing and implementing quality standards for providers;</strong></td>
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<tr>
<td><strong>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 are met.</strong></td>
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<td><strong>The health carrier’s process for making available, in consumer-friendly language, the criteria it has used to build its provider network.</strong></td>
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<tr>
<td><strong>The health carrier’s process for enabling covered persons to change primary care professionals, if applicable.</strong></td>
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<tr>
<td><strong>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</strong></td>
</tr>
<tr>
<td><strong>Any other information required by the commissioner to determine compliance with the provisions of this Act.</strong></td>
</tr>
<tr>
<td><strong>(4) 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 subspecialists and surgical specialists.</strong></td>
</tr>
<tr>
<td><strong>The access plan shall describe or contain at least the following:</strong>*</td>
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AHIP/BCBSA

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<td>(4)</td>
<td>The health carrier's process for enabling covered persons to change primary care professionals if applicable.</td>
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<td>(5)</td>
<td>The health carrier's process for ensuring provision of essential health benefits in accordance with legal requirements.</td>
</tr>
<tr>
<td>(6)</td>
<td>The health carrier's process for providing covered persons with information about the plan's services and features and any referral or prior approval processes, if applicable.</td>
</tr>
<tr>
<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.</td>
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<tr>
<td>(8)</td>
<td>The health carrier's process for ensuring covered persons have access to specialty providers as needed, including information on the health carrier's efforts to ensure the quality of care and health outcomes of its participating providers.</td>
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**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 or tiered networks.

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<td>(9)</td>
<td>The health carrier's method of informing covered persons of the criteria it has used to build its provider network, which must be made available through indirect information about the breadth of the network and how the provider network affects the criteria it has used to build its provider networks.</td>
</tr>
<tr>
<td>(10)</td>
<td>The health carrier's process for ensuring that its networks meet its quality of care standards and health outcomes for certain types of network plans, such as HMOs and narrow or tiered networks.</td>
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**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 or tiered networks.

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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.</td>
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**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 or tiered networks.
The health carrier's methods for assessing and monitoring, on an ongoing 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;

Drafting Note: States may want to consider requiring a health carrier to assess and monitor 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.

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

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

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 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

- 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

- The health carrier's criteria and any methodologies used in tiering or publicly designating participating providers with a label.

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

- 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.

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

- The health carrier's criteria and any methodologies used in tiering or publicly designating participating providers with a label.
<table>
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<th><strong>Access Plan</strong></th>
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<tr>
<td>MIA F.</td>
<td>The access plan shall describe or contain at least the following:</td>
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<td>(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable; and plans for coordinating referrals with Indian health facilities, if applicable;</td>
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<tr>
<td>NCQA</td>
<td>The access plan shall describe or contain at least the following:</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 how the carrier selects and/or tiers providers;</td>
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<td>(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;</td>
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<td>(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 in the event of contract termination or in the event of the health carrier's insolvency or other inability to continue operations, 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>(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;</td>
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<td>(10) The health carrier's proposed plan for ensuring 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</td>
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<td>(5) 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 incentives;</td>
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<td>(6) The access plan shall describe or contain at least the following:</td>
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<td>(7) Performance, value, quality, cost, or any combination thereof;</td>
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<td>(11) The health carrier's proposed plan for ensuring 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</td>
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<td>(12) The health carrier's proposed plan for ensuring 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</td>
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<tr>
<td>DREDF</td>
<td>The access plan shall describe or contain at least the following:</td>
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<td>(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;</td>
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<td>(6) The access plan shall describe or contain at least the following:</td>
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<tr>
<td>(7) Performance, value, quality, cost, or any combination thereof;</td>
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</table>
### Additional Subsections

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACS CAN</td>
<td>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.</td>
</tr>
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### Suggested Additional Subsections

<table>
<thead>
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<td>UCACAA</td>
<td>The access plan shall describe at least the following:</td>
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<td>- The health carrier's method of informing covered persons of the plan's services and features, including those services offered through the preventive benefit, if applicable, and its procedures for providing and appealing a decision on a covered service or benefit.</td>
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### Definitions

- **Preventive benefit**: A benefit that includes services designed to prevent disease or detect it at an early stage, such as screening, counseling, and other preventive services.
- **Essential community provider**: A provider that meets the criteria under the Affordable Care Act for designation as a community health center.
- **National Cancer Institute (NCI)-designated cancer center**: A cancer center designated by the National Cancer Institute for its excellence in cancer research, treatment, and patient care.

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(7) The health carrier's method of informing covered persons of the plan's services and features, including those services offered through the preventive benefit, if applicable, and its procedures for providing and appealing a decision on a covered service or benefit.
network provider. Such determination shall be made by an independent reviewer organization or other entity that has no

writing agreement of the pharmacies or retail networks.

(2) A MCO or PBM may not automatically enroll or disenroll a retail pharmacy in a contract or modify an existing agreement without

applicable federal and state licensure and permit requirements and may not be excluded from participation in any federal or state

provided under the Affordable Care Act, and applicable federal or state requirements. Retail pharmacies must meet applicable federal

Drafting Notes: Although this Act does not provide specific language regarding essential community provider standards, inclusion of

the essential community provider requirements that apply to qualified pharmacy benefit managers (PBM) shall not mandate that a covered individual

Consider extending specific standards to ensure compliance with the essential community provider requirements of the Affordable Care Act

that apply to qualified retail pharmacies under federal and state law. Regulations or guidance.

A health carrier shall ensure that their networks meet, at a minimum, the essential community provider requirements

with the network. A health carrier shall provide adequate language regarding essential community provider standards, inclusion of

that apply to qualified health plans under federal and state law. Regulations or guidance.

A health carrier shall ensure that their networks meet, at a minimum, the essential community provider requirements

requirements associated with the terms.

lightless, urgent care facilities, and at least one NCI-designated cancer center. Covered persons must be informed of cost sharing

must contain a sufficient number of retail pharmacies and other specialty

in-network or covered services. In plans with limited provider networks, the lowest cost-sharing tier shall include a sufficient number of

provision. 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 limited retail network. The MCO or PBM shall allow a pharmacy to opt-out of the discount card network.

networks managed by such MCO or PBM should be available to a MCO or PBM. NACDS

A managed care organization (MCO) or contracted pharmacy benefit manager (PBM) may not exchange in pharmacy agreements or other network managed by the same MCO or PBM.

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

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

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.
(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.

The department determines that a plan is inadequate for physician specialist services in emergency room care, anesthesiology, hospitalist care, radiology and/or pathology/laboratory services the plan shall be required to either a) refund out-of-pocket expenses for access to non-network physicians for emergency room care, anesthesiology, hospitalist care, radiology and/or pathology/laboratory services. The network adequacy plan for these physician specialist services 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.

In order to ensure accessibility, a health carrier must have an ongoing plan for providing network adequacy for physician specialist services in emergency room care, anesthesiology, hospitalist care, radiology and/or pathology/laboratory services. This plan must be designed to guarantee that covered persons have timely access and utilization of physician specialist services. The provision shall be substantiated by any in-network physicians or any network of providers, or the specific covered health services for which the provider will be responsible. The provision shall not be construed to establish a basis for any implied contract or contract of adhesion between a non-participating physician or a health plan. This provision shall establish a mechanism by which the participating provider will be notified of any material changes to the network or network status. Pose a similar requirement.

Requirements for Health Carriers and Participating Providers

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.

B. Every contract between a health carrier and a participating provider shall contain a hold harmless provision specifically for covered persons. This requirement shall be met by including a provision substantially similar to the following:

A health carrier shall establish mechanisms 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.

In order to ensure accessibility, a health carrier must have an ongoing plan for providing network adequacy for physician specialist services in emergency room care, anesthesiology, hospitalist care, radiology and/or pathology/laboratory services. This plan must be designed to guarantee that covered persons have timely access and utilization of physician specialist services. The provision shall be substantiated by any in-network physicians or any network of providers, or the specific covered health services for which the provider will be responsible. The 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.
(1) Every contract between a health carrier and a participating provider shall set forth in the event of a health carrier or intermediary insolvent or medically necessary, or other cessation of operations, covered benefits to covered persons will continue through the period for which a premium has been paid, covered persons continued in an inpatient facility on the date of insolvency or other cessation of operations, covered persons will continue through the period for which a premium has been paid to the health carrier, 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.

(2) After the period for which a premium has been paid to the health carrier, covered persons shall have no recourse against the health carrier for any reason, whether or not the health carrier is insolvent or medically necessary. Covered persons may continue to receive covered services from the health carrier after the period for which a premium has been paid in the event that the health carrier has not been paid for the services provided before the period for which a premium has been paid.

(3) After the period for which a premium has been paid, covered persons shall have no recourse against the health carrier or intermediary, or their agents, for any services provided on a covered basis to covered persons under any agreement or arrangement that is not a covered service.
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.

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:

1. The effective date of new health benefit plan coverage; or
2. Their discharge from the inpatient facility because their continued confinement in the inpatient facility is no longer medically necessary.

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

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.

No comments received

Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional subjected by subsections B and C of this section.

A. 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.

B. The contract provisions that satisfy the requirements of Subsections B and C of this section 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.

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier's insolvency or other cessation of operations, the provider's obligation to provide covered benefits 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. The provider's obligation to provide covered benefits will continue until the date of discharge, or a date specified in an agreement entered into by the health carrier and the provider, whichever is later.

D. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

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.

F. Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional subjected by subsections B and C of this section.

G. The contract provisions that satisfy the requirements of Subsections B and C of this section 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.

H. 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.

I. The contract provisions that satisfy the requirements of Subsections B and C of this section 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.

J. The contract provisions that satisfy the requirements of Subsections B and C of this section 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.
<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Text</th>
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<tbody>
<tr>
<td>(3)</td>
<td>Selection of providers shall not be established in a manner that fails to take into account provider performance on quality metrics and patient outcomes.</td>
</tr>
<tr>
<td>(4)</td>
<td>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.</td>
</tr>
<tr>
<td>(5)</td>
<td>The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which it contracts, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria. This provision does not require that a health carrier establish standards for participation under the plan that cover any provider that is acting within the scope of their license or certification under applicable state law.</td>
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</table>

**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 encourage providers to avoid high-risk populations. Exclusion based on performance metrics has a similar effect. Exclusion based on performance metrics, however, is not as likely to be effective because high-risk populations are likely to need frequent care from specialists. Exclusion based on licensing, on the other hand, is more likely to be effective because providers are licensed to practice in the state in which they practice. **Health Law Program**

**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)**

**Consumer Advocates for Smarter, National Health Law Program**

**Families USA**

**F.***

<table>
<thead>
<tr>
<th>Paragraph</th>
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<tbody>
<tr>
<td>(a)</td>
<td>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>
</tr>
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</table>

**American Medical Association**

**American Osteopathic Association**

**League for Orthopaedic Surgeons**

**National Association of Insurance Commissioners (NAIC)**

**ACS CAN, AHA, Consumer Advocates for Smarter National Health Law Program**

**Families USA**

**F.***

<table>
<thead>
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<tbody>
<tr>
<td>(a)</td>
<td>The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. The standards shall not be used to determine the selection of providers by the health carrier and its intermediaries with which it contracts.</td>
</tr>
<tr>
<td>(b)</td>
<td>The standards shall be used to determine the selection of providers by the health carrier and its intermediaries with which it contracts.</td>
</tr>
<tr>
<td>(c)</td>
<td>That fails to take into account performance on quality metrics and patient outcomes.</td>
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**ACS CAN, AHA, Consumer Advocates for Smarter National Health Law Program**

**Families USA**

**F.***

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<td>(a) The standards shall be used to determine the selection of providers by the health carrier and its intermediaries with which it contracts.</td>
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**ACS CAN, AHA, Consumer Advocates for Smarter National Health Law Program**

**Families USA**

**F.***
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 take into account provider performance on quality metrics and patient outcomes as a major and essential component of provider selection criteria.

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. 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 some of the requirements of the provider networks with which they contract to provide specific covered health care services or benefits.

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 some of the requirements of the provider networks with which they contract to provide specific covered health care services or benefits.

American Medical Association (AMA)

F. (2) (a) The standards shall be used in determining the selection of tiers of providers by the health carrier and its intermediaries with each tier.

(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.

(2) The standards shall meet the requirements of interest referents to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act.

(4) The standards shall be developed for providers and each health care professional specialty.
(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 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; or
| **(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.

**Drafting Note:** Any metrics of quality-of-care and patient outcomes against which provider performance is judged must:

1. **(1)** Be specific to the type of care provided;
2. **(2)** Meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment;
3. **(3)** Be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.

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| **(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 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.

**Drafting Note:** Any metrics of quality-of-care and patient outcomes against which provider performance is judged must:

1. **(1)** Be specific to the type of care provided;
2. **(2)** Meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment;
3. **(3)** Be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.

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| **(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 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.

**Drafting Note:** Any metrics of quality-of-care and patient outcomes against which provider performance is judged must:

1. **(1)** Be specific to the type of care provided;
2. **(2)** Meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment;
3. **(3)** Be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.
(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 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.

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

Section criteria shall not be established in a manner:

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

(2) 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:

(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 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.

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

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

The provisions of this Act do not negate a health carrier’s intermediaries of the provider networks with which they contract to:

(1) Conduct or allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in a geographic area that contains populations of providers specializing in treating populations presenting a risk of higher than average claims, losses or health care services utilization;

(2) Conduct or allow a health carrier to discriminate against high-risk populations by excluding providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or

(3) Conduct or allow a health carrier to discriminate against high-risk populations by excluding providers because they fail to take into account provider performance on quality metrics and patient outcomes.

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.

The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to:

(1) 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.

(2) Require that a health carrier make its standards for selecting and tiering, as applicable, participating providers available for review and approval by the commissioner.

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

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

(b) That fails to take into account health care services utilization or claims, losses or health care services utilization or risk of higher than average claims, losses or health care services utilization.

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

(d) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they fail to take into account provider performance on quality metrics and patient outcomes.

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

The health carrier also shall make its standards publicly available.
<table>
<thead>
<tr>
<th>Health Insurance Portability and Accountability Act (HIPAA)</th>
<th>Section 1302(a)</th>
<th>Section 1313(b)</th>
<th>Section 1313(c)</th>
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<tr>
<td>A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the carrier’s position on the treatment options or from disclosing any specific or all treatment options with covered persons irrespective of the carrier’s position on the treatment options.</td>
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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.

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

L. (t) (a) A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care of insured persons, and to comply with the applicable state and federal laws relating to the confidentiality of medical or health records.

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.

K. A health carrier shall require a participating 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.

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, such as some patient care coordinators.

A health carrier shall require a participating 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.

DREDF

K. A health carrier shall require a participating 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.

Families USA

J. A health carrier shall require a participating 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.

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, such as some patient care coordinators.
(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, regardless 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.

(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 the provider to continue to provide medically necessary treatment to a covered person who has a special circumstance as defined below.

(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 or chronic medical condition 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.

(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 the covered person has a special circumstance; and

(ii) The contract termination was not for cause.

(d) Except as provided in subparagraph (a) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment shall end if:

(i) The contract termination was for cause; or

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

The provider shall supply the health carrier with a list of those patients of the provider who have a special circumstance and for whom ongoing treatment is requested within five (5) working days of the date on which the provider was notified of the contract termination. The list shall identify the special circumstance and the manner in which the treating physician or provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person.

(e) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt of any notice of termination.

(f) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt of any notice of termination.
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 is enrolled in a health benefit plan, it is the result of a material error, incorrect 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.

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.
(4)(d) 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 the specified for one of the conditions specified in Paragraph (2).

(4)(e) In circumstances where a covered person with a disability, a mental health condition, or a substance use disorder; an 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.

(4)(f) 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 90 days, twelve (12) months, whichever is less.

(4)(g) 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.

(4)(h) 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.

(4)(i) 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.

(4)(j) 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

(c) A health carrier shall allow the health carrier to continue to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of the specified for one of the conditions specified in Paragraph (2).

(d) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(e) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(f) 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.

(g) The health carrier shall allow the covered person to continue care with the provider for up to 90 days, whichever is less.

(h) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(i) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(j) 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.

(k) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(l) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(m) 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.

(n) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(o) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(p) 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.

(q) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(r) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(s) 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.

(t) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(u) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(v) 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.

(w) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

(x) The health carrier shall allow the covered person to continue care with the provider for the duration of their illness.

(y) 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.

(z) The health carrier shall allow the covered person to continue care with the provider through the postpartum period.

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(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, “active treatment” means regular visits with a provider to monitor the status of a chronic medical condition in active treatment or to continue such treatment until it is completed or for up to ninety (90) days, whichever:

(1) The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and
(2) The contract termination was not “for cause.”

(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 the child and applies to immediate postpartum care and a follow-up check 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, when a consumer’s enrollment or non-enrollment in a health carrier’s plan is affected by a material error, inaccuracy or misrepresentation in a provider directory, including when a primary care provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.
(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 posttermination period.

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(1) 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 under the 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 under the 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 under the 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 under the notice of termination.

(2) (a) (i) "Active treatment" means regular visits with a provider to monitor the status of an illness or disorder, provide initial/treatment, prescribed medications or other treatments or modify a treatment protocol.

(ii) "Active treatment" does not include routine monitoring for a chronic condition (e.g., monitoring of patients who have a special circumstance) or a condition in which the treating physician or provider believes that discontinuing care could cause harm to the covered person.

(iii) "Special circumstance" means a condition in which the treating physician or health care provider believes that discontinuing care could cause harm to the covered person.

(iv) "Terminal illness" means an incurable or irreversible condition that has a high probability of causing death within one year or less.

(3) "Leaving the network" means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and cannot be treated by a provider under the health carrier's network.

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

(i) "Defined benefit plan" means a plan that provides fixed benefits to participants based on their plan participation and contributions.

(ii) "Defined contribution plan" means a plan that provides benefits to participants based on their plan participation and contributions, and other factors such as age, length of service, and investment performance.

(iii) "Provider directory" means a list of providers that are covered by a plan under the notice of termination.

(iv) "Provider network" means a list of providers that are covered by a plan under the notice of termination.

(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 posttermination 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 physician 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 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 if a covered person who has a special circumstance meets one of the conditions laid out in Paragraph (2) if the treating physician or health carrier can provide 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) Acknowledges a special circumstance with respect to the covered person.

(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 for the duration of time laid out for one of the conditions in Paragraph (2)(f) if:

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

(ii) the contract termination was not "for cause."
(b) The health carrier shall 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.

(1) 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 altered through a change in treatment.

(ii) “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.

(iii) “Acute condition” means a condition that is typically short-term and requires immediate medical attention.

(iv) “Chronic condition” means a condition that is typically long-term and requires ongoing medical attention.

(v) “Provider network” means a group of providers who have entered into agreements with a health carrier to provide services to covered persons who are enrolled in a health benefit plan.

(2) 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.

(3) 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.

(4) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall provide written notice of the 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.

(5) 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 a termination.
(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, an 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) 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 rate negotiated with 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 negotiated 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 in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory.

(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.

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

[Table]
(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.
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.

(2) A 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. Where a contract termination involves a participating provider, all covered persons who are patients of the participating provider shall also be notified, within five (5) days of the date the provider becomes aware of the loss of access to services, that the contract will be terminated.

Drafting Note: When a contract termination involves a participating provider, written notice to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, should also be provided, in accordance with the provisions of the contract, within thirty (30) working days of receipt or issuance of a notice of termination.

(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) 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.

(2) (a) (i) For purposes of this paragraph, “active treatment means regular visits with a provider to monitor the status of an illness.

(ii) “Active treatment” does not include routine monitoring for chronic conditions or preventive care.

Drafting Note: For purposes of this paragraph, “active treatment means regular visits with a provider to monitor the status of an illness.

(iii) “Active treatment” means that the provider shall supply the health carrier with a list of those patients of the provider whose enrollment is covered by a plan of the health carrier.

(iv) When a contract termination involves a participating provider, all covered persons who are patients of the provider whose contract is terminating shall also be notified, within thirty (30) working days of receipt or issuance of a notice of termination, of the proposed change in level of cost-sharing.

(2) (b) (c) Where a contract termination involves a participating provider, all covered persons who are patients of the provider whose contract is terminating shall also be notified, within thirty (30) working days of receipt or issuance of a notice of termination, of the proposed change in level of cost-sharing.

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. 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 reimbursemants during the transition period. When considering continuity of care requirements, states should consider provisions which prohibit providers from balance-billing covered persons during transition periods of coverage.

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. Transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursemants 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 reimbursemants during the transition period. When considering continuity of care requirements, states should consider provisions which prohibit providers from balance-billing covered persons during transition periods of coverage.

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. Transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursemants 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 reimbursemants during the transition period. When considering continuity of care requirements, states should consider provisions which prohibit providers from balance-billing covered persons during transition periods of coverage.

(2) (b) (c) Where a contract termination involves a participating provider, all covered persons who are patients of the provider whose contract is terminating shall also be notified, within thirty (30) working days of receipt or issuance of a notice of termination, of the proposed change in level of cost-sharing.

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. Transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursemants 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 reimbursemants during the transition period. When considering continuity of care requirements, states should consider provisions which prohibit providers from balance-billing covered persons during transition periods of coverage.

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. Transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursemants 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 reimbursemants during the transition period. When considering continuity of care requirements, states should consider provisions which prohibit providers from balance-billing covered persons during transition periods of coverage.
(a) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons who are pregnant to continue care with the provider through the postpartum period.

(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 to continue care with the provider through the postpartum period.

(d) Except as provided in subparagraph (c) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person whose course of treatment ends or whose health carrier’s contract ends shall cease when the covered person has a special circumstance, which includes a covered person with a disability, acute condition, or life-threatening disease or a covered person who is past the 24th week of pregnancy.

(e) If the contract termination was not "for cause," the health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and the health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment of the covered person.

(f) If the physician or provider were still a participating provider, the provider would be responsible for the covered person’s costs exceeding the provider’s usual and customary charges.

(g) If the contract termination was not "for cause," the health carrier agrees to accept the same reimbursement from the health carrier for the covered person as provided under the carrier’s provider contract.

(h) 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.

(j) "Special circumstance" means a condition regarding which the treating physician or 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.

(k) In the event that a provider’s contract is terminated without cause and the provider continues to provide medically necessary treatment at the in-network rate, the health carrier shall provide extended reimbursement to the provider for ongoing treatment of the covered person.

(l) If the covered person is past the 24th week of pregnancy at the time of termination and the provider continues to provide medically necessary treatment at the in-network rate, the health carrier shall reimburse the provider for ongoing treatment of the covered person.

(m) A covered person’s course of treatment shall not cease if the covered person is past the 24th week of pregnancy at the time of termination and the provider continues to provide medically necessary treatment at the in-network rate.

(n) For purposes of this paragraph:

(i) "The treating physician or provider shall cease" means a condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(j) "Postpartum period" means a condition occurring in the period following childbirth.

(k) "The provider’s contract is terminated without cause" means a contract termination without cause that was not "for cause."
(1) The health carrier 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, including when a provider is listed as a participating provider, but subsequently is found not to be in-network or a participating provider. Providing a health carrier 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.

ASDSAL 1. The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt of notice of termination.

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, including when a provider is listed as a participating provider, but subsequently is found not to be in-network or a participating provider. Providing a health carrier 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.
| (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.

*(CHL.)*

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

(i) “Life-threatening” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has limited duration.

(ii) “Active treatment” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has limited duration.

(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, acute condition or life-threatening disease, or a covered person who is past the 24th week of pregnancy.

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

(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. **(NAIC Consumer representatives, NAIC)*

(e) 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. **(NAIC Consumer representatives, NAIC)*
(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 physician or provider for ongoing treatment of the disease or condition within the time period provided for in paragraph (2) if:

- The health carrier or covered person agrees not to seek reimbursement from another source for the covered person's treatment at the time of termination.
- The health carrier agrees to accept the same reimbursement from the health carrier for the treated person as provided under the carrier's provider contract.
- The health carrier agrees to continue reimbursement for the covered person's care.
- The health carrier agrees to continue reimbursement for the covered person's care if the physician or provider does not 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.
- The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance.
- The health carrier agrees to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the then-network or non-network rate for the duration of time laid out for one of the conditions laid out in Paragraph (2) if:

- The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance.
- The health carrier agrees to continue reimbursement for the covered person's care.
- The health carrier agrees to continue reimbursement for the covered person's care if the physician or provider does not 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.
- The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance.
- The health carrier agrees to continue reimbursement for the covered person's care.
- The health carrier agrees to continue reimbursement for the covered person's care if the physician or provider does not 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.
- The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance.
- The health carrier agrees to continue reimbursement for the covered person's care.
- The health carrier agrees to continue reimbursement for the covered person's care if the physician or provider does not 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.

(2) For purposes of this paragraph:

- "Life-threatening" means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
- "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 who is past the 24th week of pregnancy.
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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 in the provider directory.

Within the 6-week period after delivery, the health carrier shall draft a letter with the five elements listed below:

1. The health carrier shall draft a letter with the five elements listed below:

   a. The health carrier shall draft a letter with the five elements listed below:

   b. The health carrier shall draft a letter with the five elements listed below:

   c. The health carrier shall draft a letter with the five elements listed below:

   d. The health carrier shall draft a letter with the five elements listed below:

   e. The health carrier shall draft a letter with the five elements listed below:

   f. The health carrier shall draft a letter with the five elements listed below:

Families USA

L. (2)

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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 in the provider directory.

Within the 6-week period after delivery, the health carrier shall draft a letter with the five elements listed below:

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5. The health carrier shall draft a letter with the five elements listed below:

6. The health carrier shall draft a letter with the five elements listed below:

Families USA

L. (2)
terminal illness should last for the duration of the illness.

(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; and

(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.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment for the duration of time laid out for one of the conditions 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."
A health carrier shall provide at least sixty (60) days written notice to the other party 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 before terminating the contract without cause:

(1) A health carrier and/or a participating provider shall provide at least sixty (60) days written notice to each other party to explain the reasons for termination.
(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 postpartum period. If the covered person is past the 26th 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 postpartum period. As long as coverage is still in force, the health carrier must reimburse the treating physician or provider for ongoing treatment of provider for ongoing treatment of provider for ongoing treatment of provider.
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.

A health carrier shall not penalize a 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.

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 checkup within the 6-week period after delivery.

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 costs 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.

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.

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.

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.

No comments received

O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles.

No comments received

P. A health carrier shall not penalize a 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.

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.

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No comments received

Q. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles.

No comments received

R. 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.

A health carrier shall not penalize a 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.

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.

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.
A. 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 under the established mechanism are binding on the carrier.

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

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

D. 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.

E. A contact between a health carrier and a provider shall not contain provisions that conflict with the requirements of this Act.

F. 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 provider.

G. Any material changes to those documents while the contract is in force shall not be binding on the provider unless those changes have been given reasonable notice to the provider. The burden of proof shall be on the provider to show that the contract is in force. 

H. A health carrier shall establish a mechanism to ensure that its network access and adequacy procedures and standards fully comply with applicable provisions of state law.

I. 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.

J. A health carrier shall not contain provisions that conflict with the requirements of this Act.

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

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

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

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

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

P. A health carrier shall appropriately inform providers of their network status on any plan in which they are included in-network.
### Section 7. Disclosure and Notice Requirements

<table>
<thead>
<tr>
<th>Drafting Note: Some states should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide care within the hospital.</th>
</tr>
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<tbody>
<tr>
<td>1. 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.</td>
</tr>
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<tr>
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<td><strong>ADP</strong></td>
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<td><strong>DREDF</strong></td>
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<td><strong>Consumers Union</strong></td>
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#### Disclosures for In-Network Services

<table>
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<tr>
<th>Drafting Note: Add examples of “cause” for removal such as loss of license 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.</th>
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</thead>
<tbody>
<tr>
<td>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 provider acts within the scope of their license or certification.</td>
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<tr>
<td>A contract between a health carrier and a provider shall not contain or refer to participation or coverage of mental health care.</td>
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<tr>
<td>For non-emergency services, a requirement of an provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification.</td>
</tr>
<tr>
<td>B. A health carrier is not in the same network as the hospital. If applicable, for a covered benefit or the provided at an in-network hospital, there is no possibility that the covered person could be treated by a provider outside the network.</td>
</tr>
<tr>
<td><strong>Section 5C(2) of this Act</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
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</table>

#### Disclosures for Out-of-Network Services

| **APA** |
| **ASRS** |
| **ADP** |
| **DREDF** |

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</table>
Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers who are not in the same network as the hospital-based providers.

**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.** 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.

**C.** 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.

**D.** 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.

**E.** 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.

**F.** 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.
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).

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, if applicable.

A health carrier shall develop a written disclosure or notice to be provided to covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable. 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, if applicable.

In the same network as the hospital:

Provided by a non-participating provider.

Written disclosure or notice should include an estimate of the applicable charges that may be billed to the covered person for services provided by a non-participating provider in the same network as the hospital, if the hospital may not be a participating provider in the network.

Written disclosure of cost-sharing should be provided to the covered person at the time of pre-certification, if applicable. For a covered person of the carrier that is not in the same network as the hospital, the carrier shall provide a written disclosure of cost-sharing that includes estimates of the charges that may be billed to the covered person.

This written disclosure or notice should be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services, if applicable.

Program

AHA/BCBSA

NAIC Consumer

Approved Health Law

Dr. J. Wright: Stays new to consider applying disclosure and notice requirements to hospitals in same network as the hospital.

Disclosures:

1. The carrier to reimburse for out-of-network services, if applicable. For a provider that is not in the same network as the hospital, the carrier shall provide a written disclosure of cost-sharing that includes estimates of the charges that may be billed to the covered person.

2. 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 covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable.

3. A health carrier shall develop a written disclosure or notice to be provided to covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable. 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, if applicable.

4. A health carrier shall develop a written disclosure or notice to be provided to covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable. 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, if applicable.

5. A health carrier shall develop a written disclosure or notice to be provided to covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable. 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, if applicable.

6. A health carrier shall develop a written disclosure or notice to be provided to covered persons as to whether a health care provider scheduled to provide the service is an in-network provider, if applicable. 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, if applicable.
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 determine provider status, and a description of what the consumer will be responsible for paying if care is delivered by an out-of-network provider, 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:

1. The hospital is a participating provider of the covered person’s network plan.
2. If applicable, 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.
3. If applicable, that there is the possibility that the covered person could be responsible for cost-sharing at nonparticipating levels and for balance billing by the non-participating provider.

5A. Hosp...
A health carrier shall provide a current provider directory to the extent described in Subsection C upon request of a covered person or a prospective covered person.

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.

A 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.

A health carrier shall provide a current copy of a prospective covered person of a prospective covered person to a request of a covered person to a network of providers for the same network of providers included in the online provider directory.

A health carrier shall include in plain language, as clearly as possible, in both the online and print directory:

- The name and address of the hospitals that are in the network of the hospital or may provide services to the covered person who is in need of a hospital admission, and
- The name and address of the hospitals that are not in the network of the hospital, and
- The name and address of the hospitals that are in the same network as the network of the hospital, and
- The name and address of the hospitals that are not in the same network as the network of the hospital, and
- The name and address of the hospitals that are not in the network of the hospital.
A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions described in subsection B upon request of a covered person or prospective covered person.

B. (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, a health carrier shall do so in a manner that:

(i) Makes it clear what provider directory applies to which network plan to the maximum extent possible; and

(ii) Does not require a covered person or prospective covered person to log in or enter a policy number in order to access the provider directory.

C. (1) 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 prospective covered person.

D. (1) A health carrier shall include in plain language, as clearly as possible, in both the online and print directory:

(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 limits 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.

(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 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.

(4) 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.

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(6) 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.

(7) 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.
applicable provider directory.

(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 for each of its network plans 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 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.
(c) **Provider Directory** information for each network plan:

- **Name**
- **Gender**
- **Contact information**
- **Specialty**
- **Whether accepting new patients**

(1) The health carrier shall make available in print the following provider directory information for each network plan:

<table>
<thead>
<tr>
<th><strong>Insurance</strong></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 to accommodate individuals with disabilities or limited English language proficiency or disabilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maine Bureau of Insurance</strong></th>
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</thead>
<tbody>
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<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 disabilities or limited English language proficiency or disabilities.</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>DREDF</strong></th>
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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 disabilities or limited English language proficiency or disabilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Consumers Union</strong></th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>APA</strong></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 to accommodate individuals with disabilities or limited English language proficiency or disabilities.</td>
</tr>
</tbody>
</table>
The health carrier shall make available in print the following provider directory information for each network plan:

For health care professionals:

1. Name;
2. Gender;
3. Contact information;
4. Specialty;
5. Network tier to which the professional is assigned, if applicable;
6. Whether accepting new patients.

For hospitals:

1. Hospital name;
2. Hospital location and telephone number;
3. Hospital accreditation status;
4. Network tier to which the hospital is assigned, if applicable;
5. Whether accepting new patients.

For hospitals, other facilities by type:

1. Facility name;
2. Facility type;
3. Procedures performed;
4. Network tier to which the facility is assigned, if applicable;
5. Facility location and telephone number.

The health carrier shall make available in print the following provider directory information for each network plan:

For health care professionals:

1. Name;
2. Gender;
3. Contact information;
4. Specialty;
5. Languages spoken by the health care professional or clinical staff;
6. Whether accepting new patients;
7. 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.

For hospitals:

1. Hospital name;
2. Hospital location and telephone number; and
3. Hospital accreditation status; and
4. Network tier to which the hospital is assigned, if applicable; and
5. Whether accepting new patients.

For hospitals, other facilities by type:

1. Facility name;
2. Facility type;
3. Procedures performed;
4. Network tier to which the facility is assigned, if applicable; and
5. Facility location and telephone number.
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:

<table>
<thead>
<tr>
<th>Health Care Professional</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Contact Information</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Network Tier</td>
<td></td>
</tr>
<tr>
<td>Whether Accepting New Patients</td>
<td></td>
</tr>
</tbody>
</table>

| Hospital Name           |             |
| Hospital Location       |             |
| Hospital Accreditation Status |         |
| Network Tier            |             |

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Facility Type</th>
<th>Procedures Performed</th>
<th>Network Tier</th>
<th>Whether Accepting New Patients</th>
<th>Provider Information</th>
</tr>
</thead>
</table>

For hospitals:

- Hospital name
- Hospital location and telephone number
- Hospital accreditation status
- Network tier

For except hospitals, other facilities by type:

- Facility name
- Facility type
- Procedures performed
- Network tier
- Facility location and telephone number
<table>
<thead>
<tr>
<th><strong>Facility Information</strong></th>
<th><strong>Health Care Professionals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name</td>
<td>(a) Name</td>
</tr>
<tr>
<td>2. Type</td>
<td>(b) Gender</td>
</tr>
<tr>
<td></td>
<td>(c) Contact information</td>
</tr>
<tr>
<td></td>
<td>(d) Specialty and subspecialty if applicable</td>
</tr>
<tr>
<td>3. Location and telephone number</td>
<td>(e) Network tier to which the facility is assigned if applicable</td>
</tr>
<tr>
<td>4. Procedures performed</td>
<td>(f) Procedure performed</td>
</tr>
<tr>
<td></td>
<td>(g) Facility name</td>
</tr>
<tr>
<td>5. Other facilities by type</td>
<td>(h) Facility location and telephone number</td>
</tr>
<tr>
<td>6. Network tier to which the facility is assigned and hospital accreditation status</td>
<td>(i) Hospital location and telephone number</td>
</tr>
<tr>
<td></td>
<td>(j) Hospital name and type (e.g. General acute care, children’s cancer, rehab, etc.)</td>
</tr>
<tr>
<td></td>
<td>(k) Whether accepting new patients</td>
</tr>
<tr>
<td></td>
<td>(l) Network tier to which the provider is assigned if applicable</td>
</tr>
<tr>
<td></td>
<td>(m) Specialty and subspecialty if applicable and indication of whether the provider may be chosen as a primary care provider</td>
</tr>
<tr>
<td></td>
<td>(n) Network tier to which the provider is assigned if applicable and indication of whether the provider may be chosen as a primary care provider</td>
</tr>
<tr>
<td>7. Network tier to which the provider is assigned and hospital accreditation status</td>
<td>(o) Connect information</td>
</tr>
<tr>
<td></td>
<td>(p) Contact information</td>
</tr>
<tr>
<td></td>
<td>(q) Name</td>
</tr>
</tbody>
</table>

**Notes:**
- (a) The health carrier shall make available in print and online the following provider directory information for each network plan:
  - Name:
  - Type:
  - Procedures performed:
  - Location and telephone number:
- (b) The health carrier shall make available in print and online the following provider directory information for each network plan:
  - Name:
  - Gender:
  - Contact information:
  - Specialty and subspecialty if applicable:
  - Network tier to which the provider is assigned:
  - Whether accepting new patients:
  - Network tier to which the provider is assigned and hospital accreditation status:
  - Specialty and subspecialty if applicable and indication of whether the provider may be chosen as a primary care provider:
  - Network tier to which the provider is assigned and hospital accreditation status:

**APA**

B. The health carrier shall make available in print and online the following provider directory information for each network plan:

<table>
<thead>
<tr>
<th><strong>Facility Information</strong></th>
<th><strong>Health Care Professionals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name</td>
<td>(a) Name</td>
</tr>
<tr>
<td>2. Type</td>
<td>(b) Gender</td>
</tr>
<tr>
<td></td>
<td>(c) Contact information</td>
</tr>
<tr>
<td></td>
<td>(d) Specialty and subspecialty if applicable</td>
</tr>
<tr>
<td>3. Location and telephone number</td>
<td>(e) Network tier to which the facility is assigned if applicable</td>
</tr>
<tr>
<td>4. Procedures performed</td>
<td>(f) Procedure performed</td>
</tr>
<tr>
<td></td>
<td>(g) Facility name</td>
</tr>
<tr>
<td>5. Other facilities by type</td>
<td>(h) Facility location and telephone number</td>
</tr>
<tr>
<td>6. Network tier to which the facility is assigned and hospital accreditation status</td>
<td>(i) Hospital location and telephone number</td>
</tr>
<tr>
<td></td>
<td>(j) Hospital name and type (e.g. General acute care, children’s cancer, rehab, etc.)</td>
</tr>
<tr>
<td></td>
<td>(k) Whether accepting new patients</td>
</tr>
<tr>
<td></td>
<td>(l) Network tier to which the provider is assigned if applicable</td>
</tr>
<tr>
<td></td>
<td>(m) Specialty and subspecialty if applicable and indication of whether the provider may be chosen as a primary care provider</td>
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<td></td>
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**Notes:**
- (a) The health carrier shall make available in print and online the following provider directory information for each network plan:
  - Name:
  - Type:
  - Procedures performed:
  - Location and telephone number:
- (b) The health carrier shall make available in print and online the following provider directory information for each network plan:
  - Name:
  - Gender:
  - Contact information:
  - Specialty and subspecialty if applicable:
  - Network tier to which the provider is assigned:
  - Whether accepting new patients:
  - Network tier to which the provider is assigned and hospital accreditation status:
  - Specialty and subspecialty if applicable and indication of whether the provider may be chosen as a primary care provider:
  - Network tier to which the provider is assigned and hospital accreditation status:
<table>
<thead>
<tr>
<th>Provider Directory Information</th>
<th>CHA</th>
<th>DREDF</th>
<th>ERIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) Gender; (c) Contact information; (d) Specialty; and (e) Whether accepting new patients.</td>
<td><strong>CHA</strong></td>
<td><strong>DREDF</strong></td>
<td><strong>ERIC</strong></td>
</tr>
<tr>
<td>For hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Hospital name; (2) Hospital location and telephone number; and (3) Hospital accreditation status; and (4) Gender of support staff; and (5) Provide same gender care for; and (6) Gender of support staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Whether accepting new patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Health plan accepted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Network tier</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(10) Network tier information</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>For health care professionals:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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<td>(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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) For hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Hospital name; (b) Hospital location and telephone number; and (c) Gender of support staff; and (d) Provide same gender care for; and (e) Hospital accreditation status; and (f) Whether accepting new patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Except hospitals, other facilities by type (i.e. acute, rehabilitation, children’s, cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Facility name; (b) Facility type; (c) Gender of support staff; and (d) Provide same gender care for and (e) Whether accepting new patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) Health plan accepted; and (g) Network tier</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(h) Network tier information</td>
<td></td>
<td></td>
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(e) Procedure performed; and
(f) Facility type;
(g) Facility name;
(h) Contact information;
(i) Whether accepting new patients.

**NCQA**

For each network plan, a health carrier shall include:

(1) For health care professionals, the following information in Subsection B(1) that includes search functions for specific data types 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;

(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 and telephone number.
### 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 in their directories to determine if a provider is still in-network.
  2. A requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings, to assess:
     - Whether their contact information is correct.
     - Whether they are really in the plan's network.
     - Whether they are taking new patients.
  3. Closely monitoring consumer complaints.

### AHA

<table>
<thead>
<tr>
<th><strong>AHA</strong></th>
</tr>
</thead>
<tbody>
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<td><strong>Drafting Note:</strong> 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 in their networks to determine if a provider is still in-network.</td>
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</tr>
<tr>
<td>(c) Facility or agency name;</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>(e) Procedures performed;</td>
</tr>
<tr>
<td>(g) Facility or agency location;</td>
</tr>
</tbody>
</table>

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

- The health care professional information required under Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:
  - Hospital affiliations;
  - Medical group affiliations;
  - Board certification(s); and
  - Office location(s);

In addition, to help improve the accuracy of the directories, states could consider the following:

1. A requirement that health carriers 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. An internal audit of provider directories and modification of directories based on audit findings to ensure:
   - Their contact information is correct
   - They are really in the plan’s network
   - They are taking new patients
3. A requirement for health carriers to establish a process for updating and assuring the accuracy in the directories and monitoring consumer complaints related to provider directories

---

**Drafting Note:** In addition to requiring health carriers to update their provider directories at least monthly, states may consider the following:

- A requirement that health carriers establish a process for updating and assuring the accuracy in the directories, and monitoring consumer complaints related to provider directories.
D. If a patient has made a decision to participate 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

C. (1) ***
(d) Affiliation(s) with cancer centers;

(1) For the online provider directories, for each network plan, a health carrier shall include:

C. ***

CHA triple underline.

C. (2) For hospitals, the following information with search functions and instructions for accessing additional information on the health care professional, such as:

(1) For the online provider directories, for each network plan, a health carrier shall include:

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 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 whether their directory information is accurate, that their directory information is complete, and that their directory includes all health care professionals in network; 3) closely monitoring consumer complaints.

DREDF 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 or clinical staff:

(d) Languages spoken by the health care professional or clinical staff;

(b) Medical group affiliations;

(c) Board certification(s);

(e) Structural accessibility, presence of accessible exam and diagnostic equipment, and availability of programmatic accessibility; and

Office location(s);
<table>
<thead>
<tr>
<th>Section</th>
<th>Information Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e)</td>
<td>Gender of support staff; and</td>
</tr>
<tr>
<td>(g)</td>
<td>Provide same gender care for; and</td>
</tr>
<tr>
<td>(h)</td>
<td>Office location(s); and</td>
</tr>
<tr>
<td>(j)</td>
<td>Protein source(s); and</td>
</tr>
<tr>
<td>(k)</td>
<td>Fruits and vegetables; and</td>
</tr>
<tr>
<td>(l)</td>
<td>Whole grain products; and</td>
</tr>
<tr>
<td>(m)</td>
<td>Nuts and seeds; and</td>
</tr>
<tr>
<td>(n)</td>
<td>Legumes and soy products; and</td>
</tr>
<tr>
<td>(o)</td>
<td>Low-fat dairy products; and</td>
</tr>
<tr>
<td>(p)</td>
<td>Lean meats, poultry, and fish; and</td>
</tr>
<tr>
<td>(q)</td>
<td>Plant-based protein sources; and</td>
</tr>
<tr>
<td>(r)</td>
<td>Low-sodium foods; and</td>
</tr>
<tr>
<td>(s)</td>
<td>Calorie-dense snacks; and</td>
</tr>
<tr>
<td>(t)</td>
<td>Unsweetened beverages; and</td>
</tr>
<tr>
<td>(u)</td>
<td>Fat-free or lower-fat milk; and</td>
</tr>
<tr>
<td>(v)</td>
<td>Skim milk and nonfat milk; and</td>
</tr>
<tr>
<td>(w)</td>
<td>Plant-based milks; and</td>
</tr>
<tr>
<td>(x)</td>
<td>Low-fat cheeses; and</td>
</tr>
<tr>
<td>(y)</td>
<td>Fat-free or lower-fat cheese; and</td>
</tr>
<tr>
<td>(z)</td>
<td>Deli meats; and</td>
</tr>
<tr>
<td>A</td>
<td>For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:</td>
</tr>
<tr>
<td>(a)</td>
<td>Hospital name; and</td>
</tr>
<tr>
<td>(b)</td>
<td>Hospital location; and</td>
</tr>
<tr>
<td>(c)</td>
<td>Gender of support staff; and</td>
</tr>
<tr>
<td>(d)</td>
<td>Provide same gender care for; and</td>
</tr>
<tr>
<td>C</td>
<td>For the online provider directories, for each network plan, a health carrier shall include:</td>
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<td>(1)</td>
<td>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:</td>
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<tr>
<td>(d)</td>
<td>Languages spoken by the health care professional or clinical staff; and</td>
</tr>
<tr>
<td>(e)</td>
<td>Office location(s); and</td>
</tr>
<tr>
<td>B</td>
<td>Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:</td>
</tr>
<tr>
<td>(a)</td>
<td>Facility name;</td>
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<tr>
<td>(b)</td>
<td>Facility type;</td>
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<tr>
<td>(c)</td>
<td>Procedures performed; and</td>
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<tr>
<td>(d)</td>
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<tr>
<td>(e)</td>
<td>Gender of support staff; and</td>
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<tr>
<td>(f)</td>
<td>Provide same gender care for; and</td>
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<td>(g)</td>
<td>Office location(s); and</td>
</tr>
<tr>
<td>(h)</td>
<td>Gender of support staff; and</td>
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<tr>
<td>(j)</td>
<td>Protein source(s); and</td>
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<td>(k)</td>
<td>Fruits and vegetables; and</td>
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<td>Whole grain products; and</td>
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<td>Legumes and soy products; and</td>
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<td>(o)</td>
<td>Low-fat dairy products; and</td>
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<td>Lean meats, poultry, and fish; and</td>
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<tr>
<td>(q)</td>
<td>Plant-based protein sources; and</td>
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<tr>
<td>(r)</td>
<td>Low-sodium foods; and</td>
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<td>(s)</td>
<td>Calorie-dense snacks; and</td>
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<tr>
<td>(t)</td>
<td>Unsweetened beverages; and</td>
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<tr>
<td>(u)</td>
<td>Fat-free or lower-fat milk; and</td>
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<tr>
<td>(v)</td>
<td>Skim milk and nonfat milk; and</td>
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<tr>
<td>(w)</td>
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</tr>
<tr>
<td>(z)</td>
<td>Deli meats; and</td>
</tr>
<tr>
<td>D</td>
<td>For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:</td>
</tr>
<tr>
<td>(a)</td>
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<td>Hospital location; and</td>
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In addition to requiring updating each provider directory at least monthly, to maintain the accuracy of the directory information:

1. 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 if the provider still intends to be in network. Based on the results of this process and any limitations, if applicable, health carriers shall make available through their directories the source of that information and any limitations, if applicable. 2) For each piece of information about the health care professional and hospitals referenced in Paragraphs (1) through (3), the health care professional and hospitals must retain and update the directory information regularly. 3) For the online provider directories, for each network plan, a health carrier shall include:

   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);
   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. 2) Develop and maintain an internal audit process to audit the information in a provider directory and modify the directory information accordingly. 3) Develop and maintain a web-based search function that enables consumers to access 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).

   (5) Whether the provider is currently accepting new patients.

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 if the provider still intends to be in network. Based on the results of this process and any limitations, if applicable, health carriers shall make available through their directories the source of that information and any limitations, if applicable. 2) For each piece of information about the health care professional and hospitals referenced in Paragraphs (1) through (3), the health care professional and hospitals must retain and update the directory information regularly. 3) For the online provider directories, for each network plan, a health carrier shall include:

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   a) Hospital affiliations;
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   c) Board certification(s);
   d) Languages spoken by the health care professional or clinical staff; and
   e) Office location(s).

   (5) Whether the provider is currently accepting new patients.
The commissioner shall adopt standards for noncompliance with directory accuracy standards. In the event that a patient relies on
(2) the health carrier's network and whether the provider is accepting new patients; or (3) use some other verification process the
provider remains in network and whether the provider is accepting new patients; or (3) use some other verification process the
commissioner may require.

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
an automated verification process, contact providers listed as in network who have not submitted claims within the past six months and
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; and 3) closely monitoring consumer complaints.

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.

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 total number of claims submitted by physicians in the directory to the commissioner. The health care program
also shall report and publish the number of in-network and out-of-network claims submitted by physician specialty on a quarterly basis.

Submission of contracted provider data to regulators. Health carriers must submit contracted 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
contact with the provider. This should enable state agencies to periodically verify that the contact information is accurate and
whether the provider remains in network and whether the provider is accepting new patients, and

Enforcement. (1) The commissioner shall adopt through promulgation regulations that establish a process for oversight for health
carrier compliance with the standards set forth in Sections 8A-C and shall include specific penalties for failure to ensure accuracy in the
information required in the information required in the directory. The commissioner shall adopt a process for overseeing the health carrier
compliance with these regulations. (2) The commissioner shall adopt penalties for noncompliance with directory accuracy
standards. In the event that a patient relies on the health carrier's network and whether the provider is accepting new patients; or (3) use some other verification process the
commissioner may require.
If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the transmission and appropriateness of payments made to providers and health care services received by covered persons. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the transmission and appropriateness of payments made to providers and health care services received by covered persons.

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 for situations that may indicate that providers are ceasing to participate or assigning new providers, and that health carriers are not modifying their directories accordingly. Effective immediately, health carriers need to be able to determine when providers still intend to be in network, and to determine whether the provider will still be participating in the network when the plans change.

A contract between a health carrier and an intermediary shall comply with all the applicable requirements of this Act. A contract between a health carrier and an intermediary shall comply with all the applicable requirements of this Act.

No comments received.
<table>
<thead>
<tr>
<th>Section</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>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.</td>
</tr>
<tr>
<td>B.</td>
<td>No comments received</td>
</tr>
<tr>
<td>C.</td>
<td>An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons in the state, as necessary to determine compliance with this Act.</td>
</tr>
<tr>
<td>D.</td>
<td>No comments received</td>
</tr>
<tr>
<td>E.</td>
<td>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.</td>
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</tr>
<tr>
<td>I.</td>
<td>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 all legal responsibility for any other entity's compliance with this Act.</td>
</tr>
</tbody>
</table>

**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.
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: In states that do not have a file-and-use procedure, a health carrier shall file the contract forms with the commissioner before they come into effect.

Insurance

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

Drafting Note: States that require prior approval of contract forms may wish to have the forms reviewed by the insurance commissioner to ensure they meet administrative requirements and are not considered public and commercially sensitive information.

Main Bureau of Insurance

A. [Drafting Note:} A health carrier shall file with the commissioner, sample contract forms proposed for use with its participating providers. The forms shall be filed within [x] days prior to use.

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 within [x] days prior to use.

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 access to participating providers. When such changes 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, a state should choose which option is appropriate for the state.

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Drafting Note: In states that do not have a file-and-use procedure, a health carrier shall file the contract forms with the commissioner before they come into effect.

AHIP/BCBSA

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 access to participating providers. When such changes 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, a state should choose which option is appropriate for the state.
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 of applicable regulations.

Section 11, Contracting

<table>
<thead>
<tr>
<th>Suggested Additional Subsections</th>
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<tbody>
<tr>
<td>C. If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, the change is deemed approved.</td>
</tr>
<tr>
<td>Families USA</td>
</tr>
</tbody>
</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 [x] days prior to use.

Drafting Note: Subsections A and B and provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract that would affect a provision required under this Act or implementing regulations.

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 that would affect a provision required under this Act or implementing regulations.
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 the provisions of 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.

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].
Section 4. Penalties

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

No comments received

Section 5. 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 6. Effective Date

This Act shall be effective [insert date].

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

Maine Bureau of Insurance

Suggested Additional Sections

No comments received

Maine Bureau of Insurance
<table>
<thead>
<tr>
<th>Section</th>
<th>Additional Section to Model</th>
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<tbody>
<tr>
<td>Suggested Additional Sections to Model</td>
<td>WHA</td>
</tr>
<tr>
<td>Recommendation to network adequacy standards.</td>
<td>For states without access plan requirements comparable to pre-2015 Model. No later than twelve (12) months after insertion effective.</td>
</tr>
<tr>
<td>For states with network adequacy standards.</td>
<td>Consistent with Section 5 of this Act, as amended, for all-in-force network plans.</td>
</tr>
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<td>© 2015 National Association of Insurance Commissioners</td>
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