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Intended for Use by the States as Guidance Only

**Plan Management Function: Network Adequacy White Paper**

## I. Introduction

The federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) provides for the establishment of American Health Benefit Exchanges to facilitate the purchase of health insurance by qualified individuals and qualified employers.[1] Under the Affordable Care Act, states electing to establish an Exchange must do so and meet certain minimum requirements by Jan. 1, 2014.[2] For states that do not establish a qualifying Exchange, the ACA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish and operate an Exchange, known as a federally facilitated Exchange (FFE), for the residents of that state.[3]

In the proposed rules on "Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" published in the *Federal Register* July 15, 2011, HHS announced the State Partnership Federally Facilitated Exchange (PFFE) model. Under this model, both HHS and the states will operate functions of the Exchange. HHS, however, will remain responsible and accountable to ensure the Exchange meets all of the standards and requirements under the ACA. As stated by HHS, the PFFE model is intended to give the states another option to tailor their Exchange to accommodate local needs and market conditions. In addition, the PFFE model is a way for states to transition into fully operating their own state-based Exchange (SBE).

On Sept. 19, 2011, at a State Exchange Grantee meeting, HHS' Center for Consumer Information and Insurance Oversight (CCIIO) provided additional information to the states on PFFEs.[4] As provided at this meeting, states entering into a PFFE must agree under the terms of their grants to ensure state insurance department, Medicaid and Children's Health Insurance Program (CHIP) cooperation to coordinate business processes, systems, data/information and enforcement. Also, as part of a PFFE agreement, a state may choose to operate plan management functions and/or some consumer services—such as consumer assistance programs—using Exchange grant funding to establish functionality, thereby maintaining existing relationships and allowing for easier transitions to SBEs in future years.

Specifically, under the proposed PFFE, CCIIO stated that a state may choose to operate the following Exchange functions:

- Option 1 – Plan management functions, such as collection and analysis of plan information and plan monitoring and oversight.
- Option 2 – Selected consumer assistance functions, such as Navigator management and in-person application and other assistance.
- Option 3 – Both selected consumer assistance and plan management functions.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.

These plan management and consumer assistance functions can be further defined as including: 1) licensure and solvency; 2) network adequacy; 3) rate and form review; 4) benefit design standards; 5) marketing and consumer information, which includes reviewing marketing materials and overseeing Navigators; 6) accreditation; and 7) quality ratings, quality improvement strategies and enrollee satisfaction surveys.

On May 16, 2012, CCIIO issued additional guidance, "General Guidance on federally facilitated Exchanges."[5] The guidance outlined HHS' approach to implementing an FFE in any state where an SBE is not operating. It also described more specifically HHS' approach on how the states can partner with HHS to implement select functions in

[1] Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010).
[2] ACA §1311(b).
[3] ACA §1321 (c).
[4] http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf.

[5] http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

 

an FFE. Consistent with the information provided at the State Exchange Grantee meeting in September 2011, the guidance provides that the states will have the option to enter into a PFFE under which the state may assume primary responsibility for the plan management function; in-person consumer assistance functions, including oversight and management of Exchange Navigators; or both. The guidance requires those states that decide to assume primary responsibility for plan management under the PFFE to conduct all plan management activities. In addition, the state will collect and transmit necessary data to HHS in a specific format and manage certified QHPs. The guidance also details responsibilities for the states that enter into a PFFE to assume primary responsibility for in-person consumer assistance functions.

The purpose of this white paper is to provide a framework for the states to consider for ensuring compliance with the network adequacy requirements (both statutory and regulatory) for both inside an Exchange for qualified health plans (QHPs)—whether a state is implementing an SBE, FFE or PFFE—and outside an Exchange for managed care plans.

**Section II. Background**

The Affordable Care Act requires the Secretary of HHS to establish, by regulation, criteria for the certification of health plans as QHPs.[6] The regulations must include certain specified criteria that a plan must satisfy in order to be certified as a QHP and, as such, eligible to be offered on an Exchange. Some of those criteria are related to plan network adequacy requirements. Specifically, the ACA requires the certification criteria to:

> 1) Ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act (PHSA)) and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.
>
> 2) Include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the PHSA and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure (*see* Appendix A for the full text of Section 1311(c)(1)(B) and (C) of the ACA).[7]

In the March 27, 2012, *Federal Register*, the Secretary of HHS published the final rules, "Exchange Establishment Standards and Other Related Standards under the Affordable Care Act."[8] The final rules set out the minimum requirements for network adequacy that a plan must meet to be certified as a QHP. Subpart C – Qualified Health Plan Minimum Certification Standards, section 156.230 Network Adequacy standards, states that a QHP issuer must ensure that the provider network of each of its QHPs meets these standards:

> 1) Include essential community providers in accordance with §156.235.
>
> 2) Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.
>
> 3) Is consistent with the network adequacy provisions of section 2702(c) of the PHSA.

In addition, the final rules require a QHP issuer to make its provider directory for a QHP available to the Exchange for publication online and to give to potential enrollees upon request. The provider directory must identify providers that are not accepting new patients (*see* Appendix B for the full text of 45 CFR §156.230).

Section 156.235 of the final rules sets out the requirements related to the inclusion of essential community providers in a QHP provider network (*see* Appendix B for the full text of 45 CFR §156.235). As defined in §156.235(c),

[6] ACA §1311(c)(1).
[7] ACA §1311(c)(1)(B) and (C).
[8] *www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf*.

 

essential community providers, including providers that meet specified criteria, serve predominately low-income, medically underserved individuals. This section includes an alternative standard for meeting this requirement for QHP issuers that provide a majority of their covered professional services through physicians employed by the issuer or through a single contracted medical group.

In developing the language for the final rules, HHS reviewed many comments concerning the network adequacy standard initially included in the proposed 45 CFR §155.1050. As noted in the preamble to the final rules, many commenters supported the flexibility provided to the states in the proposed rules, noting that such flexibility could facilitate the alignment of markets inside and outside of an Exchange. Other commenters suggested that HHS establish a national, uniform network adequacy standard. Among the standards suggested was the NAIC *Managed Care Plan Network Adequacy Model Act* (Model #74). Again, as noted in the preamble, in balancing the competing policy goals and considerations that come into play with examinations of network adequacy (that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange), HHS modified the language in 45 CFR §155.1050, as reflected in 45 CFR §156.230(a)(2) in the final rules, to better align with the language used in the NAIC Model.

Specifically, the final rules establish a minimum standard for QHP issuers as to QHP network adequacy requirements while also providing sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside an Exchange and are relevant to local conditions. HHS notes in the preamble that placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current state practice.

While the Affordable Care Act and the final rules prescribe that mental health providers be incorporated into networks for plans inside the Exchange, it must be recognized that mental health is covered under many circumstances outside the Exchange such as federal mental health parity, state-specific mental health mandates and plans that choose to cover mental health. Therefore, mental health providers should be a component of networks inside and outside the Exchange.

To the extent that a state already has network adequacy standards, it would make sense for the state to extend those requirements to QHPs to minimize adverse selection against the Exchange. However, in some cases, the ACA's network adequacy standards may go beyond a state's existing requirements, particularly as related to its requirement that essential community providers be included in the QHP's provider network. Whether a state has existing network adequacy standards or not, each state will need to consider whether to apply the same standards for QHP certification to the outside market; the potential for adverse selection against the Exchange if they choose not to require the same standards; and the cost to issuers in the outside market to comply if they choose to require the same standards.

For a comparison of the language in the final rules and the NAIC Model, please see Appendix C.

## III. Network Adequacy Regulatory Standards

The final rules provide the states with considerable flexibility in fashioning network adequacy standards for QHPs that wish to participate in an Exchange. One of the ways that the states can put into place network adequacy standards that, with the following exceptions, would be sufficient to meet the final rules would be the adoption of the NAIC Model. While some states have adopted the NAIC model in a manner such that it only applies to HMOs, it and the final rules are designed so that these standards apply to all network plans, including PPOs and any plan that either requires enrollees to use—or creates incentives, including financial incentives, for enrollees to use—the plan's participating provider network.

Areas in which the NAIC Model can be enhanced to ensure compliance with §156.230 include: 1) inclusion of essential community providers, as defined in §156.235(c), in networks; and 2) inclusion of mental health and substance abuse providers in networks.

Regardless of whether a state has adopted the NAIC Model, general regulatory authority should be applied to ensure that the network is adequate to deliver the services promised under the benefit contract. Further, if financial incentives are provided for the use of certain preferred providers, a sufficient number of the preferred providers must be made available in a given service area. In addition, some carriers[9] may be required under state law to deliver prepaid health services through contracts with participating providers. An insufficient number of providers in any given service area may prevent the carrier from selling or renewing benefit plans in that area.

National accreditation entities such as the National Committee for Quality Assurance (NCQA)[10] and URAC[11] have established provider network criteria that measure network adequacy and provide guidance for reviewing networks. States may also refer to standards established by the federal government for Medicaid managed care or Medicare programs. States could consider relying on a QHP plan's accreditation for network adequacy as a complementary tool—but not as a replacement for regulatory oversight—for assessing compliance with the ACA and the final rules network adequacy standards for QHP certification.

Section 5B of the NAIC Model requires a carrier to file an "access plan" with the state insurance commissioner. The review of a carrier's "access plan" is one component of determining compliance with the NAIC Model's requirements and is part of a process known as "Network Adequacy Analysis." This analysis typically is performed by state insurance department personnel, and also involves the review of the carrier's actual networks in order to confirm that there is adequate access to all providers and facilities in a carrier's service area without unreasonable delay or the need to travel an unreasonable distance. The process also accounts for differences in provider availability, capacity to treat patients, provider types (specialties), facilities and practice referral patterns. Although general guidelines—including ratios of patients to providers, distance traveled and waiting times for appointments—can be helpful measures in this process, effective analysis also generally accounts for differences between suburban, urban and rural areas. General provider availability and the interrelationship between various providers in treatment of a patient requires a more complete analysis of the network to ensure that there are no direct or indirect barriers to access. States with existing network adequacy standards, in reviewing a carrier's access plan, may need to consider the impact on network adequacy given the expected increase in enrollees.

When developing a network analysis approach, regulatory staff should have a general familiarity with or request information about:

1. General provider availability in a given geographic area. Consideration should be given to what providers and facilities are located in a given area. General availability will vary depending on population, urban density and the provider's willingness to enter into provider contracts under reasonable terms and conditions. It should also be kept in mind that, as part of the network analysis, network adequacy considerations may have to be modified, depending on a state's specific geographic makeup.

2. Medical care referral patterns and hospital admission privileges. Network analysis must include a review of the hospital admission privileges of providers as well as typical referral patterns for a given community or area. This information may be obtained from the state's health department. Hospital admission privileges are typically gathered as part of the carrier's provider credentialing process. Analysis must confirm that providers requiring the use of facilities—including hospitals, ambulatory surgical centers or specialty treatment facilities—are able to admit their patients to network facilities. As an example, obstetricians must have admitting privileges to network hospitals for delivery services.

3. Hospital-based providers—such as radiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or may not be in any network. Absence from the network may

[9] The ACA uses the term "issuer" instead of "carrier." The term "carrier" used in this white paper is consistent with the term "issuer" used in the ACA.
[10] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: www.ncqa.org.
[11] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: www.urac.org.

 

result in an inadequate network for these services. This is particularly the case if the hospital providers hold an exclusive contract with the facility.

4. Geographical barriers may exist that impede access to care, and the analysis should not rely on a simple mileage factor to determine accessibility. Examples of geographical barriers include mountain ranges and rivers or other bodies of water.

5. The location and availability of essential community providers as well as mental health and substance abuse providers is not addressed in the NAIC Model. However, as previously mentioned, inclusion of essential community providers is required for QHP certification in §156.230(a)(1) of the final rules.

6. The availability and access to centers of excellence for transplants and other medically intensive services as well as the availability of critical care services such as advance trauma centers, burn units, etc. If a carrier does not have such providers in their networks, then arrangements must be made by the QHP issuer to ensure access to these specialized services.

7. The availability of provider types as well as the capacity of providers to accept new patients is a critical component of understanding the network. It is also imperative to recognize that different health plans may be including the same provider or facility in a network, thereby reducing the overall capacity to accept new patients from a single QHP issuer.

In-depth review of network adequacy should occur at the time a network is established and at least annually. In addition, issuers should be required to submit notification at least quarterly of general changes in their network, as well as prompt notice of a potential loss of a material provider such as a hospital or multi-specialty clinic. An overarching goal of network review is to ensure that the network provides access to the participating providers in order to deliver the services promised under the benefit contract. If such access is not available, then the carrier must make arrangements acceptable to the state insurance department or other accountable entity that the services are provided at no greater out-of-pocket expense to the enrollee. Because non-participating providers may balance-bill their patients for the amount of charges in excess of the carrier's allowed amount, any alternative arrangement must recognize the possibility of greater out-of-pocket expense, resulting in the possibility of issuers basing their payments on billed charges rather than "allowed amounts" or usual and customary fees.

## IV. Minimum Network Adequacy Processes

The network adequacy processes outlined in this white paper are designed so that either an Exchange or a state insurance department can perform those functions. However, where a state insurance department either has or will be implementing network adequacy standards for the outside market, for purposes of administrative efficiency and consistency between the markets, a state insurance department performing functions for both the Exchange for QHP certification and the outside market would be desirable.

### A. Review of Health Carrier's Provider Networks

#### *i. Timing*

A health carrier shall seek approval of a service area when initially entering into a new service area market. Once approved, a health carrier must maintain an adequate network. A state shall perform regular reviews of the carrier's approved network to ensure adequacy. The state shall have the flexibility to determine the frequency of a network adequacy review, performing network service area reviews when regulatory concerns arise due to consumer complaints, market conduct activities and other department regulatory functions.

#### *ii. Areas of Network Adequacy Review*

A health carrier shall maintain a network that is sufficient in number and types of providers to ensure all services will be accessible without unreasonable delay. In a state's review of an adequate network, it must also ensure the inclusion of the following within the network:

- Essential community providers.
- Mental health and substance abuse providers.

- Providers that offer essential health benefit services.

However, this requirement should not be interpreted as an "any willing provider" requirement.

Other state considerations could include:
- Geographic distribution of providers within a service area.
- The area's population density.
- Time and/or distance to access providers.
- Location of predominantly low-income, medically underserved individuals population.

States may consider using tools that measure network adequacy, such as OptumInsight (formerly GeoAccess) or Quest Analytics, checklists, time travel analysis, critical care hospital locations, U.S. Census and all other applicable tools. The initial implementation of the new ACA and PHS Act network adequacy rules may gain efficiencies with the use of a state-specific streamline review process that includes for QHP certification specific review criteria pertaining to essential community providers and mental health and substance abuse providers for network-based carriers with previous state approval.

Given that network adequacy evaluation is a component of the QHP certification process, states may also want to consider the potential to leverage the NAIC's System for Electronic Rate and Form Filing (SERFF), which is being modified with the intent to be able to support plan management for Exchanges. There are plans under way to enable the ability to submit network adequacy data through SERFF, either through a third-party submission or by the carrier during the plan filing submission process.

*iii. Adequacy Standards*

The burden of network sufficiency shall lie with the health carrier requesting the new service area or certification as a QHP for the Exchange. The health carrier shall demonstrate its adequacy by providing supporting documentation that demonstrates its network sufficiency. A health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees.

States may determine sufficiency by using reasonable criteria that may include but are not limited to: provider-covered person ratios by specialty; rural/urban geographic accessibility; appointment waiting times; hours of operation; primary care provider (PCP) covered person ratios; availability of PCPs and high-utilization provider specialties; provider acceptance of new patients; hospital access; and patient referral patterns in the requested service area.

There are no specific requirements in either the NAIC Model or the final rules that specify the minimum distances for access to providers or minimum time frames in which to access the providers. Due to the geographic variability of many states, a standard distance or timing may prove to be difficult. States may consider using urban and rural access time standards when reviewing provider access. If no statewide standard exists, measuring adequacy may be accomplished by comparing the health carrier's network to the geographic region served by the applicable provider types. States may give consideration of the relative availability of health care providers in the service area. When considering access to rural geographic areas, states may consider a health carrier's adjacent service area networks that may augment providers if a provider deficiency exists within the service area.

If a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health 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 participating providers, or shall make other arrangements acceptable to the state insurance commissioner.

To ensure that a health carrier possesses an adequate network within a requested service area, the states may require that carriers submit a detailed listing of their network provider specialties, locations, acceptance of new patient status, total unduplicated providers, and all other applicable categories using electronic filings. These requirements should be applied uniformly to all health carriers offering QHPs on an Exchange.

 

### B. Review of Contracts Between Health Carrier and Providers/Intermediaries

As part of the processes considered in determining network adequacy, states should consider reviewing the contracts that carriers have with providers and intermediaries to create and maintain their provider networks. These reviews may entail new, additional filing and review responsibilities.

Section 6 of the NAIC Model sets forth requirements that a carrier must address in its contractual and other dealings with participating providers. These include the requirement of a "hold harmless" provision in the carrier's contract with providers to ensure that providers will not seek payment from enrollees if the carrier or intermediary should become insolvent or fail to pay the provider for any reason. This section also requires a continuation of care provision in the contract between the carrier and the participating provider. The contract provision must set forth the arrangements for continuing covered services to enrollees for a specified period if the health carrier or the intermediary should become insolvent or cease operations. States should note that for individuals who have exhausted the ACA's grace period for nonpayment of premiums, the final rules allow carriers to minimize costs on other consumers by paying, pending or denying a claim under certain circumstances. Specific to these circumstances it is important to note also that the NAIC Model's proposed contract provision allows a provider and an enrollee to agree to continue services solely at the expense of the enrollee.

Among the other provisions in Section 6 of the NAIC Model that the states, as part of their review, should consider having carriers include in their contracts are provisions:

1) Prohibiting providers from attempting, under any circumstances, to collect from an enrollee any money owed to the provider by the carrier.

2) Prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations.

3) Requiring carriers to make their provider selection standards available for review by the state insurance commissioner.

4) Prohibiting a carrier from penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the carrier that jeopardizes patient welfare.

Although not expressly included in the NAIC Model, given the shared responsibility of providers to report timely to carriers of any changes in office locations, their capacity to no longer accept new patients and other pertinent information related to network adequacy, states may also want to permit carriers to include such reporting requirements in their provider contracts. States may also want to permit the inclusion of continuity of care commitments to accept plan payment for courses of treatment in process until completed if the provider leaves the network.

The NAIC Model defines an intermediary as "a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network." Section 7 of the NAIC Model sets out the contracting requirements between a carrier and intermediary. One important provision in that section is a requirement that intermediaries and participating providers comply with all of the NAIC Model's applicable requirements for the relationship between carriers and providers. Another important provision in this section of the NAIC Model specifies that the carrier retains the statutory responsibility for monitoring the provision of covered benefits to enrollees and that the carrier cannot assign or delegate that legal responsibility to the intermediary. Other provisions of this section establish record keeping and related requirements intended to ensure that the carrier and the state insurance commissioner have appropriate access to the books and records of intermediaries.

 

### C. Review of Access Plans

Subsection A above outlines processes and standards for review of a carrier's network adequacy. Those regulatory processes are intended to incorporate the review criteria for purposes of this component of overall network adequacy. Incorporating the network adequacy review, as outlined in Subsection A above, within the access plan filing allows a panoramic view of the carrier's overall network adequacy. Those items in the access plan for review on an annual basis, at a minimum, should include the following:

*i. Health carrier's network*

While the access plan should have the provider network information, additional items should be reviewed in addition to the count of the number and type of providers in the network. Even where the network has sufficient numbers and types of providers overall, individual situations of a lack of network adequacy can occur. Those circumstances can include a hospital or other facility being in-network, but particular providers treating patients at those facilities being non-network (anesthesiologists, for example); the person's provider of choice leaving the network during the course of treatment or during a period in which choice of primary care providers is not available; and geographic disparities in the availability of providers. Regulatory options for dealing with a lack of adequacy in these narrower circumstances may include in-network coinsurance and copayments and allowing for the provider to continue under the network contract for the course of treatment for affected enrollees.

*ii. Provider network types*

Determinations on network adequacy generally consider both the number of providers and specialties as well as the provider network types. HMOs may provide in-network-only coverage, except in the case of emergencies. PPOs may provide coverage for both in-network and out-of-network coverage, with the higher level of coverage provided when obtained in-network (or in the case of an emergency). Other network arrangements have evolved; for example, HMO issuers offering Point of Service (POS) plans that provide for coverage outside of the network, and PPOs offering Exclusive Provider Organizations (EPOs), which provide for in-network coverage only, except in the case of emergency.

Network adequacy determinations focus on an adequate number of network providers to address the health needs of the enrolled or prospective enrolled members. So in the case of HMOs, PPOs, POS plans and EPOs, the analysis is to ensure adequacy of those networks. When the plan includes one of those network types in a tiered network arrangement—and only if the same network providers are included—no additional network adequacy analysis should be required. If the tiered network contains different providers in each tier, then it is important that the network analysis focus on the preferred tier to ensure that there are a sufficient number of providers in the tiers to provide adequate access.

Tiered network arrangements may encourage enrollees to utilize the highest-tier providers for services or key services, such as "Centers of Excellence."

*iii. Health carrier's procedure for making referrals*

The NAIC Model contemplates a review of the carrier's procedures for both in-network and out-of-network referrals and stipulates that the review of the access plan should involve determining what processes and procedures are in place to carry out this requirement. It does not provide any specific standards as to what processes and procedures should be required. In order to determine whether the procedures are appropriate, it is necessary to understand the plan requirements for referrals. If, for example, a primary care provider referral is required, then the procedures that the enrollee must use to obtain the referral must be outlined. Likewise if there are differences in out-of-network and in-network referrals, those differences need to be specified. Finally, a review should identify how enrollees are notified of the referral requirements and a determination as to whether those methods of notification are adequate.

*iv. Health carrier's process for monitoring and assuring ongoing network sufficiency*

A health carrier's network is never static. In order to ensure it meets the minimum standards for network adequacy on a consistent basis, a carrier must maintain a system for monitoring its network and develop procedures to react to

 

impending and existent changes in its network that impair adequacy. This would entail a regulatory review of the procedures for monitoring as well as what procedures are in place as to when and how to take corrective action as it applies to its network.

*v. Health carrier's efforts to address enrollees with special needs*

The NAIC Model requires as part of the access plan that the carrier develop a process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled population. In addition to looking at the needs from an overall enrollee population standpoint, the access plan review should include a review of the carrier's efforts to address the needs of those with limited English proficiency and literacy. This would of necessity include providing the services of professionals who can communicate to and for the enrollees with special needs. The review would involve determining what processes and procedures are in place for those with special needs and specificity as to what services are available to such enrollees.

*vi. Health carrier's methods for assessing enrollee satisfaction*

There are two common measures of assessing enrollee satisfaction with their plan—enrollee complaints and enrollee satisfaction surveys. The review should entail a determination as to how the carrier reviews and maintains enrollee complaints and how it uses this information to measure satisfaction. In addition to determining if and how often a carrier surveys satisfaction and how it uses the results to determine enrollee satisfaction, the regulatory review might include an examination of the survey document and the survey results.

*vii. Health carrier's method for informing enrollees of plan features*

Section 5 the NAIC Model contemplates the following as it relates to methods of informing covered persons:

> *"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, and its procedures for providing and approving emergency and specialty care."*

Therefore, not only must there be the existence of a grievance system, processes for changing providers and approval of emergency and specialty care, but there must also be a review of how the carrier notifies enrollees of those features. At a minimum, the existence of the right to file a grievance, change providers in certain circumstances, and when and how emergency or specialty care may be accessed should be incorporated into the carrier's policy form. Additional information relating to these processes should be available upon request and accessible via the carrier's website.

Although not in the NAIC Model, but required under the Exchange final rules in45 CFR §156.230(b), QHP issuers must make their provider directories for a QHP available to the Exchange for publication online and to potential enrollees in hard copy upon request. The provider directory must also specifically identify those participating providers not accepting new patients. States should ensure compliance with these requirements as part of their review. States may consider relying on standards set by national accreditation entities, such as NCQA[12] and URAC,[13] for addressing provider directory information in the Exchange. In addition, for compliance with this requirement and the requirement under 45 CFR §155.205(b)(1)(viii) that the provider directory be made available to the Exchange as part of the comparative standardized information on each available QHP required to be on an Exchange website, the states may want to consider providing a direct link on the Exchange website to the QHP issuer's provider directory.

*viii. Health carrier's system for ensuring coordination and continuity of care*

[12] For more information about NCQA's health plan accreditation standards related to network adequacy, please see its website at: www.ncqa.org.

[13] For more information about URAC's health plan accreditation standards related to network adequacy, please see its website at: www.urac.org.

One aspect of coordination and continuity of care that presents unique challenges in the Exchange environment is the transition between Medicaid and QHPs. Due to Medicaid eligibility guidelines, certain enrollees will frequently be in a transition mode between the two types of coverage. The provider of choice that the enrollee sought care from while on Medicaid may or may not be part of a QHP carrier's network. If not a part of the QHP network, enrollees who are in the course of treatment are especially vulnerable when considering what level and type of coordination and continuity of care should be utilized. Strategies designed to minimize disruptions in the care provided to such enrollees are critical to enhancing the quality of care intended for coverage in the Exchange. Strategies may include requiring in-network benefits while a new enrollee is in the course of treatment and a limited based network agreement for treatment of specified enrollees.

*ix. Health carrier's procedure enabling enrollees to change primary care providers*

One of the challenges for enrollees is the protean nature of provider networks. Their provider of choice may for various reasons leave the network. Furthermore, an enrollee's provider preference may change over time. If the carrier's plan requires use of a primary care provider as a gatekeeper, then allowing enrollees to switch primary care providers is an important provision in any network arrangement.

In the access plan filing, a review of the carrier's procedures relating to changing primary care providers is normally within the scope of review. The NAIC Model includes a general provision requiring carriers to disclose their process for enabling enrollees to change primary care providers, but does not specify what procedures would be acceptable. At a minimum, in implementing this standard, states may want to considering applying a reasonableness test to determine if the procedures are designed to allow enrollees to switch based upon designated circumstances (such as a provider leaving the network) or at designated time intervals (such as annually upon open enrollment). States also may want to consider conducting a regulatory review of consumer complaints and consumer satisfaction surveys to help determine if the process is, in practice, performing as outlined in the procedures.

*x. Health carrier's plan for providing continuity of care in the event of provider contract termination*

Continuity of care, depending upon the nature of the care needed, may be critical for an enrollee's health. Provider disruption can also be very problematic when the course of treatment does not involve an immediate life threatening situation but involves very strong enrollee provider preference, such as pregnancy.

At a minimum, a carrier must provide notice to enrollees of provider terminations. In addition, specific regulatory standards may be appropriate to allow for the enrollee to continue care with the provider for a specified period of time, such as 90 days, with the applicable provisions of the terminated provider contract applying to care for the affected enrollee. Another option would be to allow the enrollee in the case of pregnancy to continue treatment through postpartum care with the provider once a certain stage of the pregnancy has been reached, such as the second trimester.

The access plan review would take into account specific standards required for continuity of care and review the carrier's plan to determine if it is reasonably designed to meet those standards for continuity of care.

### D. Enforcement

There are multiple regulatory responses, as outlined in the NAIC *Market Regulation Handbook*, available to regulators when identifying compliance issues associated with network adequacy. The regulatory response chosen may vary depending upon the severity and nature of the problem, the preferred regulatory strategy or strategies of the state, and the nature of the state's health care delivery system. No one response will necessarily fit every state or fit a particular state for all circumstances. This multivariate approach is contemplated by the general nature of the enforcement section of the NAIC Model. Specifically, Section 10 of the model includes the following: "The commissioner may institute a corrective action 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." Therefore, each of the following approaches or methods should be not be viewed as separate and distinct alternatives for a state to adopt to the exclusion of other options, but rather a list of regulatory options available depending upon the facts and circumstances of each particular situation.

#### *i. Notice and an opportunity to correct*

A lack of network adequacy can in some circumstances be correctable. There may be additional providers that can be added to the network to provide the desired level or type of provider availability to enrollees. This method would typically involve a regulatory notice, either formal or informal, to the carrier specifying how the carrier's network is inadequate and request that the carrier take appropriate remedial steps. That notice could contain a timeline for bringing the network's adequacy into compliance.

#### *ii. Restricting the carrier's service area*

This approach may be appropriate in circumstances where notice and opportunity to correct has not brought about the desired level of network adequacy, or where a review of the availability of providers in the area in question may make a viable network unworkable in a particular area. This approach is prospective and would specify that the carrier would not be able to continue to sell the network product(s) in question in the areas where the network is no longer determined to be adequate. Depending upon the nature of the state's authority, this could be accomplished by a notice of withdrawal of approval of the network in part or in whole or it could involve a hearing process under the state's administrative procedures act.

#### *iii. Requiring in-network benefits*

For particular areas or for particular types of providers where the network is inadequate, the state's regulatory response may be that the carrier is required to base an enrollee's responsibility for any coinsurance, deductibles or copayments related to such treatment on in-network benefits. This may be an appropriate regulatory response in instances where particular types of providers are unavailable due to either inadequate numbers of providers accepting patients or an unwillingness to contract.

#### *iv. Disapproval of policy forms containing the inadequate network*

If a carrier's network proves to be inadequate on a state-wide basis, an option may be to withdraw approval or disapprove the carrier's network policy forms, effectively precluding the sale of new policies.

#### *v. Formal administrative penalties*

There may be more acute problems related to network adequacy, such as intentional violations or a pattern and practice of noncompliance. In such circumstances, a state may wish to initiate more formal administrative action. Many states have authority to issue temporary cease and desist orders. If the actions of the carrier are particularly egregious, a state may wish to consider whether the action in question warrants a monetary penalty or even revocation or suspension of the carrier's license.

## V. Conclusion

As noted in this white paper, the Exchange final rules provide the states with considerable flexibility in fashioning network adequacy standards for QHP certification, whether a state decides to establish an SBE or enter into a

Partnership Exchange with HHS to carry out the plan management functions in a FFE. This white paper provides a framework that the states may consider in fashioning their network adequacy standards and in developing procedures and processes for implementing those standards.

**APPENDIX A**

**SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.**

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(c) Responsibilities of the Secretary-

(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum--

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

*(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;*

*(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;*

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION- Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

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**APPENDIX B**

**PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

**Subpart C – Qualified Health Plan Minimum Certification Standards**

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**§156.230 Network adequacy standards.**

(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

**§156.235 Essential community providers.**

(a) General requirement. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act[14]; and

[14]Section 340B(a)(4) of the PHSA (Prescription Drug Pricing program, which provides drugs at deeply discounted prices to certain health care providers) defines those entities qualified to receive discounted drugs, which includes federally-qualified health centers, family planning projects receiving grant funds under Title X of the PHSA, Ryan White Care Act providers furnishing HIV/AIDS services, state AIDS drug purchasing assistance (ADAP) programs,

(2) Providers described in section 1927(c)(1)(D)(i)(IV)[15] of the Act as set forth by section 221 of Pub. L. 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

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black lung clinics, hemophilia diagnostic treatment centers, urban Indian health clinics, Native Hawaiian Health Centers, STC and tuberculosis treatment clinics, public hospitals receiving disproportionate share adjustment payments under Medicare, children's hospitals, critical access hospitals, and rural referral centers and sole community hospitals meeting disproportionate share adjustment payment thresholds. See 42 USC §256(a)(4): www.law.cornell.edu/uscode/text/42/256b.

[15]See 42 USC §1396r-8 – Payment for covered outpatient drugs: www.law.cornell.edu/uscode/text/42/1396r-8.

 

**APPENDIX C**

**COMPARISON OF**

**NAIC MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT AND EXCHANGE ESTABLISHMENT FINAL RULE**

| ***NAIC Managed Care Plan Network Adequacy Model Act (#74)*** | ***ACA Establishment of Exchanges and Qualified Health Plans Final Rule*** |
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| **Section 4. Applicability and Scope** | **Subpart C – Qualified Health Plan Minimum Certification Standards** |
| This Act applies to all health carriers that offer managed care plans.<br><br>The term "managed care plan" is defined broadly in section 3O to mean 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. As defined, a "managed care plan" would include HMOs as well as PPOs. | Applies to qualified health plans (QHPs). |
| **Section 5. Network Adequacy** | **§ 156.230 Network Adequacy standards.** |
| | (a) A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards – |
| No equivalent provision. | (1) Includes essential community providers in accordance with § 156.235. |
| A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services covered persons will be accessible without unreasonably delay.<br><br>For emergency services, covered persons shall have access 24/7.<br><br>Sufficiency shall be determined in accordance with this section, and may be established by reference by any reasonable criteria used by the carrier, including: provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technology advanced or specialty care.<br><br>(1) 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 ensure | (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. |

 

| *NAIC Managed Care Plan Network Adequacy Model Act (#74)* | *ACA Establishment of Exchanges and Qualified Health Plans Final Rule* |
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| 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, or shall make other arrangements acceptable to the commissioner.<br><br>(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a 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.<br><br>(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons. | |
| N/A | (3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act. |
| B. Access plan. 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 managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive 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 information, available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update 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:<br><br>(1) The health carrier's network;<br>(2) The health carrier's procedures for making referrals within and outside its network;<br>(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 plans; | No equivalent provision |

 

| *NAIC Managed Care Plan Network Adequacy Model Act (#74)* | *ACA Establishment of Exchanges and Qualified Health Plans Final Rule* |
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| (4) 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;<br>(5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;<br>(6) 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, and its procedures for providing and approving emergency and specialty care;<br>(7) 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;<br>(8) The health carrier's process for enabling covered persons to change primary care professionals;<br>(9) 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<br>(10) Any other information required by the commissioner to determine compliance with the provisions of this Act. | |
| No equivalent provision. | (b) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP must identify providers that are not accepting new patients. |
| | **§ 156.235 Essential community providers.** |
| No equivalent provision. | (a) (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. |

 

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| | (2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.<br><br>(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider. |
| No equivalent provision. | (b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. |
| No equivalent provision. | (c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:<br><br>(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and<br><br>(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8. |
| No equivalent provision. | (d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer. |
| No equivalent provision. | (e) Payment of federally qualified health centers. If an item or service covered by a QHP is provided by a federally qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates |

 

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| | other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section. |
| **Section 6. Requirements for Health Carriers and Participating Providers** | No equivalent provision |
| A health carrier offering a managed care plan shall satisfy all the requirements contained in this section.<br><br>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.<br><br>B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons.<br><br>C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services 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. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.<br><br>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.<br><br>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. | |

| *NAIC Managed Care Plan Network Adequacy Model Act (#74)* | *ACA Establishment of Exchanges and Qualified Health Plans Final Rule* |
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| F. (1) Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. 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:<br>(a) That would allow a health carrier to avoid 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 services utilization; or<br><br>(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.<br><br>G. A health carrier shall make its selection standards for participating providers available for review by the commissioner.<br><br>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 procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.<br><br>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.<br><br>J. A health carrier shall not prohibit a participating provider from discussing 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 processes established by the carrier or a person contracting with the carrier.<br><br>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 | |

 

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| 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.<br><br>L. 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 make a good faith effort to provide written notice of a termination within fifteen (15) 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. 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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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| 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.<br><br>R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.<br><br>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 plan or this Act. | |
| **Section 7. Intermediaries** | No equivalent provision. |
| This section describes the requirements that must be contained in a contract between a health carrier and an intermediary.<br><br>The term "intermediary" is defined in section 3N to mean a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network. | |
| **Section 8. Filing Requirements and State Administration** | No equivalent provision. |
| A. A health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.<br><br>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 approval [cite period of time in the form approval statute] 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.<br><br>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. | |

 

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| 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 9. Contracting** | No equivalent provision. |
| 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.<br><br>B. All contracts shall be in writing and subject to review.<br><br>C. All contracts shall comply with applicable requirements of the law and applicable regulations. | |
| **Section 10. Enforcement** | No equivalent provision. |
| A. If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's 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 institute a corrective action 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.<br><br>B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination. | |

 