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

*PENDING:* --March 19 Minutes
Network Adequacy Model Review (B) Subgroup
Conference Call
March 12, 2015

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.
Network Adequacy Model Review (B) Subgroup
Conference Call
March 2, 2015

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. to 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 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.

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 enrollees, 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.

B. “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: The conditions and circumstances under which a medical condition must be attended to are set forth in Federal law, 42 U.S.C. § 1395ss, and regulations issued thereunder, 42 C.F.R. § 412.130, et seq.

F. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition, with respect to an emergency medical condition, as defined in Subsection E:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(2) Any further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.
G. “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.

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

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

HI. “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.

**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.”

J. “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.

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

LM. “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.

MN. “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.”

NO. “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.

**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 should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a managed care network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements 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 appointment visits with participating providers;

(6) Hours of operation;

(7) New health care service delivery system options, such as telemedicine or telehealth; and

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

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

C. In any case where the 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 the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers an in-network level of benefits from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

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

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

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

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

  (b) The health carrier:

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

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

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

D. (2) The 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.

(3)(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 network plans 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;
The health carrier’s proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier’s insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier’s insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

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

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

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 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 discriminating against high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;

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

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

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

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

(1) For health care professionals:
   (a) Name;
   (b) Gender;
   (c) Contact information;
   (d) Specialty; and
   (e) Whether accepting new patients.

(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.

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

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

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

(b) Hospital location; and

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:

(a) Facility name;

(b) Facility type;

(c) Procedures performed; and

(d) Facility location.

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

**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 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 may 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 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.

Suggested Revisions to Draft Dated Nov. 12, 2014

Jan. 12, 2015 Comment Deadline (Assumes proposed revisions are adopted)

Managed Care Plan Network Adequacy Model Act (¶4)

American Association of Insurance and Reinsurance Plans (AIP)

Children's Hospital Association (CHA)

American's Health Insurance Plans (AHIP)

American Academy of Family Physicians (AAFP)

***

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate regulations. States should review existing statutes to determine whether to adopt this model or to promulgate similar regulations.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form.
<table>
<thead>
<tr>
<th>Section 3. Definitions</th>
<th>MO DOI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B.</strong> Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:</td>
<td><strong>(2)</strong> 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 <strong>(2)</strong> 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.</td>
</tr>
</tbody>
</table>

**Section 5B of this Act**

Promotes consumer protection by ensuring that network plans are not marketed or sold without informed consent of the consumer. Includes requirements for the establishment of network plans and for the maintenance of 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.

**A.** Balance Billing

"Balance billing" means the practice of a (non-participating) provider billing for the difference between the provider's charge and the health carrier's allowed amount.

**Illinois Hospital Association (IHA)**

**B.** Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

1. Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and
2. Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks.

**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.

**Missouri Department of Insurance, Financial Institutions & Professional Registration (MO DOI)**

**B.** Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

1. Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and
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**American Medical Association (AMA)**

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<thead>
<tr>
<th>Commissioner</th>
<th>Covered Person</th>
<th>Covered Benefits</th>
<th>Emergency Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. Commissioner</strong></td>
<td>&quot;covered person&quot;</td>
<td>&quot;covered benefits&quot;</td>
<td>&quot;emergency medical condition&quot;</td>
</tr>
<tr>
<td><strong>Drafting Note:</strong> Use the title of the chief insurance regulator official whenever the term &quot;commissioner&quot; 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No comments received.
### F. Emergency Services

"Emergency services" means with respect to an emergency medical condition, as defined in subsection E, (1) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including emergency medical services routine mall as medical screening examinations.

#### CHA

The hospital to stabilize the patient and medical or mental health examination and treatment to the extent they are within the capability of the emergency medical services, including such other services as the hospital chooses, that are capable of examining and treating the condition.

#### Wisconsin Hospital Association (WHA)

"Emergency services" means with respect to an emergency medical condition, as defined in subsection E, (1) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including emergency medical services routine mall as medical screening examinations.

#### Shriver Center

"Emergency services" means with respect to an emergency medical condition, as defined in subsection E, (1) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including emergency medical services routine mall as medical screening examinations.

#### American Psychiatric Association (APA)

"Emergency services" means with respect to an emergency medical condition, as defined in subsection E, (1) a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including emergency medical services routine mall as medical screening examinations.

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An "emergency medical condition" means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, 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;
4. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another hospital before delivery;
   b. That transfer to another hospital may pose a threat to the health or safety of the woman or the unborn child.

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### Drafting Note

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

### AHIP/BCBSA

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

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### CHA

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

#### AAFP

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

#### ACS CAN

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

#### Drafting Note:

- States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities.
- Facilities, long-term care facilities, and home health agencies.
- Hospices and inpatient rehabilitation facilities.
- Ambulatory surgical centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and other therapeutic health settings.

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### AHIP/BCBSA

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

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

### CHA

"Facility" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of physical and mental/behavioral health services.

*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.

### Academy of Managed Care Pharmacy (AMCP)

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

*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.

### National Kidney Foundation (NKF)

"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, transplant centers, and rehabilitation and other therapeutic health settings.

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

### Urgent Care Association of America (UCAOA)

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

*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.

### Delta Dental Plans Association (DDPA)

"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.

*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 Exclusions

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Description</th>
</tr>
</thead>
</table>
| (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. |

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Description</th>
</tr>
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</table>
| (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 centers or other similar services; |

| 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 Professional

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Health care professional&quot; means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.;</td>
</tr>
<tr>
<td>Health Care Provider</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health care services</td>
<td>Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.</td>
</tr>
<tr>
<td>Physical or mental/behavioral health care professional</td>
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</tr>
<tr>
<td>Specialty pharmacy</td>
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</tr>
<tr>
<td>Retail pharmacy</td>
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<tr>
<td>Facility</td>
<td>A facility.</td>
</tr>
<tr>
<td>Health condition</td>
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</tr>
<tr>
<td>Illness</td>
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</tr>
<tr>
<td>Injury</td>
<td>An injury.</td>
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**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.

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<table>
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<tr>
<th>DREDF</th>
<th>&quot;Health care services&quot; means services and devices for the diagnosis, prevention, treatment, cure of relief of a health condition, illness, injury or disease; maintaining of bodily function, or slowing or preventing the deterioration of bodily function.</th>
</tr>
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<table>
<thead>
<tr>
<th>Resources</th>
<th>Network means the group of participating providers providing services to a network plan.</th>
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<tr>
<td></td>
<td>P. Network</td>
</tr>
<tr>
<td></td>
<td>No comments received</td>
</tr>
<tr>
<td>O. Intermediary</td>
<td>&quot;Intermediary&quot; means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers on behalf of a network plan.</td>
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<td>MD DOI</td>
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| Drafting Note: | States that license health maintenance organizations pursuant to statutes other than the insurance laws 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. |

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| 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. |

| MO DOI    | "Health indemnity plan" means a health benefit plan that is not a network plan.            |
| N. Health Indemnity Plan | "Health indemnity plan" means a health benefit plan that is not a 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 accountable care plans (ACOs) and other care models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.

**AHIP/BCBSA, AMCP**

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**CHA**

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**California Medical**

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**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.

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**Families USA**

"Network plan" means a health benefit plan that either requires a covered person to use health care providers managed, owned, or employed by the health carrier.

[Continued on next page]
<table>
<thead>
<tr>
<th>Section</th>
<th>Text Content</th>
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<tbody>
<tr>
<td>T. Primary care professional</td>
<td>&quot;Primary care professional&quot; 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.</td>
</tr>
<tr>
<td>U. Telemedicine or telehealth</td>
<td>&quot;Telemedicine&quot; 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>
<tr>
<td>V. To stabilize</td>
<td>&quot;To stabilize&quot; means with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in Subsection E(4), to deliver, including the placenta.</td>
</tr>
<tr>
<td>II. Telecommunications technologies</td>
<td>Telemedicine means the delivery of clinical health care services by means of real time two-way audio-visual communications technology, which is located where the covered person is located using telecommunications technology, or where the covered care professional is located using telecommunications technology.</td>
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### Additional Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Board certification</td>
<td>(i) Certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association; (ii) Legitimate successful completion of postgraduate training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.</td>
</tr>
<tr>
<td>Specialist</td>
<td>A physician who has successfully completed a residency or fellowship training program which is accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.</td>
</tr>
<tr>
<td>Subspecialist</td>
<td>A physician whose scope of residency or fellowship training encompasses the treatments, conditions, or specialty on economic and subjective quality criteria to the detriment of patient access to needed care.</td>
</tr>
<tr>
<td>Narrow network</td>
<td>Health insurance plans that place limits on the doctors and hospitals available to their subscribers based on cost and quality criteria.</td>
</tr>
<tr>
<td>Tiered network</td>
<td>Health insurance plans that limit access to doctors and hospitals based on cost and quality criteria.</td>
</tr>
<tr>
<td>Ultra-narrow network</td>
<td>(suggests defining based on percentage of hospital participation, family physician and other primary care physician percentage participation and other factors).</td>
</tr>
<tr>
<td>W. Transfer</td>
<td>&quot;Transfer&quot; means, for the purposes of subsection V, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who: (1) has been declared dead; or (2) leaves the facility without the permission of such person.</td>
</tr>
<tr>
<td>Insurance</td>
<td>&quot;Transfer&quot; means, for the purposes of subsection V, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who: (1) has been declared dead; or (2) leaves the facility without the permission of such person.</td>
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2. "Transfer" means, for the purposes of subsection V, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who: (1) has been declared dead; or (2) leaves the facility without the permission of such person.
<table>
<thead>
<tr>
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<th>Definition</th>
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<tbody>
<tr>
<td>Preferred provider</td>
<td>means a physician, hospital or other provider that has agreed to join, participate in or become a member of a network based by a health carrier based primarily on criteria related to cost or resource utilization or other measures determined by the carrier.</td>
</tr>
<tr>
<td>Narrow network</td>
<td>means a panel of providers within a network that is composed of a limited number of providers who have been selected by the health carrier based primarily on criteria related to cost or resource utilization or other measures.</td>
</tr>
<tr>
<td>Peer provider</td>
<td>means a provider who provides specialized services. The term can be used to describe a physician or health care professional offering a specialty.</td>
</tr>
<tr>
<td>Community-based organization</td>
<td>means a set of providers in the following categories: 1. Ambulatory care; 2. Emergency services; 3. Preventive and wellness services; and Chronic disease management; and 10. Pediatric services.</td>
</tr>
<tr>
<td>Specialty care</td>
<td>means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions. Provided by physicians with advanced training who meet and are certified by a specialty examining board.</td>
</tr>
<tr>
<td>Essential health benefits</td>
<td>means a set of benefits in the following categories: 1. Ambulatory care; 2. Emergency services; 3. Hospitalization; 4. Maternity and newborn care; 5. Mental health and substance abuse disorder services; 6. Described services; and 8. Preventive and wellness services.</td>
</tr>
<tr>
<td>Material change</td>
<td>is a change in the composition of the network that affects network access and utilization. It generally occurs when participating providers in a health plan network are differently grouped into categories that differ in terms of their access, reimbursement rates, provider performance, or any combination thereof.</td>
</tr>
<tr>
<td>Narrow network</td>
<td>or tiered network means a network that identifies and groups participating providers into specific tiers that reflect different provider reimbursement or other measures that affect access, quality of care, or other factors established by the health carrier.</td>
</tr>
<tr>
<td>Preferred provider</td>
<td>or tiered provider network means a network of providers that are provided access and reimbursement rates that are different from other providers within the health plan's network.</td>
</tr>
<tr>
<td>Preferred provider</td>
<td>can be used to describe a facility offering specialized services (e.g., cancer center). The term also can be used to describe a physician or health care professional offering a specialty.</td>
</tr>
<tr>
<td><strong>Tiered provider network</strong> or <strong>tiered provider network</strong></td>
<td><strong>Specialty care</strong> means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions.</td>
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<tr>
<td><strong>American Society for Dermatologic Surgery</strong> (ASDS)</td>
<td><strong>Physician</strong> means licensed medical doctor or doctor of osteopathic medicine.</td>
</tr>
</tbody>
</table>
"Tiered provider network" or "Tiered network" means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered access to providers. The Tiered Provider Network also establishes a network that differentiates participating providers into specific groups based on the basis of their agreement, the quality of their provision of health care, and their ability to influence enrollees’ selection of providers.

National Indian Health Board (NIHB), Tribal Technical Advisory Group

"Indian health provider" means a facility or program that is funded in part by the federal government or a federally recognized Tribe to serve primarily American Indians and 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").

Section 4. Applicability and Scope

This Act applies to all health carriers that offer network plans.
Dicussion Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some

standards met or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state's requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier's private certification and eligibility for deemed compliance.

In addition, accreditation in this section of this Act is defined as meeting the standards required for network adequacy. States should consider accreditation as a tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state's requirements as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier's private certification and eligibility for deemed compliance.
should periodically review a health carrier’s private certification and eligibility for deemed compliance. The Commissioner must assure that the current accrediting entity’s standards are well-received under the Act. Under such circumstances, the Commissioner must assure that the current accrediting entity’s standards are well-received under the Act. The accrediting entity should formulate and maintain a process for ensuring that the accrediting entity’s standards are being effectively and appropriately applied. The agreement between the parties should be evidenced by a written agreement that is publicly available.

Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with 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. The private accrediting entity shall provide the state with documentation that a network plan has been accredited by the entity and the private accrediting entity shall make its standards publicly available. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements as meeting the requirements of the relevant sections of this Act, 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. The agreement between the parties should be evidenced by a written agreement that is publicly available.

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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 to the extent that such services are provided in every hour of the day to which the network may be extended when the network and the carrier are responsible for services that are not covered in the network. The network must include providers with documented experience and expertise in treating and supporting those with discrete health care needs, including those with chronic conditions and disabilities.

<table>
<thead>
<tr>
<th>A HEALTHCARE PROVIDER MUST 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 TO THE EXTENT THAT SUCH SERVICES ARE PROVIDED IN EVERY HOUR OF THE DAY TO WHICH THE NETWORK MAY BE EXTENDED WHEN THE NETWORK AND THE CARRIER ARE RESPONSIBLE FOR SERVICES THAT ARE NOT COVERED IN THE NETWORK. THE NETWORK MUST INCLUDE PROVIDERS WITH DOCUMENTED EXPERIENCE AND EXPERTISE IN TREATING AND SUPPORTING THOSE WITH DISCRETE HEALTH CARE NEEDS, INCLUDING THOSE WITH CHRONIC CONDITIONS AND DISABILITIES.</th>
</tr>
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</table>

**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 hour of the day. Regulators should pay close attention to the provisions of the plan and how the carrier is responsible for services not provided in the network. Regulators should review the standards for access to Tier 4 services and the process for determining when the Tier 4 services are accessible. The standards for access to Tier 4 services should be commensurate with the standards for covered services in the network. Regulators should consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of Tier 4 services.
A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers, including:

- A health carrier providing a network plan shall have access twenty-four (24) hours per day, seven (7) days per week.

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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 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 in-network sharing requirements that deter appropriate care or refer patients to out-of-network providers. This type of arrangement does not protect consumers from balance billing even when benefits are provided at an "in-network" benefit level as this type of arrangement does not protect consumers from balance billing.
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 described, 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.

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 mulheres USA

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Families USA

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Physicians Advocacy Institute (PAI)

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

NAIC Consumer Representatives

Indicators whose choices will influence conditions and disparities include the following: providers with documented expertise and experience in treating and supporting those with disabilities; and networks with disappointing health care needs. The indicators include: care delivered by an appropriate provider; the lowest cost-sharing tier of the network; the lowest cost-sharing tier of the network.

DREDF

Lowest cost-sharing tier of the network.
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 to emergency services twenty-four (24) hours per day, seven (7) days per week.

***

**Drafting Note:** States may want to pay particular attention to network sufficiency, marketing, and disclosure issues that may arise with respect to certain health carrier network designs, such as so-called “tiered networks.” Tiered networks may be designed, marketed and sold in different ways. Regulators should review what information carriers are providing to consumers on a particular tiered network at the time of sale. In some cases, the network may be designed such that not all covered services are provided in every tier. Regulators should pay close attention to ensuring that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.
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, or within a specified radius from the carrier’s headquarters), maximum travel times to see a provider, minimum number of primary care physicians, or maximum waiting times to obtain an appointment. These standards could be incorporated into a law; however, in many cases, these standards are more likely to be included in regulations.

A. **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, or within a specified radius from the carrier’s headquarters), maximum travel times to see a provider, minimum number of primary care physicians, or maximum waiting times to obtain an appointment. These standards could be incorporated into a law; however, in many cases, these standards are more likely to be included in regulations.
normal confines of an existing plan network area. For example, in some areas of the country, access to pediatric specialty and
subspecialty care might require travel to a neighboring or nearby state. As such, network adequacy measures must document the
availability and coverage of non-emergency transport in such cases; and

(2) Telehealth care may provide opportunities to meet the needs of enrollees, particularly in underserved areas. Network adequacy
standards documenting access to care via telehealth technologies, but should be balanced with safety,
quality, licensing and certification standards, and must take into account the needs of enrollees who are medically
unstable or have special needs.

(3) 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 commissioner through rulemaking. Such
reasonableness criteria may include the following:

(1) Provider covered population ratios:

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

(b) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care provider.

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

(d) Maximum time and distance standards in miles by county to access full time equivalent diagnostic and ancillary services.

(e) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

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

(a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.

(b) Maximum allowable wait times for an appointment with a primary care physician, specialty, and other health care provider.

(c) Regular assessment of provider capacity, including the availability of providers to accept new patients.

(d) The breadth of hours of operation for network providers.

(e) The quality measures used to evaluate providers for network inclusion.

(f) The ability of physicians to admit patients to in-network hospitals.

(g) The ability of hospitals to support in-network care.

(h) The ability of network providers to provide in-network services.

(i) The ability of network providers to provide in-network services for patients with special needs.

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.
(d) 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.

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

(a) Provider covered person ratios by specialty;

(b) Geographic accessibility;

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

(d) Maximum travel time and distance standards to access full time equivalent primary care physicians, specialists, facilities, and other health care providers.

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

(f) Maximum travel time and distance standards in miles by county to access general hospital services with emergency care.

(c) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care, including but not limited to:

(1) New health care service delivery options, such as telemedicine or telehealth.

(2) Hours of operation.

(3) Waiting times for tests and procedures.

(4) Geographical accessibility.

(5) The availability of services by specialty.

(6) The availability of services by specialty.

(7) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care, including but not limited to:

(i) The department shall consider the following factors in establishing criteria for determining the adequacy of network providers:

(a) Manner in which the network providers are paid;

(b) The relationship of the payment method to the provider's resulting participation in the network;

(c) The ability of the department to ensure that the provider's performance is in compliance with the requirements of this section;

(d) The ability of the department to ensure that the provider's performance is in compliance with the requirements of this section; and

(e) The ability of the department to ensure that the provider's performance is in compliance with the requirements of this section.

(2) The department shall determine 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 maximum allowable waiting times for an appointment with a participating physician or other health care provider.

(c) The regular assessment of provider capacity, including the availability of providers to accepting new patients.

(d) The breadth of hours of operation for network providers.

(e) The ability of the department to ensure that the provider's performance is in compliance with the requirements of this section; and

(f) The ability of the department to ensure that the provider's performance is in compliance with the requirements of this section.
(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. These standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), maximum travel distance to providers, maximum travel time to providers and maximum waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations. As each state has unique health care delivery issues, there are standards that are more likely to be included in regulations. At each state’s discretion, these standards could be 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. These standards could differ widely based on geographic barriers, population and provider density differences within and among the states. The elements of Subsections A and 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. These standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), maximum travel distance to providers, maximum travel time to providers and maximum waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations. As each state has its own unique health care delivery issues, state regulators are best positioned to determine the appropriate network adequacy review criteria that will work in their state. These can differ widely based on geographic barriers, population and provider density differences within and among the states.

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. These 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.
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<tr>
<th>(8) <strong>Plan's service area:</strong></th>
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<tr>
<td>(9) <strong>Provision of linguistically and culturally appropriate care and other services tailored to low-income and vulnerable populations:</strong></td>
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<tr>
<td>(10) <strong>With regard to institutional providers, the availability of trauma care, public health services, behavioral health and substance abuse services:</strong></td>
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</table>

**AMA**

(1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking.

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

(a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.

(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider.

(c) Regular assessment of provider capacity, including the availability of providers to accepting new patients.

(d) The breadth of hours of operation for network providers.

(e) Geographic access to providers without referral restrictions, and otherwise present in-network access to specialty care.

(f) The frequency of provider visits with participating providers.

(g) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care provider.

(h) Minimum number and range of types of full-time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and physical and mental disabilities.

(i) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(j) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(k) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(l) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(m) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(n) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(o) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(p) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(q) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(r) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(s) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(t) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(u) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(v) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(w) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(x) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(y) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

(z) Maximum time and distance standards in miles by county to access general hospital services with emergency care.

**Footnotes:**

1. *Note:* The term "sufficient" as used by the commissioner, including those not limited to the requirements of this section, and may be established by reference to any reasonable measure 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 geographic area, to have a certain number of specialty providers, and to have a certain volume of services provided. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations and should reference numbers of providers in terms of full-time equivalents.

### CHA

Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any of the following:

1. Provider-covered person ratios by specialty and subspecialty.
2. Provider-covered person ratios by specialty and subspecialty care.
3. The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

### ADFSA

Immune Deficiency Foundation

B. ***

1. Provider-covered person ratios by specialty and subspecialty care.
2. The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

### APHA

B. ***

1. Hours each participating physician dedicates to coverage under the plan.
2. The ability of network providers to accommodate patients relying on wheelchairs or other wheeled mobility devices.
3. Provider-covered person ratios by specialty and subspecialty care.

### MS Society

B. ***

1. Provider-covered person ratios by specialty and subspecialty care.
2. The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

### ASDSA

Immune Deficiency Foundation

B. ***

1. Provider-covered person ratios by specialty and subspecialty care.
2. The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

### ASA

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

### ASAM

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

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(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

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(4) The commissioner shall conduct or review available periodic patient surveys to help inform its monitoring of network sufficiency and

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(6) The commissioner must include a broad set of measurable criteria and any other requirements that the commissioner deems appropriate.
(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 distribution;
(5) Waiting times for visits with participating providers;
(6) Hours of operation;
(7) New health care service delivery system options, such as telemedicine or telehealth;
(8) The volume of technologically and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care services, diagnostics or ancillary services;
(?I) 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.

**Drafting Note:** Instead of

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In addition to the general standards provided in Subsection B for determining network sufficiency, some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metro or non-metro area), a minimum travel distance to providers within a specified area, a maximum travel time to providers, and maximum wait times to obtain an appointment with a primary care provider. It’s important to note that quantitative standards do not diminish the need for regulators to individually assess networks that may employ innovative techniques to ensure access to care that may not outline the established objective requirements. For instance, regulators may consider to have a sufficient network if they have arranged for access to that specialized care as an in-network provider outside the geographic region. It’s important to note that quantitative standards can help inform its monitoring of network adequacy and should be applied to the lowest cost-sharing tier of any network.

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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.

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; and
8. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.

The commissioner shall consider the following factors in the access standards identified in Paragraph (1): geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.

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

1. Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
2. Maximum allowable wait times for an appointment with a primary care provider.
3. Regular assessment of provider capacity, including the availability of providers to accepting new patients.
4. The breadth of hours of operation for network providers.
5. 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.
6. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.
7. Examinations/diagnostic equipment and programmatic accessibility.
8. Examinations/diagnostic equipment and programmatic accessibility.
9. Precedence of network primary care and specialty providers who establish functional accessibility, and offer accessible

Program, Policy, and Procedures

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; and
8. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.

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

1. Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
2. Maximum allowable wait times for an appointment with a primary care provider.
3. Regular assessment of provider capacity, including the availability of providers to accepting new patients.
4. The breadth of hours of operation for network providers.
5. 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.
6. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.
7. Examinations/diagnostic equipment and programmatic accessibility.
8. Examinations/diagnostic equipment and programmatic accessibility.
9. Precedence of network primary care and specialty providers who establish functional accessibility, and offer accessible

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:

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; and
8. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.

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

1. Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
2. Maximum allowable wait times for an appointment with a primary care provider.
3. Regular assessment of provider capacity, including the availability of providers to accepting new patients.
4. The breadth of hours of operation for network providers.
5. 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.
6. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.
7. Examinations/diagnostic equipment and programmatic accessibility.
8. Examinations/diagnostic equipment and programmatic accessibility.
9. Precedence of network primary care and specialty providers who establish functional accessibility, and offer accessible

NAIC Consumer

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; and
8. The volume of technologically and specialty services available to serve the needs of covered persons recognizing technology.
(f) The degree to which in-network physicians are authorized to admit patients to or, in the case of in-network hospital-based physicians, practice at in-network hospitals.

(g) New health care service delivery options, such as telemedicine or telehealth.

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

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

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

**Drafting Note:** States may want to include some of the factors under Paragraph (f) as mandatory factors for inclusion under Paragraph (f).

<table>
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<th>Families USA</th>
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<td>(f) The availability of in-network providers at in-network hospitals; and</td>
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<td>(g) The availability of providers to accept new patients;</td>
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<tr>
<td>(a) Maximum travel time and distance standards in miles to access a full-time equivalent primary care physician, specialist, or other health care provider; and</td>
</tr>
<tr>
<td>(b) Maximum allowable wait times for an appointment with a primary care physician, specialist, or other health care provider.</td>
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(2) The commissioner shall consider the following factors in the access standards identified in Paragraph (1): |

| (a) Minimum ratio of providers to covered persons for primary care physician, specialist, and other health care providers |
| (b) Minimum number and range of types of full-time equivalent physicians and health care providers needed in a network to meet the needs of covered persons with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities. |
| (c) Regular assessment of provider capacity, including the availability of providers to accepting new patients, and of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: |
| (d) The breadth of options of operation for network providers to increase access during non-business hours for covered persons who must work long hours; |
| (e) The quality measures used to evaluate providers for network inclusion; |
| (f) The degree of specialty care available to covered persons, and any other regulations that the commissioner deem appropriate. When revising this section, the commissioner shall consider the following: |
| (g) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. |

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

| (a) Provider coverage of out-of-network services; |
| (b) Provider coverage of network services; |
| (c) Provider coverage of out-of-network specialty services; |
| (d) Provider coverage of network specialty services; and |
| (e) The quality measures to evaluate providers for network inclusion. |

The definitions and standards in this section may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

- The degree to which in-network physicians are authorized to admit patients to in the case of in-network hospital-based physicians, practice at in-network hospitals; and
- The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.
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 (ACA) to qualify as essential community providers shall be included in the provider network. Provider networks shall also include at least one National Cancer Institute (NCI)-designated cancer center or cancer center that is a member of the Association of American Cancer Institutes (AACI). The 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 (ACA) to qualify as essential community providers shall be included in the provider network. Provider networks shall also include at least one National Cancer Institute (NCI)-designated cancer center or cancer center that is a member of the Association of American Cancer Institutes (AACI).
(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:

<table>
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<tr>
<th>Condition</th>
<th>Action</th>
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<tr>
<td>(a) The health carrier has a sufficient network, but has determined that it does not have a type of participating provider, or does not have a participating provider capable to provide the service without unreasonable travel or delay; and or</td>
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<tr>
<td>(b) The health carrier does not have a type of participating provider available to provide the covered benefit to the covered person.</td>
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(2) The health carrier shall specify the process a covered person may use to obtain a covered benefit at an out-of-network level of benefits from a non-participating provider as provided in Paragraph (1) when:

<table>
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<th>Condition</th>
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<tr>
<td>(a) 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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</table>
| (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 the condition or disease |
  | or |
  | (ii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat the condition or disease. |

(3) (a) 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.

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<th>Requirement</th>
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<td>(b) 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 health carrier must notify the covered person and the requesting provider of covered reason to address 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.</td>
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(4) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law, or proceedings in an internal claims grievance and appeals process, including in instances where a covered person's request to access provider is denied.

(5) The health carrier shall ensure that these processes are documented and made publicly available.

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<th>Requirement</th>
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<td>(c) The health carrier shall maintain a system in place that documents all requests to obtain a covered benefit from a non-participating provider.</td>
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<th>Requirement</th>
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<td>(d) The process described in Paragraph (3)(b) must ensure that requests to obtain a covered benefit from a non-network provider pursuant to Paragraph (3) are:</td>
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<tr>
<td>(i) Subject to review of the discretion of the commissioner to be updated no less than a quarterly basis.</td>
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(6) The health carrier shall treat the services the covered person receives from a non-network provider as if they were provided by a network provider.
(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;

(b) The health carrier:

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

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

(3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider, including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit.

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

(1) All such requests;

(2) The name of the covered person involved;

(3) The name and address of the provider making the request;

(4) Whether the request was approved or denied; and

(5) The date of approval or denial. The log 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-network provider or covered person as provided in Paragraph (1) and (2) and that must ensure that requests to obtain a covered benefit from a non-network provider 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 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 health care provider of the decision within twenty-four (24) hours. If the request is approved, the carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-network 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:

(1) All such requests;

(2) The name of the covered person involved;

(3) The name and address of the provider making the request;

(4) Whether the request was approved or denied; and

(5) The date of approval or denial.

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 of participating providers available to provide the covered benefits to the covered persons.
ADCC

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-participating provider, or shall make other arrangements acceptable to the commissioner, when:

(a) The health carrier has a sufficient network, but has determined that it does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay; and

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit without unreasonable travel or 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-participating out-of-network provider as provided in Paragraph (1) when:

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

(b) The health carrier:

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

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

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 no later than seven (7) calendar days from receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

(b) The carrier shall maintain a record of all such requests to obtain a covered benefit from a non-participating provider, including the name of the covered person involved, the name and address of the provider making the request, whether the request was approved or denied, the date of approval or denial, and the relevant authorization number, if the request was approved.

(c) 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 cost-sharing toward the maximum out-of-pocket limit are provided by a non-network provider.

Note: The data of approval of denial and the name and address of the provider making the request shall be subject to expedited carrier review, and if necessary, external review.
(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 decline the request within seven (7) calendar days of receipt of the request. However, if the covered person requests an out-of-network provider using the alternate process is denied by the carrier, then the health carrier is not required to adhere to a seven (7) calendar day requirement. The health carrier, at its discretion, may provide timely notice to the covered person and requesting provider of the denial if a reasonable time to provide timely notice is not possible and there is an extenuating reason for the denial or if the denial is a final determination. The health carrier shall provide the covered person with the reason for denial and the right to appeal if the denial is not beneficial to the health carrier or its network providers.

(3) The health carrier shall reallocate the services covered person receives from a non-network provider pursuant to Paragraph (2) and shall include the covered person's financial responsibilities for the covered services.

(2) The health carrier shall specify the process a covered person may use to request access to 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 the covered person or the requesting provider requests access to a non-network provider.

(b) The health carrier:

(i) Does not have a network provider of the required specialty or subspecialty with the professional training, expertise, and experience to treat or provide the services the covered person needs; or

(ii) Cannot provide reasonable access to a network provider within a reasonable period of time.

(3) The health carrier shall treat the services the covered person receives from a non-network provider as if the services were provided by a network provider. The health carrier shall ensure that the covered person's financial responsibilities are not greater than if the service had been provided by an in-network provider pursuant to Paragraph (1) and shall include the covered person's cost-sharing toward the maximum out-of-pocket limit.

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

Drafting Note: States that seek to protect covered persons from additional charges by establishing hold-harmless provisions, which would permit providers to charge whatever they want and require the plan to cover the difference, would undermine incentives for providers to participate in networks. Therefore, policy should focus on creating incentives for providers to participate in networks, rather than penalizing providers who choose not to participate. This section prioritizes patient access to covered services by establishing hold-harmless provisions, which would permit providers to charge whatever they want and require the plan to cover the difference.
must notify the covered person and requesting provider of approval or denial within 24 hours of receipt of the request. Denials will be subject to internal claims review and, if necessary, external review.

4. A health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider and health carrier shall be responsible for any payment owed the non-network provider.

5. A health carrier shall disclose on a quarterly basis an 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 area in that area.

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

7. 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.

8. (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 as provided in Paragraph (1) when:

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

(ii) The health carrier:

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

(B) 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.

9. (a) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider and health carrier shall be responsible for any payment owed the non-network provider.

(b) 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 disclose on a quarterly basis an 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 area in that area.
IHA C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a non-participating provider such that the covered person incurs no greater out-of-pocket expenses than had that person used an in-network provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has in-network providers available to provide the covered benefit to the covered person.

(b) The health carrier has an insufficient number or type of participating providers 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 out-of-network provider as provided in Paragraph (1) in the rare instances when:

(a) The covered person is determined to have a condition or disease that requires specialized health care services or medical services; and

(b) The health carrier:

(i) Does not have an appropriate network provider of the required specialty with the professional training and expertise and experience to treat or provide health care services for the condition or disease; 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 pay covered expenses to covered persons at a covered provider pursuant to Paragraph (1) as if the services were provided by a network provider. Indications by the covered person that the covered person receivers from a non-network provider pursuant to Paragraph (2) is not

(4) Use of non-network providers may not be a substitute for establishing an adequate network of appropriate providers to deliver benefits.

(2) The health carrier shall maintain records of the covered person’s use of services received from a non-network provider.

(3) The health carrier shall maintain an internal and external claims grievance and appeals process as provided in paragraph (2) in the rare instances when:

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

(b) The health carrier:

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

(4) 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 federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s
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C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a non-network provider, or shall make other arrangements acceptable to the commissioner when:

(i) The health carrier has a sufficient network, but has determined that it does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit without unreasonable travel or delay; and

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

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

(3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider, including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit.

(4) 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.

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

(i) Does not have a network provider of the required specialty or subspecialty with the professional training and expertise and experience to treat or provide services to the covered person.

(ii) Does not have a network provider of the required specialty with the professional training and expertise and experience to treat or provide health care services for the condition or disease without unreasonable delay.

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

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

(b) The health carrier:

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

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

(3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider, including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit.
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 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 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.

Paragraphs (5) and (6) require 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; (v) the date of approval or denial; and (vi) the relevant authorization number, if the request was approved.

Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.
(4) The health carrier shall have a process to ensure 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 insufficient resources to provide the covered benefit at an in-network level of benefits.

(b) The health carrier cannot or does not wish to offer a covered benefit at an in-network level of benefits.

(c) The health carrier has insufficient resources to provide the 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 insufficient resources to provide the covered benefit at an in-network level of benefits.

(2) The health carrier cannot or does not wish to offer a covered benefit at an in-network level of benefits.

(3) The health carrier has insufficient resources to provide the covered benefit at an in-network level of benefits.

(4) The health carrier has insufficient resources to provide the covered benefit at an in-network level of benefits.

(5) The health carrier has insufficient resources to provide the covered benefit at an in-network level of benefits.

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<th>Paragraph</th>
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<tr>
<td>C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
<td>(a) The health carrier has a sufficient network, but has determined that it does not have a network provider with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
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<td>(b) The health carrier:</td>
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<td>(i) Does not have a network provider of the required specialty with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
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<td>(ii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
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<td>(iii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
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<td>(iv) Does not have a network provider with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:</td>
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<td>(v) 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 shall make other arrangements acceptable to the commissioner when:</td>
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<td>(vi) 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 shall make other arrangements acceptable to the commissioner when:</td>
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<td>(vii) 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 shall make other arrangements acceptable to the commissioner when:</td>
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<td>(viii) 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 shall make other arrangements acceptable to the commissioner when:</td>
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<td>(ix) 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 shall make other arrangements acceptable to the commissioner when:</td>
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<td>(x) 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 shall make other arrangements acceptable to the commissioner when:</td>
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Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law. The maximum out-of-pocket limit applicable to in-network services under the plan provides for the covered benefit to the covered person; and the health carrier shall have a process to assure that a covered person obtains a covered benefit 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 network provider with the professional training and expertise to treat or provide health care from a non-participating provider, or shall make other arrangements acceptable to the commissioner when: (b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person.
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<th>D.</th>
<th>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.</th>
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<td>D.</td>
<td>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.</td>
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<td>D. ***</td>
<td>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 of essential community providers. States must monitor how often the alternate process is being used as a potential indicator of an inadequate network.</td>
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D. (1) A health carrier shall establish and maintain adequate arrangements to ensure reasonable access of participating providers to the business or personal residence of covered persons. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

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

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

**Drafting Note:** States may establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to submit an access plan to the insurance commissioner for prior approval. Some states may prefer that a health carrier simply submit an access plan to the insurance commissioner for information purposes. Some states may allow the commissioner to require that a health carrier submit an access plan in order to ensure reasonable access to the services of participating providers.

E. **(1) A health carrier shall 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.**

Option 2. **Filing of Access Plan**

Option 1 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 require the commissioner to take action on the plan. Some states may allow the insurance commissioner to review the plan but not require action.

**Drafting Note:** States may 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 allow the insurance commissioner to review the plan but not require action.
Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans. (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, 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 be considered proprietary, competitive or trade secret and, as such, no provision of the plan may be made public.

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 appropriate agency to approve or receive access plans, an access plan meeting the requirements of this Act for each of the network plans the carrier offers in this state. 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 submit to the commissioner a proposal for approval prior to or at the time it files a new access plan. The proposal must include a reasonable timeframe within which the carrier plans to submit or file an access plan. The commissioner shall have thirty (30) days in which to act on the proposal.

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. 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 any such request in writing, and the health carrier shall maintain the information as confidential. The access plan may be deemed proprietary, competitive or trade secret by the commissioner, in whole or in part, on a case-by-case basis. The access plan may be made public or subject to public access and may be used or published by the commissioner or any other person, and the access plan may be used or published by the commissioner or any other person.

(b) For the purposes of this subsection, information is proprietary, competitive or trade secret information 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 be considered proprietary, competitive or trade secret, and, as such, no provision of the plan may be made public.

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

(b) For purposes of this section, “material change” is a change in the composition of a health carrier’s provider network that renders the health carrier’s network non-compliant with one or more of the network adequacy standards set forth in this section or rules adopted pursuant to this section.

Drafting Note: States should be aware that requirements in this section for the access plan may be duplicative of other requirements in 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 will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to file the access plan, while Option 2 requires approval of the access 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, in whole or in part, on a case-by-case basis.

Drafting Note: States will establish different requirements for 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.
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 may want to consider defining "material change" for purposes of Paragraph (3) above in a manner consistent with the commissioner's interpretation of the term. Some states may want to provide that a health carrier may 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 require that the health carrier provide a reasonable timeframe within which the health carrier will submit to the commissioner for approval or file with the commissioner, as appropriate, an updated access plan.

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

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

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

Drafting Note: States should be aware that the intent of Paragraph (3) above is that the access plan be considered public information.

(4) 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 for each of the network plans the carrier offers in this state.

(5) The carrier shall provide an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to an existing access plan.
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<td>(1) Beginning [insert effective date], a health carrier shall submit to the commissioner an access plan meeting the requirements of this Act.</td>
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<td>For each of the network plans the carrier offers in this state, the access plan must meet the requirements of this Act.</td>
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<td>To the extent there is such duplication, the intent is that the health carrier be required to file or submit one time.</td>
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Option 2 of Paragraph (1) below. Other states may prefer that a health carrier file the access plan with the commissioner for prior approval. Other states may prefer that a health carrier not file the access plan with the commissioner and instead maintain the access plan on file at the health carrier’s place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

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 available online, 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. 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 applicable.

Drafting Note: States should be aware that the access plan is considered a regulatory filing. If the state makes these regulatory filings available online, 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. 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 applicable.

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Drafting Note: States should be aware that the access plan is considered a regulatory filing. If the state makes these regulatory filings available online, 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. 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 applicable.
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 submit to the commissioner for approval prior to the time itfilesize a newly offered network plan, in writing and from details by notice of the commissioner, an access plan meeting the requirements of this Act.

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

E. Option 1. Prior Approval of Access Plan

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.

Paragraph (2) below—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 will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires the insurance commissioner to receive or approve access plans. Some states may specify or require the insurance commissioner to receive or approve access plans.

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Option 2. Filing of Access Plan

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

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

Option 2. Filing of Access Plan

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, 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.

(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 Notes: 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] and, as such, no provision of the plan may be made public. States should review their open records laws in determining whether particular provisions of the plan may be made public. 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.

Option 2. Filing of Access Plan

(3) The carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The health carrier shall include in the notice to the commissioner a reasonable statement of the reasons for the change.

Drafting Notes: 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 the access plan once.
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.

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

(b) The carrier shall notify the commissioner of any material change to any existing network plan that comprises 75 percent or more of the participating physicians or any facility-based physician group that comprises 75 percent or more of the participating physicians for that specialty at the participating facility for which the carrier is responsible for the delivery of network services.

(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 file the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall file the access plan as [proprietary, competitive or trade secret] information that shall not be made public.

(b) For the purposes of this paragraph, information is [proprietary, competitive or trade secret] information if revealing the information would cause the health carrier’s competitors to obtain valuable business information. The health carrier shall file the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall file the access plan as [proprietary, competitive or trade secret] information that shall not be made public.

Drafting Note: States should be aware that the information 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.
(3) The carrier’s process for making available the criteria for the health carrier’s network, which must be made available through the health carrier’s consumer-friendly health care network, is used to build its provider network, and shall notify the commissioner of any material changes to the access plan, as required by law. Access plans shall be filed with the commissioner, which shall notify the commissioner of any access plan that includes or modifies the criteria for the health carrier’s network, which shall be used by the health carrier to build its provider network.

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 the quality of care standards and health outcomes for certain types of network plans, such as HMOs and narrow network plans that the health carrier has designated to include providers that have high quality of care and health outcomes.
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**CMA**

**(2) 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**

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**CMA**

**(3) 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**

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**CMA**

**(4) The health carrier’s criteria and any methodologies used in tiering or publicly designating participating providers with a label**

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**CMA**

**(5) The health carrier’s process 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;**

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**CMA**

**(6) The health carrier’s efforts to address the needs of covered persons who may face barriers to access care, including but not limited to, children with serious, chronic or complex medical conditions, individuals with limited English proficiency and illiteracy, individuals with diverse cultural and ethnic backgrounds, and individuals with physical and mental disabilities;**

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**CMA**

**(8) The health carrier’s system for ensuring the coordination and continuity of care for covered persons who may need to transition from one health plan to another in the event of a contract termination, carrier insolvency or other event affecting plan operations, for covered persons using health care coordination and continuity systems for covered persons who may need to transition from one health plan to another in the event of a contract termination, carrier insolvency or other event affecting plan operations. This includes the health carrier’s process for ensuring the coordination and continuity of care for covered persons who may need to transition from one health plan to another in the event of a contract termination, carrier insolvency or other event affecting plan operations;**

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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, and 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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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 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.

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

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

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

ACS CAN

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

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

ACS CAN

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

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

(3) “Designated services” means those services offered through the preventative benefit that have high quality of care and health outcomes.

(4) “Grievance” means a covered person who a referring health care professional deems necessary to treat the life-threatening disease or condition is informed.

(5) “Network” means any disease or condition from which the likelihood of death is probable unless the disease or condition is treated.

(6) “Provider network” means those services offered through the preventative benefit.

(7) The health carrier’s method of informing covered persons of the plan’s services and features, including those services offered through the preventative benefit.

ADCC

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

ADCC

A health carrier shall ensure that its networks meet, at a minimum, the essential community provider requirements that apply to:

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

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

ACS CAN

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ACS CAN

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ACS CAN

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(6) “Provider network” means those services offered through the preventative benefit.

(7) The health carrier’s method of informing covered persons of the plan’s services and features, including those services offered through the preventative benefit.
network provider. Such determination shall be made by an independent reviewer organization or other entity that has no affiliation with the health carrier.

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

A health carrier shall ensure that its networks meet, at a minimum, the essential community provider requirements that apply to qualified health plans under federal and state law, regulations or guidance. (A) A managed care organization (MCO), or contracted pharmacy benefit manager (PBM), shall not mandate that a covered individual use a specific retail pharmacy, mail order pharmacy, specialty pharmacy or other pharmacy or entity if the MCO or PBM has an ownership interest in such pharmacy, practice site, or entity or that the pharmacy, practice site or entity has ownership interest in the MCO or PBM.

A MCO or PBM may not require that a pharmacist or retail pharmacy participate in a network managed by such MCO or PBM as a condition for the retail pharmacy to participate in another network managed by the same MCO or PBM. A MCO or PBM may not mandate that a pharmacist or retail pharmacy participate in a network managed by such MCO or PBM as a condition for the retail pharmacy to participate in another network managed by the same MCO or PBM.

A health carrier shall ensure that its networks meet, at a minimum, the essential community provider requirements that apply to qualified health plans under federal and state law, regulations or guidance.
At least 90 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.

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.

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.
C. (1) Every contract between a health carrier and a participating provider shall set forth in the event of a health carrier or intermediary insolvency or no longer medically necessary.

MIA

"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."
Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider’s obligation to provide covered benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater without balance billing will continue until the earlier of:

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

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.

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

Selection criteria shall not be established in a manner that would allow a health carrier to discriminate against or exclude providers because they are located in geographic areas that contain populations of providers posing a risk of higher than average claims loss or higher than average cost to the health carrier.

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

Selection criteria shall not be established in a manner that would allow a health carrier to discriminate against or exclude providers because they are located in geographic areas that contain populations of providers possessing a risk of higher than average claims loss or higher than average cost to the health carrier.

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

Selection criteria shall not be established in a manner that would allow a health carrier to discriminate against or exclude providers because they are located in geographic areas that contain populations of providers possessing a risk of higher than average claims loss or higher than average cost to the health carrier.

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

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

Selection criteria shall not be established in a manner that would allow a health carrier to discriminate against or exclude providers because they are located in geographic areas that contain populations of providers possessing a risk of higher than average claims loss or higher than average cost to the health carrier.
Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

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

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are acting within the scope of their license or certification under applicable state law that may meet the carrier’s selection criteria, or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. 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 individuals from enrolling in the plan because they would be geographically located in areas with extremely high-risk populations or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located.

The provisions of this Act do not require a health carrier to make all the carrier’s requirements for participation in the provider network applicable to all participating providers. The carrier’s network may consist of providers who meet all the carrier’s requirements for participation, or it may consist of providers who meet some but not all of the carrier’s requirements for participation. The carrier’s network may consist of providers who meet all the carrier’s requirements for participation, or it may consist of providers who meet some but not all of the carrier’s requirements for participation.
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<td>(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.</td>
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American Association of Health Plans (AAHP) |

American Medical Association (AMA) |

American Nurses Association (ANA) |

American Optometric Association (AOA)
(3) Selection criteria shall not be established in a manner:

- 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;
  - that fails to use appropriate peer comparisons, including at the specialty and subspecialty levels of services provided and billed.

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

- be specific to the type of care provided;
- meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment;
- be special to the specialty and subspecialty level of services provided and billed; and
- be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.
Geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services or (a) that would allow a health carrier to discourage access to higher risk populations by excluding providers because they are located in such areas. The standards shall be developed for providers by the health carrier and its intermediaries with which it contracts.

(b) That would allow a health carrier to discriminate against high-risk populations by excluding providers because they are located in such areas. The standards shall be developed for providers by the health carrier and its intermediaries with which it contracts.

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

### Drafting Note

This subsection is intended to prevent health carriers from increasing their 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 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 provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. In addition, states should be aware that certain providers, notwithstanding the scope of their licenses, limit their practices to either children or adults. Any evaluation of network adequacy should include an analysis of the availability and capability of providers to deliver age and medically appropriate treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

### Maine Bureau of Insurance

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

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

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

### Drafting Note

This subsection is intended to prevent health carriers from increasing their 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 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.

### DREDF

(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 such areas. The standards shall be developed for providers by the health carrier and its intermediaries with which it contracts.

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

### Drafting Note

This subsection is intended to prevent health carriers from increasing their 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 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 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.
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<td><strong>(5)</strong> The provisions of this Act do not require a health carrier’s intermediate designation of the provider networks with which they contract to be approvable but are a matter of investor choice.</td>
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A health carrier shall not offer an inducement or penalty to a provider to furnish services to a covered person, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeal procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuation of acceptable new patients; confidentially requirements and any applicable Federal or state programs.

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 process established by the carrier or a person contracting with the carrier.
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.

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.

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.

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 covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

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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 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.

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.

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

Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified.

For purposes of this paragraph:

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

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

(iii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or health care 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 conditions in active treatment until it is completed or for up to ninety (90) days, whichever is less.

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

(c) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation 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.

Within thirty (30) working days of receipt of the covered person’s written request, 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) 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.

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

(c) The health carrier shall make a good faith effort to ensure that any covered person who is a patient of a provider whose contract is terminating who has a special circumstance is provided with notification of the nature of the special circumstance and of the potential negative impact of the termination on the covered person. 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.

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

(i) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or health care 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 conditions in active treatment until it is completed or for up to ninety (90) days, whichever is less.

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

(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 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 contract termination was not for cause;

(ii) The contract termination was not for cause and the health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance; and

(iii) The health carrier agrees to continue treatment at the same reimbursement level as provided under the carrier’s provider contract, so long as the following conditions are met:

(A) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation 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.

(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 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 contract termination was not for cause;

(ii) The contract termination was not for cause and the health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance; and

(iii) The health carrier agrees to continue treatment at the same reimbursement level as provided under the carrier’s provider contract, so long as the following conditions are met:

(A) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation 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.

(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 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 contract termination was not for cause;

(ii) The contract termination was not for cause and the health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance; and

(iii) The health carrier agrees to continue treatment at the same reimbursement level as provided under the carrier’s provider contract, so long as the following conditions are met:

(A) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation 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.

(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 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;
States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues that 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, 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, but subsequently is not.

Drafting Note: States may want to review other state laws and regulations and consider addressing them to speak to enrolment periods to address potential issues that 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, 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, but subsequently is not.

AADA

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.

The health carrier shall mail any notice of network termination or a change in network status to the office(s) at which the physician is listed as practicing.

(b) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

AAFP

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

When a provider whose contract is terminating without cause:

(i) “Active treatment” means treatments with acute or chronic medical conditions in active treatment to continue until the end of the benefit year.

(ii) “Active treatment” means treatments with acute or chronic medical conditions in active treatment to continue until the end of the benefit year, including treatments for acute or chronic medical conditions that have been diagnosed or discovered within the benefit year.

(iii) “Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and treatment.

(iv) “Failure to contract” means a medical condition involving a sudden onset of symptoms that is likely to result in death.

(v) “Foreseeable termination” means a medical condition involving a sudden onset of symptoms that is likely to result in death.

(vi) “Material error” means 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, but subsequently is not.

L. (2) (a) For purposes of this paragraph, “foreseeable termination” means regular visits with a provider to monitor the status of an illness or disease, or to provide treatment other than that involved in an acute condition.

(b) The health carrier shall provide written notice of a provider’s termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(c) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

L. (4) (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.

AADA

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.

When a provider whose contract is terminating without cause:

(i) “Active treatment” means a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(ii) “Active treatment” means a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(iii) “Material error” means 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, but subsequently is not.

L. (2) (a) For purposes of this paragraph, “foreseeable termination” means regular visits with a provider to monitor the status of an illness or disease, or to provide treatment other than that involved in an acute condition.

(b) The health carrier shall provide written notice of a provider’s termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(c) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

L. (4) (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.

AADA

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.

When a provider whose contract is terminating without cause:

(i) “Active treatment” means regular visits with a provider to monitor the status of an illness or disease, or to provide treatment other than that involved in an acute condition.

(ii) “Active treatment” means a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(iii) “Material error” means 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, but subsequently is not.

L. (2) (a) For purposes of this paragraph, “foreseeable termination” means regular visits with a provider to monitor the status of an illness or disease, or to provide treatment other than that involved in an acute condition.

(b) The health carrier shall provide written notice of a provider’s termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

(c) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt of a notice of termination to all covered persons who are patients seen on a regular basis at least once during the past three (3) years leading up to the provider’s termination date, irrespective of whether the termination was for cause or without cause.

L. (4) (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.
(4) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the
in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow the covered person to continue care with the provider for:

(1) up to 90 days, whichever is less;

(2) the duration of time specified for one of the conditions specified in Paragraph (2); or

(3) each contract between a health carrier and a participating provider shall provide that termination of contract does not release the
health carrier from its obligation to continue reimbursement for ongoing treatment at the
in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).

(c) For purposes of this paragraph:

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

(2) "Special circumstance" means a condition with respect to which the treating physician or health care provider believes that discontinuing care could cause harm to the covered person. Examples include a covered person with a disability, a mental health condition, or a substance use disorder; a covered person who is pregnant; or a covered person who is past the 24th week of pregnancy.

(d) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the
health carrier from its obligation to continue reimbursement for ongoing treatment at the
in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).

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

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

(2) "Special circumstance" means a condition with respect to which the treating physician or health care provider believes that discontinuing care could cause harm to the covered person. Examples include a covered person with a disability, a mental health condition, or a substance use disorder; a covered person who is pregnant; or a covered person who is past the 24th week of pregnancy.

(5) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the
health carrier from its obligation to continue reimbursement for ongoing treatment at the
in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow the covered person to continue care with the provider for:

(1) up to 90 days, whichever is less; or

(2) the duration of time specified for one of the conditions specified in Paragraph (2); or

(3) each contract between a health carrier and a participating provider shall provide that termination of contract does not release the
health carrier from its obligation to continue reimbursement for ongoing treatment at the
in-network rate for the duration of time specified for one of the conditions specified in Paragraph (2).
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1. (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.”

2. (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.

3. (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, when a consumer’s enrollment or non-enrollment in a health plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, non-enrollment in a health plan, or the receipt of incorrect or misleading information from a provider directory. Consumers may want to review other state laws and regulations and consider adopting special enrollment periods to ensure continuity of care.

Drafting Note: States may want to review other state laws and regulations and consider adopting special enrollment periods to ensure continuity of care.
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The postpartum period. 

Center shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health network, whichever is less.

(ii) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for active treatment in the network if:

(I) The health carrier agrees that a condition for which ongoing treatment is being provided is part of a short-term agreement for enrollees undergoing active treatment; and

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

(c) In the event that a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with active or prior authorization for a procedure or surgery by a provider to continue care with the provider through the postpartum period.

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Drafting Note:

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

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(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 up to 90 days, whichever is less.

(g) A health carrier shall allow a covered person 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. The enrollee's cost-sharing for accessing the out-of-network provider should be no greater than the enrollee would pay if the provider were included in-network. The first and second opinions are to be performed by providers who have specialty care expertise equivalent to the specialty care expertise of the provider whose service is being provided.

(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 covered persons who have special circumstances include covered persons 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 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) Denies a special circumstance with respect to the covered person;

(iv) Provides a special circumstance with respect to the covered person.

(c) A health carrier shall allow a covered person to obtain a second opinion from an out-of-network provider if no alternative in-network provider is available, qualified, and within a reasonable distance. The enrollee's cost-sharing for accessing the out-of-network provider should be no greater than the enrollee would pay if the provider were included in-network. The first and second opinions are to be performed by providers who have specialty care expertise equivalent to the specialty care expertise of the provider whose service is being provided.

(d) In the event that a provider's contract is terminated without cause and the provider treats covered persons with terminal illnesses.
(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier's obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

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

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

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

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, misrepresentation 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 or treatment, or treatment of a chronic condition (e.g., monitoring diabetes or asthma, not for any specific reason different from routine monitoring or treatment of a chronic condition).
within the 6-week period after delivery.

provider or provider's contract. In the event of (i) the death of the covered person; (ii) the covered person's covered condition is currently untreated; (iii) the covered person's covered condition is currently untreated unless the condition is determinable.

(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 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 in-network rate for ongoing treatment at 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.

provider or provider's contract. In the event of (i) the death of the covered person; (ii) the covered person's covered condition is currently untreated; (iii) the covered person's covered condition is currently untreated unless the condition is determinable.
Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be in-network or a participating provider.

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

Drafting Note: Health plans already support transitional care policies and procedures that result in continuity of care for covered persons undergoing active courses of treatment, such as radiation therapy or chemotherapy, for a serious or terminal illness; and mothers in their second or third trimester of pregnancy, to include at least six weeks post-partum care. For new enrollees transitional care policies ensure access to the same doctor or hospital used by the covered person under the prior plan at in-network reimbursements during the transition period, and for existing covered persons of a plan whose provider is no longer in the plan’s network, at in-network reimbursements during the transition period.

Drafting Note: 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.

Drafting Note: 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.
(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 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.

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

(g) The breach of the contract was not due to the fault or negligence of the health carrier.

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

(i) The health carrier agrees to continue to reimburse the treating physician or provider for ongoing treatment of the covered person.

(j) A health carrier shall agree to continue its obligation to reimburse the treating physician or provider if:

(1) 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 the patient-covered person as provided under the carrier’s provider contract between the physician or provider and the health carrier; and

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

(2) The physician or provider must meet the following conditions:

(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 requiring which the treating physician or health care provider believes that discontinuing care would substantially increase the risk of harm to the covered person.

(3) A covered person who is past the 24th week of pregnancy at the time of termination is entitled to ongoing treatment from the covered person’s treating physician or provider unless the treating physician or provider has been provided notice in writing by the health carrier that the treating physician or provider is no longer a participating provider.

(4) The covered person is entitled to ongoing treatment from the covered person’s treating physician or provider unless the following conditions are met:

(i) The treated condition is not life-threatening.

(ii) The treating physician or provider is not a participating provider for the covered person.

(iii) The treating physician or provider is not a participating provider for the covered person’s covered person.

(iv) The treating physician or provider is not a participating provider for the covered person’s covered person.”
<table>
<thead>
<tr>
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(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.

Requirements for providers leaving a network to provide the carrier with a list of covered persons receiving active treatment from the provider shall be established by the two (2) parties upon entering the contract.

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

(i) “Life-threatening” means a disease or condition involving a sudden onset of symptoms that requires prompt medical attention and that has a high probability of causing death within one year or less.

(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, a child with a complex or chronic condition, 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.

(c) Whenever a provider’s contract is terminated without cause, the health carrier shall allow covered persons who are patients of the provider whose contract is terminated to continue care with the provider through the second (2nd) pregnancy of their covered persons.

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

(i) “Active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide treatment, prescribe medication or other treatment or modify a treatment protocol.

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

(iii) “Active treatment” does not include chronic monitoring for a chronic condition.

(iv) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, a mental health condition, or a substance use disorder, or a covered person who has received prior authorization for a procedure or surgery by a provider who subsequently leaves the network.

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic 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 covered persons who are patients of the provider whose contract is terminated to continue care with the provider through the second (2nd) pregnancy of their covered persons.

(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.
(e) In the event that a provider’s contract is terminated without cause and the provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in a new health benefit plan coverage for which the provider is not a participating provider, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or for up to 90 days, whichever is less.

(f) For purposes of this paragraph:

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

2. “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.

(g) 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 who is a participating provider who is responsible for the following:

1. Identifies a special circumstance with respect to the covered person;

2. Requests that the covered person be permitted to continue treatment under the provider’s care;

3. Agrees to accept the same reimbursement from the health carrier for the care provided by the provider as provided under the carrier’s provider contract;

4. terminates a special circumstance with respect to the covered person;

5. recognizes that the covered person is entitled to continue treatment under the provider’s care;

6. agrees not to seek reimbursement from the covered person for any amount for which the covered person would not be responsible if the treating physician or provider were still a participating provider;

7. agrees to accept the same reimbursement from the health carrier for the care provided by the provider as provided under the carrier’s provider contract;

8. agrees to accept the same reimbursement from the health carrier for the care provided by the provider as provided under the carrier’s provider contract; and

9. agrees to accept the same reimbursement from the health carrier for the care provided by the provider as provided under the carrier’s provider contract.

(h) 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 a covered person’s pregnancy.

(i) A covered person is past the 24th week of pregnancy.

(j) The contract termination was not for cause.

(k) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

(l) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

(m) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

(n) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

(o) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

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(y) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.

(z) The health carrier agrees that the condition for which ongoing treatment is being provided is a special circumstance and is not within the network of the provider prior to the condition.
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, non-enrollment in a health benefit plan is the result of a provider’s failure to properly advertise or display covered services, or a provider’s failure to properly advertise or display or update covered services.

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

(c) 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 who are pregnant to continue care with the provider through the postpartum period.

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

(f) In the event a patient with an acute or chronic medical condition, pregnancy, terminal illness or a special circumstance enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the newly enrolled person to continue care with the treating provider for up to 90 days, whichever is less.

(g) Whenever a provider is listed as an acceptable new patient, 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.

...
terminal illness should last for the duration of the illness.

Drafting Note: States may want to review other state laws and regulations and consider adding to them special enrollment periods to

(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

(ii) “Special circumstance” means a condition regarding which the treating physician or health care provider believes that discontinuing

(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

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

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

(iii) Agrees to accept the same reimbursement from the health carrier for that patient as provided

under the carrier's provider contract to in-network providers for similar services in the same or similar geographic area unless the carrier and the provider mutually

agree on a different rate;

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

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

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

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or

provider for ongoing treatment of a covered person ends the earlier of:

(i) The next plan renewal date; or

(ii) The course of treatment

ended.

(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.

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

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

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

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

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

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

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

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

(b) The health carrier shall make a good faith effort to provide written notice of a termination, within thirty (30) working days of receipt of 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 not for cause.

(c) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse the treating physician or provider for ongoing treatment of 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 the covered person as provided under the carrier's provider contract;
(iv) Agrees not to seek payment from the covered person.

(d) Except as provided in subparagraph (a) of this paragraph, the health carrier's obligation to reimburse a physician or provider for ongoing treatment ends the earlier of:

(i) The termination of the covered person's coverage under the network plan; or
(ii) The end of the course of treatment.
(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-up within the 6-week period after delivery, as long as coverage is still in force.

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

(3) ***

(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."

Shriver Center

(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 exacerbation).

(b) Whenever a provider's contract is terminated without cause, 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.

(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.

PhRMA

1. ***

2. ***

3. ***

(3) ***

(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:

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(ii) "Active treatment" does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute exacerbation).

(b) Whenever a provider's contract is terminated without cause, the health carrier shall allow affected covered persons 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 to continue care with the provider through the postpartum period.
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 not penalize a provider for ongoing treatment of a covered person that ends the earlier of: (i) The next plan renewal date; or (ii) The course of treatment ends.

R. If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier shall reimburse the provider, if any, to collect applicable coinsurance, copayments, or deductibles from the provider.

S. If a health carrier agrees to reimburse the treating physician or provider for ongoing treatment at the in-network rate pursuant to this paragraph, a covered person’s cost-sharing for services by such provider, pursuant to such an agreement, shall count toward the covered person’s maximum out-of-pocket limit applicable to in-network benefits.

***

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 participating 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 a 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, or when services are determined to be non-covered benefits.

No comments received.

O. A health carrier shall notify the participating provider of its obligations to collect applicable coinsurance, copayments, or deductibles from the covered person.

No comments received.

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.

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No comments received.

O. A health carrier shall notify the participating provider of its obligations, if any, to collect applicable coinsurance, copayments, or deductibles from the covered person.

No comments received.
<table>
<thead>
<tr>
<th>Q</th>
<th>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.</th>
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</table>

**American Chiropractic Association (ACA)**

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

**Maine Bureau of Insurance**

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

**Suggested Additional Subsections**

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

**Relevant Comments**

| No comments received |

| No comments received |

| No comments received |

| No comments received |

| No comments received |

| No comments received |
A health carrier that uses automatically renewing contracts with its provider shall provide notice to the provider three (3) weeks in advance of the notice of termination period that the contract is about to renew and failure to terminate by the contractual deadline will result in contract renewal. A health carrier may not remove a provider of services from a network or discontinue, terminate, or reduce the number of services, or limit the scope of services or treatment covered, except the following:

- Providing a written notice to enrollees that the carrier is about to terminate a contract and the carrier has the right to terminate the contract.
- A change in the law or state or federal regulations affecting the carrier’s ability to continue the contract.
- The provider’s failure to comply with the terms of the contract.
- The carrier’s inability to continue the contract due to economic or other factors.
- A change in the law or state regulations affecting the carrier’s ability to continue the contract.
- The provider’s failure to comply with the terms of the contract.
- The carrier’s inability to continue the contract due to economic or other factors.

B. Verification of Network Adequacy

- The carrier shall certify to the department that the information provided in the provider directory is consistent with the information required under other provisions of the Act, including the carrier’s access plan. The carrier shall assure that other information reported to the department is consistent with the information provided to enrollees, potential enrollees and the department pursuant to this section.

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide services that a carrier or a provider or who may provide services to the covered person while at the hospital not a participating provider in the contract. The carrier is responsible for ensuring that the provider’s network is adequate under the provisions of the Act, including the carrier’s access plan. The carrier shall assure the network of participating providers is adequate under the provisions of the Act, including the carrier’s access plan.

American Podiatric Medical Association (APMA) Drafting Note: Add examples of “cause” for removal, such as loss of licensure or conviction of fraud or abuse, as well as what may be considered “cause” for removal, such as provider economic problems and provider choice of drug/therapy.
A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital.

Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount that the covered person would be required to pay for out-of-network services.

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

Such disclosure shall include an estimate of the charges that may be billed to the covered person for services provided by a non-participating provider.

C. Health carriers providing written notices and disclosures provided under this section shall notify enrollees of any options available to them to obtain services through an out-of-network provider.

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 in-network hospital. States should actively monitor the extent to which carriers are providing written disclosures and notices to covered persons and take this information into account when determining whether a provider network is adequate and reasonable access for covered persons to covered benefits related to hospital-based providers is available.
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 notice of service (including out-of-network services) that the covered person will receive if the covered person is treated at the hospital.

For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written notice of service (including out-of-network services) that the covered person will receive if the covered person is treated at the hospital.
### Section 7. Disclosure and Notice Requirements

**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 health carrier to reimburse for out-of-network services and a description of what the consumer will be responsible for paying if care is delivered by an out-of-network provider, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).

**B.** For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or out-patient services or at the time of a non-emergency admission to 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 and provides information about the covered person’s options for obtaining care from participating providers.

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

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**WHA**

**Section 7. Disclosure and Notice Requirements**

**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 health carrier to reimburse for out-of-network services and a description of what the consumer will be responsible for paying if care is delivered by an out-of-network provider, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).

**B.** For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or out-patient services or at the time of a non-emergency admission to 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.

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

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**WHA**

**Section 7. Disclosure and Notice Requirements**

**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 health carrier to reimburse for out-of-network services and a description of what the consumer will be responsible for paying if care is delivered by an out-of-network provider, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).

**B.** For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or out-patient services or at the time of a non-emergency admission to 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.

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<table>
<thead>
<tr>
<th>Section 8. Provider Directories</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> (1) <strong>(a)</strong> A health carrier shall post online a current provider directory for each of its network plans with the information and search functions described in Subsection C.</td>
<td><strong>AAP</strong> For purposes of this section, “current” means:</td>
</tr>
<tr>
<td><strong>(b)</strong> In making a directory available online, the carrier shall do so in a manner that: (i) makes clear which providers are included in-network and which are out-of-network in a given health benefit plan; and (ii) does not require a covered person to log in or enter a policy number in order to access the applicable provider directory.</td>
<td></td>
</tr>
<tr>
<td><strong>(2)</strong> The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.</td>
<td></td>
</tr>
<tr>
<td><strong>(3)</strong> A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.</td>
<td></td>
</tr>
<tr>
<td><strong>(4)</strong> For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory:</td>
<td></td>
</tr>
<tr>
<td><strong>(a)</strong> The type of plan (i.e., HMO, PPO, FMO, etc.) and whether there is coverage for services provided by out-of-network providers.</td>
<td></td>
</tr>
<tr>
<td><strong>(b)</strong> The following general information:</td>
<td></td>
</tr>
<tr>
<td><strong>(i)</strong> The method of determining the payment amount for out-of-network services and the covered person’s liability for additional costs.</td>
<td></td>
</tr>
<tr>
<td><strong>(ii)</strong> For each network plan (i.e., HMO, PPO, FMO, etc.) and whether there is coverage for services provided by out-of-network providers.</td>
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(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;

(e) The carrier's process for allowing covered persons to use out-of-network providers with in-network cost-sharing in situations where a suitable in-network provider is not available on a timely basis; and

(f) The email address and phone number that covered persons or the public can use solely to directly notify the plan when provider directory information is inaccurate.

ACAP

(3) A health carrier shall post online 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:

(a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;

(b) The methodology used, if any, for determining the payment amount for out-of-network services and the covered person's liability for additional costs;

(c) The breadth of the network;

(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;

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<table>
<thead>
<tr>
<th>American Telemedicine Association (ATA)</th>
<th>American Health Information Management Association (AHIMA)</th>
<th>American Hospital Association (AHA)</th>
<th>Blue Cross Blue Shield Association (BCBSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. (a)</strong> The health carrier shall provide in the provider directory on where to access the plan's services and features, including those offered through the preventive care benefit.</td>
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<td><strong>4. (b)</strong> The health carrier shall update each network plan provider directory at least monthly within thirty (30) calendar days of receiving new information from providers and shall be offered in a manner to accommodate individuals with limited-English proficiency or disabilities.</td>
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A. 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.

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

- (1) Clear and conspicuous notice of which, if any, participating hospitals have no participating physicians or other providers in specific specialties, including but not limited to emergency services, or few such providers according to state-established minimums.
- (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.

### Providers'

- (a) Name;
- (b) Gender;
- (c) Contact information;
- (d) Specialty; and
- (e) Whether accepting new patients.

### Hospitals

- (a) Hospital name;
- (b) Hospital location and telephone number;
- (c) Hospital accreditation status; and
- (d) Whether accepting new patients.

### Other Facilities

- (a) Facility name;
- (b) Facility type;
- (c) Procedures performed; and
The health carrier shall make available in print the following provider directory information for each network plan:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Information Required</th>
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</thead>
<tbody>
<tr>
<td>Health Care Professionals</td>
<td>(a) Name; (b) Gender; (c) Contact Information; (d) Specialty; (e) Network tier to which the professional is assigned, if applicable; and (f) Whether accepting new patients.</td>
</tr>
<tr>
<td>Hospitals</td>
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Health Law Program

ACS CAN

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<td>Health Care Professionals</td>
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</tr>
</tbody>
</table>

AARP

ACDA AARP

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

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<table>
<thead>
<tr>
<th>Information</th>
<th>AHP/BCBSA</th>
<th>AHIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) For health care professionals:</td>
<td>(a) Name;</td>
<td>(a) Facility name;</td>
</tr>
<tr>
<td></td>
<td>(b) Gender;</td>
<td>(b) Facility location and telephone number;</td>
</tr>
<tr>
<td></td>
<td>(c) Contact information;</td>
<td>(c) Network tier to which the facility is assigned, if applicable;</td>
</tr>
<tr>
<td></td>
<td>(d) Specialty;</td>
<td>(d) Procedures performed;</td>
</tr>
<tr>
<td></td>
<td>(e) Network tier to which the facility is assigned, if applicable;</td>
<td>(e) Facility type;</td>
</tr>
<tr>
<td></td>
<td>(f) Whether accepting new patients;</td>
<td>(f) Procedures performed;</td>
</tr>
<tr>
<td></td>
<td>(g) Hospital accreditation status;</td>
<td>(g) Hospital location and telephone number;</td>
</tr>
<tr>
<td></td>
<td>(h) Network tier to which the hospital is assigned, if applicable;</td>
<td>(h) Hospital accreditation status;</td>
</tr>
<tr>
<td></td>
<td>(i) Network tier to which the professional is assigned, if applicable;</td>
<td>(i) Network tier to which the facility is assigned, if applicable;</td>
</tr>
<tr>
<td></td>
<td>(j) Whether accepting new patients;</td>
<td>(j) Network tier to which the hospital is assigned, if applicable;</td>
</tr>
<tr>
<td>2) For hospitals:</td>
<td>(a) Hospital name;</td>
<td>(a) Hospital name;</td>
</tr>
<tr>
<td></td>
<td>(b) Hospital location and telephone number;</td>
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</tr>
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<td></td>
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<td></td>
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<td></td>
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<td></td>
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<td></td>
<td>(g) Contact information;</td>
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</tr>
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<td>(h) Name;</td>
</tr>
<tr>
<td></td>
<td>(i) Gender;</td>
<td>(i) Gender;</td>
</tr>
<tr>
<td>3) Except hospitals, other facilities by type:</td>
<td>(a) Facility name;</td>
<td>(a) Facility location and telephone number;</td>
</tr>
<tr>
<td></td>
<td>(b) Facility type;</td>
<td>(b) Network tier to which the facility is assigned, if applicable;</td>
</tr>
<tr>
<td></td>
<td>(c) Procedures performed;</td>
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<td></td>
<td>(d) Network tier to which the professional is assigned, if applicable;</td>
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<td></td>
<td>(f) Network tier to which the facility is assigned, if applicable;</td>
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<td></td>
<td>(g) Contact information;</td>
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</tr>
<tr>
<td></td>
<td>(h) Name;</td>
<td>(h) Name;</td>
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<tr>
<td></td>
<td>(i) Gender;</td>
<td>(i) Gender;</td>
</tr>
</tbody>
</table>

C. To the extent the information is provided to the health carrier by its providers:

- Facilities, other facilities by type:
  - Facilities location and telephone number:
    - Network tier to which the facility is assigned, if applicable:
      - Procedures performed:
        - Specialty:
          - Whether accepting new patients:
            - Network tier to which the facility is assigned, if applicable:
              - Whether accepting new patients:
<table>
<thead>
<tr>
<th>(a) Facility/Provider Type</th>
<th>(b) Facility/Provider Name</th>
<th>(c) Procedures/Services Performed</th>
<th>(d) Network Tier</th>
<th>(e) Facility Location and Telephone Number</th>
<th>(f) Whether Accepting New Patients</th>
<th>(g) Other Network Tier Information</th>
<th>(h) Network Tier to Which the Facility is Assigned, if applicable</th>
<th>(i) Accreditation Status</th>
<th>(j) Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Professionals</td>
<td><strong>Name</strong></td>
<td></td>
<td></td>
<td><strong>Gender</strong></td>
<td><strong>Specialty &amp; Subspecialty</strong></td>
<td><strong>Primary Practice</strong></td>
<td><strong>Preferred/Preferred</strong></td>
<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
<td><strong>Contact Information</strong></td>
</tr>
<tr>
<td>Health Professionals</td>
<td><strong>Name</strong></td>
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<td></td>
<td><strong>Gender</strong></td>
<td><strong>Specialty &amp; Subspecialty</strong></td>
<td><strong>Primary Practice</strong></td>
<td><strong>Preferred/Preferred</strong></td>
<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
<td><strong>Contact Information</strong></td>
</tr>
<tr>
<td>Hospitals</td>
<td><strong>Name</strong></td>
<td></td>
<td></td>
<td><strong>Location</strong></td>
<td><strong>Contact Information</strong></td>
<td><strong>Accreditation Status</strong></td>
<td><strong>Preferred/Preferred</strong></td>
<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
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<td><strong>Accreditation Status</strong></td>
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<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
<td><strong>Contact Information</strong></td>
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<tr>
<td>Facilities</td>
<td><strong>Name</strong></td>
<td></td>
<td></td>
<td><strong>Location</strong></td>
<td><strong>Contact Information</strong></td>
<td><strong>Preferred/Preferred</strong></td>
<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
<td><strong>Contact Information</strong></td>
<td><strong>Facility Name</strong></td>
</tr>
<tr>
<td>Facilities</td>
<td><strong>Name</strong></td>
<td></td>
<td></td>
<td><strong>Location</strong></td>
<td><strong>Contact Information</strong></td>
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<td><strong>Network Tier to Which the Facility is Assigned, if applicable</strong></td>
<td><strong>Contact Information</strong></td>
<td><strong>Facility Name</strong></td>
</tr>
</tbody>
</table>

*AMA*

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

1. The type of plan (HMO, PPO, EPO, etc.) and the patient cost-sharing responsibilities (deductibles, co-pays, premiums, etc.);
2. Whether there is out-of-network coverage, and the methodology used to determine payment amounts for out-of-network services;
3. The list of plan (HMO, PPO, EPO, etc.) and the patient cost-sharing responsibilities (deductibles, co-pays, etc.);
4. The preferred/Preferred provider directory information for each network plan.
<table>
<thead>
<tr>
<th>Provider Information</th>
<th>CHA</th>
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<th>ERIC H. Bantings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) Gender;</td>
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<td></td>
<td>Gender of support staff;</td>
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<tr>
<td>(c) Contact information;</td>
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<tr>
<td>(d) Specialty;</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>B. For health care professionals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Name;</td>
<td></td>
<td></td>
<td>Name;</td>
</tr>
<tr>
<td>(a) Hospital name;</td>
<td></td>
<td></td>
<td>Hospital name;</td>
</tr>
<tr>
<td>(b) Hospital location and telephone number; and</td>
<td></td>
<td></td>
<td>Hospital location and telephone number; and</td>
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### Drafting Note:

In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following:

1. A requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as facilities 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 provides same gender care for.

### Maine Bureau of Insurance

<table>
<thead>
<tr>
<th>(a) Facility location;</th>
<th>(b) Facility type;</th>
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<tr>
<td>(c) Procedures performed; and</td>
<td>(d) Facility name;</td>
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</table>

For other facilities, the following information may be provided:

- **(f) Facility location and telephone number.**
These are the drafting notes:

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 assess: a) whether their contact information is correct, b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

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

| (1) The health care professional information in subsection (B)(1) that includes: |
| (a) Hospital affiliations in the health carrier’s network; |
| (b) Medical group affiliations in the health carrier’s network; |
| (c) Board certification(s); |
| (d) Languages spoken by the health care professional or clinical staff; and |
| (e) Office location(s); |

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

For the online provider directories, for each network plan, a health carrier shall include the information required under Subsection B that includes search functions and instructions for accessing additional information on the healthcare professional, such as:

- Language(s) spoken by the healthcare professional;
- Type of service performed;
- Office location(s); and
- Hospital affiliations.

### **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. Requiring health carriers in some manner, such as through an automated verification process, to 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. Requiring health carriers to internally audit their directories and modify directories accordingly based on audit findings to access:
   - Whether their contact information is correct,
   - Whether they are really in the plan’s network; and
   - Whether they are taking new patients;
3. Closely monitoring consumer complaints requiring health carriers to establish a process for updating and assuring the accuracy in the directories, and monitoring consumer complaints related to provider directories.

### **Examples**

#### **AHIP/BCBSA**

- The healthcare professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the healthcare professional, such as:
  - Hospital affiliations;
  - Medical group affiliations;
  - Board certification(s) and specialty(s), if applicable;
  - Languages spoken by the healthcare professional;
  - Office location(s); and
  - Physician office hours at each office location.

- The health carrier shall include:
  - Facility or agency name;
  - Facility or agency type;
  - Procedures performed; and
  - Facility or agency location.

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

- Office location(s);
- Language(s) spoken by the healthcare professional;
- Type of service performed;
- Hospital affiliations;
- Medical group affiliations;
- Board certification(s) and specialty(s), if applicable;
- Office location(s);
- Office location(s).
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.

C. (1) **Affiliation, if any, with cancer centers**;

(2) For hospitals, the following information with search functions for specific data types and instructions for searching shall include:

- Hospital name;
- Hospital type;
- Hospital location;
- Board certification(s);
- Language(s) spoken by the health care professional or clinical staff;
- Hospital affiliations;
- Structural accessibility; presence of accessible exam and diagnostic equipment and availability of programmable assistive devices;
- Languages spoken by the health care professional or clinical staff;
- Medical group affiliations;
- Board certification(s);
- Language(s) spoken by the health care professional.

Drawing 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 feedback from consumer complaints or as a result of other mechanisms, such as through the Society of Consumer Complaint Resolution's model certification program; 3) closely monitoring consumer complaints.

CMA

***

DRED

D. 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:

- Hospital affiliations;
- Medical group affiliations;
- Board certification(s);
- Languages spoken by the health care professional or clinical staff;
- Structural accessibility; presence of accessible exam and diagnostic equipment and availability of programmable assistive devices;
- Office location(s);
(e) Gender of support staff; and
(f) Provide same gender care for.

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location.

For hospitals, the following information with search functions for specific data types and instructions for searching for the following:

(a) Hospital name; and
(b) Hospital location; and

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

(1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:

(a) Hospital affiliations;
(b) Medical group affiliations; and
(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:

(a) Hospital name; and
(b) Hospital location; and

c. For hospitals, the following information with search functions for specific data types and instructions for searching for the following:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location.

For other facilities, the following information with search functions for specific data types and instructions for searching for the following:

(a) Hospital name; and
(b) Hospital location; and

c. For hospitals, the following information with search functions for specific data types and instructions for searching for the following:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location.

For other facilities, the following information with search functions for specific data types and instructions for searching for the following:

(a) Hospital name; and
(b) Hospital location; and

c. For hospitals, the following information with search functions for specific data types and instructions for searching for the following:

(a) Facility name;
(b) Facility type;
(c) Procedures performed; and
(d) Facility location.
In addition to requiring health carriers to update their provider directories at least monthly to maintain the accuracy of the directory information, 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 timeframe a state may feel is appropriate, to determine whether the provider still intends to be in network. Based on the information received, the health carrier must update the directory information. If the provider does not respond within 30 days, the health carrier must remove the provider’s name from the directory. If the provider does not respond within 30 days, the health carrier must remove the provider’s name from the directory.

2. A requirement that health carriers internally audit their directories and modify directories accordingly based on audit findings to access: a) whether their provider contact information is correct, b) whether the providers are really in the plan’s network; and c) whether they are taking new patients. If any of the information listed in the directory is found to be inaccurate based on the audit findings, the directory must be updated within one month of the date in which the specific inaccuracy is noted.

3. Ensuring that the health carrier’s online provider directories, for each network plan: a) include search functions and instructions for accessing additional information on the health care professional, such as: (i) provider’s name, address, and phone number; (ii) hospital affiliations; (iii) medical group affiliations; (iv) board certification(s); (v) languages spoken by the health care professional or clinical staff; and (vi) office location(s); and (vii) 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.

Suggested new subsections

**AADA**

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

**ACADA**

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly to maintain the accuracy of the directory information, 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 timeframe a state may feel is appropriate, to determine whether the provider still intends to be in network. Based on the information received, the health carrier must update the directory information. If the provider does not respond within 30 days, the health carrier must remove the provider’s name from the directory. If the provider does not respond within 30 days, the health carrier must remove the provider’s name from the directory. If the provider does not respond within 30 days, the health carrier must remove the provider’s name from the directory.

**Consumers Union**

C. Whether the provider is currently 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.

NCQA

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

    (1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information about the health care professional’s contact information, the health care professional’s hospital affiliations, medical group affiliations, board certification(s), languages spoken by the health care professional or clinical staff, and office location(s); and whether accepting new patients.

    (2) The source of information about 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).

(3) 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 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 in addition to updating their provider directories at least monthly to help improve the accuracy of the provider directories.

- **PAI**
  - Submission of contracted provider data to regulators. Health carriers must submit participating provider information to the commissioner in prescribed electronic format at a regular interval, no less than weekly. In addition to the information included in the provider directories, this should include valid email addresses for every physician/provider listed in the directory to facilitate a randomization verification sample.
  - Enforcement. (1) The commissioner shall adopt through rulemaking regulations that establish a process for oversight of health carrier compliance with the standards set for in Sections 8A-C and shall include specific penalties for failure to ensure accuracy in the information required with the standards set forth in Sections 8A-C and shall include specific penalties for failure to ensure accuracy in the information required with the standards set forth in Sections 8A-C.

- **AAP, ACS CAN, AHA, NAIC Consumer representatives, Families USA, National Health Law Program**
  - 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.

- **APA**
  - The health carrier shall confirm the availability of the physicians tested in the directory by providing and publishing quarterly reports by provider, by plan or the number of claims the provider submitted in the prior quarter. The health also shall report and publish the number of in-network and out-of-network claims submitted by physician specialty on a quarterly basis.

- **PA**
  - The health carrier shall confirm the availability of the physicians tested in the directory by providing and publishing quarterly reports by provider, by plan or the number of claims the provider submitted in the prior quarter.
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<th>Section 9, Intermediaries</th>
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A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

- Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.
- A health carrier shall have the right to approve or disapprove participation of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- A health carrier shall have the right to make copies of all intermediary health care contracts as its principal place of business in the state of Vermont, to keep them for a reasonable time after the contract is canceled or terminated.
- Close monitoring of intermediary compliance with the terms of the contract is necessary to ensure that the intermediary is providing the services required by the health carrier as specified in the contract.
- The health carrier shall monitor the intermediary and the participating providers to ensure that they are complying with the terms of the contract.
- The health carrier shall have the right to terminate the contract if the intermediary or participating provider fails to comply with the terms of the contract.
- The health carrier shall have the right to approve or disapprove the participation of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- The health carrier shall have the right to make copies of all intermediary health care contracts as its principal place of business in the state of Vermont, to keep them for a reasonable time after the contract is canceled or terminated.
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.

| 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. |

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.

| 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. |

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

| 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. |

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

| 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: This subsection provides an option for states to require health carriers to file with the commissioner for informational purposes.

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 a covered person's access to contracted services or reimbursement.

C. Any material changes to a contract or to require health carriers to file with the commissioner any material changes to a contract for informational purposes.

Drafting Note: States should consider whether the sample contract forms filed under Subsection A are considered public information.

Main Bureau of Insurance

A. Beginning [insert effective date], at the time it files its access plan, a health carrier shall file for approval with the commissioner any material changes to a contract or implementing regulations.

Drafting Note: This subsection provides an option for states 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 contracted services or reimbursement.
B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner within at least [x] days prior to use.

Drafting Note:
Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any changes to contracts or material changes to contracts for prior approval.

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.

Section II. Contracting

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 contract or change is deemed approved.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any changes to contracts or material changes to contracts for prior approval.

Maine Bureau of Insurance

Suggested Additional Subsections

No comments received

None suggested
### 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 to modify the access plan to bring the health carrier into compliance with the network adequacy requirements 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 this Act. **

Drafting Note: The reference to requiring the health carrier to modify the access plan to bring the health carrier into compliance with this Act. **

**B.** The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider contract or the reason for the decision, nor will he or she act to arbitrate, mediate or settle disputes regarding any other dispute between a health carrier and its intermediaries or its providers arising under or by reason of a contract or by reason of a provider contract or its termination. **

**No comments received.**

### Section 13. Regulations

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

**No comments received.**
Section 4. Penalties

A violation of this Act shall [insert 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 circumstances, 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

For states with access-plan requirements comparable to or exceeding pre-2015 Model. No later than twelve (12) months after insertion effective date, each health carrier offering or renewing network plans in this state shall file revised access plans.

Maine Bureau of Insurance

Option 1

D. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after the effective date of this Act.

No comments received

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

No comments received

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

No comments received
### Recommended New Section to Require Insurers to Demonstrate a Good Faith Effort to Contract with Providers Before Being Granted Any Exception to Network Adequacy Standards

<table>
<thead>
<tr>
<th>WHA</th>
<th>Suggested Additional Sections to Model</th>
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<tbody>
<tr>
<td><em>Section 5 of this Act</em> for all in-force network plans. Each health carrier offering or renewing network plans in this state shall file access plans consistent with the 2015 Model No later than twelve (12) months after the enactment of this section of the Act.</td>
<td><em>Option 2</em> consistent with Section 5 of this Act, as amended, for all in-force network plans.</td>
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