September 22, 2015

Mr. J.P. Wieske  
Chair, NAIC Network Adequacy Model Review (B) Subgroup  
National Association of Insurance Commissioners (NAIC)  
444 North Capitol Street, N.W., Suite 701  
Washington, D.C. 20001

ATTN: Jolie Matthews, NAIC Senior Health and Life Policy Counsel

Re: Comments and Suggested Edits to the Sept. 1 draft of the Health Benefit Plan Network Access and Adequacy Model Act

Dear Mr. Wieske, Ms. Matthews, and Work Group Members:

On behalf of the Children’s Hospital Association and our more than 200 member hospitals, we wish to express our gratitude for the work group’s diligent and ongoing work to revise this important NAIC Model Act (Model). In particular, we wish to acknowledge the growing awareness among the work group’s membership that children require in-network providers who have the specific clinical expertise, capacity and experience to appropriately diagnose and treat them. When it comes to providing health care services to children, we believe that the work group understands, and agrees with, the adage, that “children are not little adults.” We hope that you concur that a network that lacks the full range of pediatric providers, particularly pediatric specialty care providers, puts children’s health at risk, their families at financial risk, and threatens children’s long-term quality of life.

Specifically, we would like to applaud you for the following changes to the earlier version of the Model:

- The focus on preventing unfair discrimination based on health status by requiring that networks should be sufficient in numbers and types of appropriate providers to assure that all covered services will be accessible to all covered persons, including both children and adults with serious, chronic or complex medical conditions
- The inclusion of definitions of “specialists” and “specialty care.” These definitions give regulators the tools they need to assess networks’ sufficiency in terms of access to appropriate specialty providers and facilities
- The inclusion of language that recognizes that specialty care is often regionalized, which may require children and adults to travel across state lines to access that care
- The requirement that carriers address in their access plans how they meet the needs of covered persons, including children with special needs, by describing their efforts to include various types of essential community providers (ECPs) in their network
- The establishment of a clear definition of “Tiered network” to give regulators a uniform, specific description of what a tiered network is and help delineate how the Model’s standards are to be applied to those networks

Champions for Children’s Health
The strengthened process under Subsection 5C for access to non-participating providers. This process provides clear guidelines for how the carrier must ensure that consumers can access benefits from a non-participating provider when the carrier’s network does not include a provider with the professional training and expertise to provide the needed care or a participating appropriate provider is not available within a reasonable timeframe.

The Model’s acknowledgement that the carrier’s process to ensure that covered children and adults obtain a covered benefit from a non-participating provider is not intended to be a substitute for the carrier’s responsibility to establish and maintain a sufficient provider network.

Recognition throughout the Model that networks must provide adequate access to mental and behavioral health care providers as well as physical health care providers.

The requirement that provider directories specifically identify the type of hospital under the hospital listings.

Provisions that allow for continuity of care for covered persons in the midst of an active course of treatment when their health care provider leaves or is removed from their health plan’s network.

At the same time, we believe the draft Model could be strengthened further to provide adequate and appropriate protections to children, especially those with serious, chronic or complex health conditions. Therefore, we have offered some minor edits to the Sept. 1, 2015 draft (attached). Per the request of the Chair, we offer only technical corrections, which we believe help clarify agreed-upon language and can help ensure that children have access to appropriate in-network providers for all covered services. We believe these are important refinements of the underlying policy decisions made by the work group during its deliberative process:

- We have added the term “including children and adults with serious, chronic or complex health conditions” to several additional sections of the Model. This clarification reiterates the concept that carriers’ networks’ must include appropriate providers to treat both children and adults and prevents discrimination on the basis of health status. Specifically, we believe the inclusion of these terms also raises awareness among regulators that there should be an assessment of the network’s capability to meet the specialty care needs of their covered children and adults and among carriers that the networks must include the full range of primary, specialty and subspecialty providers.

- We have added the modifier “appropriate” to the term provider in relevant sections of the Model to clarify that networks must be adequate in terms of the types of providers who have the requisite training and experience to render the covered services. This modifying term aligns with the addition in this draft of the definition of “specialist” and “specialty care,” which we strongly support.

- We have expanded references to “health” to encompass “physical, mental or behavioral health” in several additional sections of the Model. By adding this reference throughout appropriate sections of the Model, the issue of mental and behavioral health services is highlighted to strengthen the ability of regulators to enforce compliance with the federal mental health and substance abuse disorder parity laws.

Finally, we wish to reiterate a few outstanding, more substantive changes that we believe will provide important protections for children, particularly those with serious, chronic or complex health conditions. We look forward to continuing to work with the NAIC to ensure these issues are addressed as the Model moves through the deliberative process.
Essential Community Providers (ECPs) – Strong, meaningful minimum ECP requirements in the Model are necessary, given the important and unique role these providers play in caring for vulnerable populations, particularly children. That is why we are pleased that the federal Center for Consumer Information and Insurance Oversight recognizes the unique role that children’s hospitals play in the care of children and intends to propose stronger requirements for QHP contracting with children’s hospital ECPs. While the revised Model Act references ECPs and acknowledges their role in providing care to vulnerable populations, it does not specifically address their inclusion in the assessment of a network’s adequacy, either inside or outside of the Exchanges.

Tiered networks – We believe that specific requirements for tiered networks are needed to assure that health benefit plans utilizing tiered networks ensure that children and adults enrolled in those plans have access to the full range of primary, specialty, tertiary and quaternary care through in-network providers at the lowest cost sharing tier. While the draft Model contains some important safeguards against discrimination based on health status in tiered networks, specific requirements around the adequacy of network in the lowest cost sharing tier will prevent issuers from developing networks that restrict access, or impose financial barriers, to providers and facilities that treat patients with serious, chronic or complex health conditions.

In closing, CHA and our member hospitals wish to thank the work group and Jolie Matthews for the incredible amount of time and effort you have dedicated to this effort. We greatly appreciate the open and inclusive process. If you have any questions or need further information, please contact me at jan.kaplan@childrenshospitals.org or 202-753-5384.

Sincerely,

Jan Kaplan
Children’s Hospital Association
Comments are being requested on this draft by Sept. 22, 2015. 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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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 services to covered persons; and

2. Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with Section 5 of this Act, including any requirements in Section 5E of this Act related to its availability to the public.

Comment [JK1]: For greater consistency in terminology, we recommend using “participating” and “non-participating” as opposed to “in-network” and “out-of-network” throughout the model.
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.

A. “Authorized representative” means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) A family member of the covered person or the covered person’s treating health care professional only when designated by the covered person and the covered person is unable to provide consent, or the covered person is a minor.

B. “Balance billing” means the practice of a provider billing for the difference between the provider’s charge and the health carrier’s allowed amount.

BC. “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.

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

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

EF. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a physical, mental or behavioral health 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. It manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead an prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual’s physical, mental or behavioral health in serious jeopardy; or, with respect to a pregnant woman, the woman’s or her [fetus’] [unborn child’s] health in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or

(4) With respect to a pregnant woman who is having contractions:

(a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
(b) That transfer to another hospital may pose a threat to the health or safety of the woman or [fetus] [unborn child]; or

(5) A threat to the individual’s safety or the safety of others],

The Subgroup said they would revisit whether to add paragraph (5) above.

Drafting Note: States should be aware that the definition of “emergency services” above is derived from the federal definition for the term. Some states have developed a broader definition of “emergency services.” For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state.

H. “Essential community provider” or “ECP” means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 540B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Pub.L.111-8.

Drafting Note: States that wish to broaden this definition may wish to list other types of facilities.

I. “Facility” means an institution providing physical, mental or behavioral 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 should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers (ECPs) in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

GI. “Facility” means an institution providing physical, mental or behavioral 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.

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 physical, mental or behavioral health services, including substance use disorder health services.

Drafting Note: States should be aware that the definition of “emergency services” above is derived from the federal definition for the term. Some states have developed a broader definition of “emergency services.” For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state.

IK. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified physical, mental or behavioral health services consistent with their scope of practice under state law.

Comment [JK5]: Same as above
Comment [JK6]: We believe this should be Subsection F given the renumbering of this section
Comment [JK7]: Same as above
Comment [JK8]: Shouldn’t be italicized
Note to the Subgroup: If the definition of “health care services” is revised, as suggested below, most likely the changes to this definition would not be needed.

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.”

**Drafting Note:** “Health care provider” or “provider” means a primary or specialty health care professional, a pharmacy or a facility.

**Drafting Note:** A pharmacy is an entity where prescription drugs are prepared, compounded, preserved or dispensed. Many types of pharmacies provide a broad range of access for prescription drug benefits in the health care services delivered to a covered person. Any determination of network sufficiency should consider the broad range of pharmacy access points available to covered persons and that certain provisions of this Act may not apply to pharmacy. States should take note of the federal rules implementing the federal Affordable Care Act (ACA) that go into effect Jan. 1, 2017, which will require carriers providing essential health benefits (EHBs) in the individual and small group markets to make prescription drug benefits accessible through in-network retail pharmacies, with a few special exceptions, to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies (see Title 45 CFR – Subpart B – Essential Health Benefits Section 156.122(c)).

**KM.** (1) “Health care services” means primary and specialty care services and devices for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, maintenance of bodily function, or slowing or preventing the deterioration of function, including for physical, mental and behavioral health conditions and mental health and substance use disorders. “Health care services” also includes maintenance of bodily function, or slowing or preventing the deterioration of function.

(2) “Health care services” is intended to include physical, mental and behavioral services.

Note to the Subgroup: Above are possible alternative revisions to the definition of “health care services” to address the issue that some commenters felt needed to be included in various definitions.

**LN.** “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 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 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.

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

**P.** “Limited scope dental benefits” means benefits that provide coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group health plan.

**Drafting Note:** In some cases, dental benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of “limited scope dental benefits” to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

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“Limited scope vision benefits” means benefits that provide coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group health plan.

Drafting Note: In some cases, vision benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of “limited scope vision benefits” to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

“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 or groups 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 covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other innovative delivery system models.

“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” means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

Drafting Note: Many states may have an existing definition of “primary care” in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term “primary care” needs to be defined for purposes of this Act using the definition above for “primary care” or the state’s existing definition of “primary care.”

“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.
X.  (1) “Specialist” means a physician or non-physician health care professional who:
   (a) Focuses on a specific area of physical, mental or behavioral health or a group of patients; and
   (b) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) “Specialist” includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

Y. “Specialty care” means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions or those health conditions as they manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

Drafting Note: Some states may have an existing definition of “specialty care” in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term “specialty care” needs to be defined for purposes of this Act using the definition above for “specialty care” or the state’s existing definition of “specialty care.”

Z. “Telemedicine” or “Telehealth” means health care services provided through telecommunications technology by a health care professional who is at a [location] other than where the covered person is located.

Note to the Subgroup: The Subgroup had agreed to revisit whether the reference should be “location” or “site.”

Drafting Note: States should review the definition of “telemedicine” or “telehealth” for consistency with any state laws or regulations related to telemedicine or telehealth.

AA. “Tiered network” means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Drafting Note: Health carriers may use different terms for other than the term “tier” to refer to the type of network described in the definition above. State insurance regulators should be aware of this for purposes of the definition above and any changes a state may want to make to the definition above as a result, such as using another term or terms in place of or in addition to the term “tier.”

BB. “To stabilize” means with respect to an emergency medical condition, as defined in Subsection EF, 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 birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

CC. “Transfer” means, for purposes of Subsection BB 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.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act applies to all health carriers that offer managed care network plans.
The following provisions of this Act shall not apply to health carriers that offer network plans that consist solely of limited scope dental benefits plan or limited scope vision benefits plan:

1. Section 5A(2) of this Act;
2. Section 5F(2)(a), (3)(b) and (11) of this Act;
3. Section 6C of this Act;
4. Section 6L(2)(a)(i)(I) and (III) and (c)(iii)/(III) of this Act;
5. Section 8 of this Act;
6. Section 9B(2) and (3) of this Act; and
7. Section 9C(1)(a) and (b), (2) and (3) of this Act.

Drafting Note: In addition to Subsection B, states will need to consider what other types of health benefit plans subject to the insurance laws and regulations of this state that use networks should be subject to the requirements of this Act. States also may want to look at how the requirements in this Act could apply to other types of network plans in the state not subject to the state’s insurance laws and regulations.

Note to the Subgroup: The second sentence in the drafting note above is meant to address an outstanding issue of applying the Act’s network adequacy standards to other types of health benefit plans, such as Medicaid managed care plans, that use networks if the state has not developed other network adequacy standards for those types of 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 and the public its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity or health carrier shall file its standards with the state in the case of emergency services. The private accrediting entity shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults with serious, chronic or complex conditions, will be accessible without unreasonable travel or 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: Particular attention should be given to network sufficiency, marketing and disclosure, in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person’s choice of provider. State insurance regulators should carefully review filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.
B. **Sufficiency shall be determined** The commissioner shall determine **sufficiency** in accordance with the requirements of this section, and may be established **sufficiency** by reference to any reasonable criteria used by the carrier, which may include, but shall not be limited to:

1. provider-covered care provider-covered person ratios by specialty;
2. primary care provider-covered care-covered person ratios;
3. geographic accessibility of providers;
4. Geographic variation and population dispersion;
5. waiting times for appointments with participating providers;
6. hours of operation;
7. The ability of the network to meet the needs of covered persons, which may include low income persons, children and adults persons with serious, chronic or complex health conditions or physical or mental disabilities, and/or persons with limited English proficiency;
8. Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and
9. The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

**Drafting Note:** When determining criteria for evaluating network sufficiency provided in Subsection B, state insurance regulators also may want to consider a number of additional factors, such as the extent to which in-network participating providers are accepting new patients, the degree to which in-network participating physicians are authorized to admit patients to in-network participating hospitals and facility-based physicians are in-network—participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care. State insurance regulators also may conduct or review available periodic surveys of covered persons and providers to help inform their monitoring of network adequacy and make the results publicly available.

**Drafting Note:** State insurance regulators should consider establishing network sufficiency and accessibility standards that are specific to limited scope dental and/or vision benefits plans. Certain network sufficiency and accessibility requirements for comprehensive health benefit plans may not be appropriate for these type benefit plans. For example telehealth is not widely utilized in the dental and vision industry.

**Drafting Note:** 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), limits on travel distance to providers, limits on travel time to providers and limits on 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 an in-network cost sharing level, including by assuring that the covered person will not be subject to balance billing from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

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

Comment [JK18]: It was our understanding that the work group agreed to change this and other references to "covered persons" to specifically refer to "children and adults"

Comment [JK19]: We are proposing to change this language to specifically refer to "cost sharing levels" rather than "in-network level of benefits."

Comment [JK20]: This protection was dropped from the earlier Model and offers important consumer protections

Comment [JK21]: We suggest this clarification that the provider must have the appropriate expertise

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(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify in plain language about the reasonable process a covered person may use to request access to obtain a covered benefit from a non-participating 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 required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay.

Drafting Note: For purposes of this subsection, “specialized health care services or medical services” include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

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

(4) The process described in under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person’s condition.

Drafting Note: In order to determine what may be considered “in a timely fashion,” state insurance regulators may want to review the timeframes and notification requirements provided in its utilization review law or regulation.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Act nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier’s network delivery system options.

(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 and external claims grievance and appeals processes.

D. (1) The health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable proximity access of participating providers to the business or personal residence located near their home or business address 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 with the requisite expertise and training in the service area under consideration.

Comment [JK22]: Same as above

Comment [JK23]: This tweak in the language is to clarify that carriers should inform the covered persons of the process

Comment [JK24]: This was in the earlier draft but somehow got dropped. The sentence doesn’t make sense without it

Comment [JK25]: This is to clarify that consideration should be given to the availability of providers with the training to provide the covered benefit rather than simply the availability of any provider in the service area

Formatted: Highlight
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.

Note to the Subgroup: In deleting the reference to “financial capability,” the Subgroup had agreed to possibly add a provision in Section 6 to address the issue.

Drafting Note: If the commissioner determines that there is a deficiency in access to care for a limited scope dental and/or vision benefits plan, the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

Drafting Note: States will establish different requirements for the access plan. Paragraph (1) provides for this by giving states the option to require a health carrier to file the access plan with the commissioner for approval before use. Paragraph (1) also gives states the option to require a health carrier to file the access plan with the commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In states that require a health carrier to file access plans with the commissioner for review, the commissioner may want to consider, for example, whether access to specific types of providers or services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

Drafting Note: State insurance regulators should be aware that the intent of Paragraph (2) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is [proprietary, competitive or trade secret] information that shall not be made public. Likewise, 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, at its business premises, and shall provide them to any interested person upon request.

Drafting Note: State insurance regulators may want to consider defining “material change” for purposes of Paragraph (3) above. For example, a “material change” may be a certain percentage change, as determined by a state, in the carrier’s network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons, including children and adults with serious, chronic or complex health conditions. If it may be any change that renders the health carrier’s network non-compliant with one or more network adequacy standards, Types of...
changes that could be considered material could include: 1) a significant reduction in the number of primary or specialty care physicians available in a network; 2) a reduction in a specific type of provider such that a specific covered service is no longer available; 3) a change to the tiered, multi-tiered, layered or multi-level network plan structure; or 4) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

**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:** State insurance regulators 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, if applicable;

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 factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select (and or tier) providers;

5. The health carrier’s efforts to address the needs of covered persons, including, but not limited to, children and adults, those with limited English proficiency or illiteracy, those with diverse cultural and or ethnic backgrounds, and those with physical or mental disabilities, and those with serious, chronic or complex medical health conditions. This includes the carrier’s efforts, when appropriate, to include various types of ECPs in its network;

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

7. How the carrier uses telemedicine or telehealth or other technology to meet network access standards, if applicable;

8. The health carrier’s method of informing covered persons of the plan’s covered services and features, including but not limited to:
   a. The plan’s grievance and appeals procedures;
   b. Process for choosing and changing providers;
   c. Its process for updating its provider directories for each of its network plans;
   d. A statement of services offered, including those services offered through the preventative care benefit, if applicable; and
   e. Procedures for providing, covering and approving emergency, urgent and specialty care, if applicable.

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Comment [JK27]: We propose making the reference to telemedicine and telehealth a separate provision below in (7)

Comment [JK28]: We made minor revisions to this for ease of reading

Comment [JK29]: Per our comment above in (1)
Drafting Note: State insurance regulators should ensure that limited scope dental benefits plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.

Drafting Note: Some states may have an existing definition of “urgent care” in their state laws or regulations. Those states that have an existing definition of “urgent care” may want to consider including that definition in this Act.

(2)(8) The health carrier’s system for ensuring the coordination and continuity of care:
(a) [for covered persons referred to specialty physicians]; and
(b) [for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning];

(2)(9) The health carrier’s process for enabling covered persons to change primary care professionals, if applicable;

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

(11) The health carrier’s process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and

Drafting Note: If a limited scope dental and/or vision benefits plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision benefits plan shall comply with the Act’s requirements pertaining to hospitals and/or other type of facility.

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

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier’s efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called “access plan” for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental benefits plans on a health insurance exchange or exchange use the term “access plan.”

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. 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 deliver 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, without balance billing will continue until the earlier of:

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

Drafting Note: The reference to termination of coverage in Paragraph (1) above is meant to encompass all the ways a covered person’s coverage can be terminated. The grounds, conditions and effective date of termination are dictated by other provisions of law, which are outside the scope of this Act, such as for nonpayment of premium or the performance of an act or practice that constitutes fraud or an intentional misrepresentation of material fact in connection with the coverage. State insurance regulators should keep this in mind in implementing Paragraph (1).

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

Drafting Note: If a limited scope dental and/or vision benefits plan uses hospitals and/or other types of facilities in its provider network, then the limited scope dental and/or vision benefits plan shall comply with the Act’s requirements pertaining to hospitals and/or other type of facility.

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.

Drafting Note: Subsection D above provides that the obligation to hold the patient harmless for services rendered in the provider’s capacity as a network provider survive the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under Subsection L.

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 and tiering, as applicable, 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 participating 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) (a) Selection criteria shall not be established in a manner:

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

(ii) 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, including children and adults with serious, chronic or complex health conditions.

(b) (i) In addition to Subparagraph (a) of this paragraph, a health carrier’s selection criteria may not discriminate with respect to the participation under the health benefit plan against any provider who is acting within the scope of the provider’s license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (b)(i) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

Drafting Note: States should be aware that the provisions of Subparagraph (b) above are based in large part on the provisions of Section 2706(a) of the Public Health Service Act (PHSA). The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, issued on May 26, 2015, sub-regulatory guidance in the form of frequently asked questions (FAQs), which provides an enforcement safe harbor for health insurance issuers subject to Section 2706(a) of the PHSA. Specifically, in the Affordable Care Act Implementation FAQs Part XXVII, Q4 and Q5 issued May 26, 2015, the Departments restated their current enforcement approach to Section 2706(a) of the PHSA which is to not take any enforcement action against a health insurance issuer offering group or individual coverage, with respect to implementing the requirements of Section 2706(a) of the PHSA as long as the issuer is using a good faith, reasonable interpretation of the statutory provision.

(ii) Paragraphs (3)(a) and (3)(b)(3) shall not be construed to prohibit a provider 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) 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 sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider’s specialty or on the type of patient contained in the provider’s practice may discourage a person unwilling to change providers in the course of treatment.

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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. A consumer-friendly description of the standards shall be available to the public.

**Drafting Note:** State insurance regulators should review how a health carrier markets or represents its network plans to consumers. Particularly for those network plans that carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier’s provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

**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 to a provider that would encourage or otherwise incent the provider to provide or deliver 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 and appeals processes established by the carrier or a person contracting with the carrier in accordance with any rights or remedies available under applicable state or federal law.

**Drafting Note:** States should be aware that the term “participating provider” is meant to include a health care professional acting within the scope of their authority who may not be in the typical physician office setting or hospital setting, and may include licensed, certified, accredited or certified staff, such as patient care coordinators, operating under the supervision of a participating provider.

K. Every contract between a health carrier and a participating provider shall require the 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 health records and the covered person’s right to effective communication of medical and 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. The provider is removed or leaves the network without cause.

**Drafting Note:** In addition to when a provider is removed or leaves the network without cause, 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 provider’s removal or leaving the network within fifteen (15) working thirty (30) days of receipt or issuance of a notice of termination provided in accordance with

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Subparagraph (a) of this paragraph applies to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, being removed or leaving the network, irrespective of whether the termination was for cause or without cause.

(c) Where a contract termination involves the removal of 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 the notice of termination in accordance with Subparagraph (a) of this paragraph, 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, the following terms have the meanings indicated:

(i) “Active course of treatment” means:

(I) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;

(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

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

(iii) “Serious acute condition” means a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

(b) For purposes of Subparagraph (a)(i) of this paragraph, a patient covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an “active course of treatment.”

(c) (i) When a covered person’s provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under Paragraph (1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request care to be continued as provided for under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the patient covered person or the patient’s authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier’s Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for...
cause. Any decisions made with respect to a request for continuity of
care shall be subject to the health benefit plan’s internal and external
grievance and appeal processes in accordance with applicable state or
federal law or regulations:

(III) The continuity of care period for covered persons who are in their
second or third trimester of pregnancy shall extend through the
postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing
an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered
person or the treating provider;

b. [Ninety (90) days] unless the Medical Director determines that
a longer period is necessary;

c. The date that care is successfully transitioned to a participating
health care provider;

d. In-network benefit limitations under the plan are met or
exceeded; or

e. Care is determined to be no longer medically necessary by
the treating provider.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When
determining the length of time for the continuity of care period, states should consider the number of providers, especially
specialty providers who are available to treat serious health conditions in their states. States that have relatively few
specialists or when consumers face significant wait times for appointments may want to adjust the continuity of care time
frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may
only be granted when:

(I) The provider agrees in writing to accept the same reimbursement from
and abide by the same terms and conditions with respect to the health
carrier for that patient as provided in the original provider contract; and

(II) The provider agrees in writing not to seek any payment from the
covered person for any amount for which the covered person would not
have been responsible if the physician or provider were still a
participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision benefits plan participating provider, the
commissioner may work with the plan’s health carrier for approval of in-network reimbursement to the covered person until
the episode of care is concluded.

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 have been in-network participating at the time of enrollment or when a participating provider was listed as
accepting new patients, but was not accepting new patients at the time of enrollment.

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 or the other party without the prior written consent of the health
carrier or the other party.
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 at the time services are provided whether or not an individual is a covered person by the carrier if the individual is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

Drafting Note: There are situations that may arise when using the mechanism established in accordance with Subsection Q above when a participating provider has verified an individual’s eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation or situations that may arise due to enrollment timing issues and other issues that may arise under the federal Affordable Care Act (ACA). Providers in this situation are permitted to bill the individual for payment of services provided. states may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility.

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. (1) (a) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(b) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(c) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider’s network participation status on any health benefit plan in which the carrier has included the provider as participating.

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Section 7. Requirements for Participating Facility Providers with Out-of-Network Non-Participating Out-of-Network Facility-Based Providers at Participating Facilities

A. For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, such as a pathologist, anesthesiologist, emergency room practitioner, radiologist or other provider associated with health care services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility’s general business operations, and a covered person or the covered person’s health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

Drafting Note: States should carefully review the definition of "facility-based provider" above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.

B. Non-emergency out-of-network services.

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;
(b) That those facility-based providers may not have contracts with the covered person’s health carrier and are therefore considered to be out-of-network;
(c) That the service(s) therefore will be provided on an out-of-network basis;
(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible; and
(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person’s health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B of this Act.

(2) At the time of admission in the facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the out-of-network services written disclosure, as outlined in Paragraph (1), and obtain the covered person’s or the covered person’s authorized representative’s signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

C. Out-of-network emergency services.

(1) For out-of-network emergency services, the out-of-network non-participating facility-based provider shall include a statement on any remittance notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the remittance to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan’s allowable amount is over $500.00.

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by an out-of-network non-participating provider, which permit an out-of-network non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit an out-of-network non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph
(1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the Utilization Review and Benefit Determination Model Act (73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where non-participating facility-based provider sends remittance notices directly to a covered person for the out-of-network, non-participating facility-based provider’s service(s), the remittance notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is out-of-network with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan’s network. With regard to the remaining balance of this out-of-network bill, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan’s allowable amount is over [$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier’s out-of-network facility-based provider remittances process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Out-of-network, Non-participating facility-based providers may not attempt to collect remittances from covered persons when the provider has elected to trigger the health carrier’s out-of-network, non-participating facility-based provider remittances process described in Subsection E.

(4) Out-of-network, Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network, non-participating facility-based provider payments.

(1) Health carriers shall develop a program for payment of out-of-network, non-participating facility-based provider remittances submitted pursuant to this section.

(2) Health carriers may elect to pay out-of-network, non-participating facility-based provider remittances as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Out-of-network, Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

(4) This section does not preclude a health carrier and an out-of-network, non-participating facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for out-of-network, non-participating facility-based provider payments. Payments to out-of-network, non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier’s contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area and shall be presumed to be reasonable.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to out-of-network, non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers reasonable.
appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of payment rates for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of out-of-network non-participating facility-based provider remittances for providers objecting to the application of the established payment rate outlined in Subsection F.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

**Drafting Note:** Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

(3) Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the out-of-network non-participating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the out-of-network non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the out-of-network non-participating facility-based provider’s charges for the out-of-network service(s).

(5) A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report annually, and upon request, to the commissioner in the format specified by the commissioner.

**Drafting Note:** In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state...]

**Comment [JK34]:** We clarify here that a minimum the report should be submitted annually. But also recognize that some carriers may resist submitting the report beyond just the annual filing, and such information may be necessary in a Market Conduct review.
law that defines long-term care insurance, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person’s health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person’s plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person’s plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person’s plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or authorized representative of options available to access covered services from a participating provider.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a facility 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 facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person’s network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

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 facility-based health care professionals who are not in the same network as the facility. States may want to consider developing appropriate laws and regulations to apply notice and disclosure standards to facilities to advise covered persons of the potential for balance billing by non-participating providers performing covered services at those facilities.

Drafting Note: If a limited scope dental and/or vision benefits plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision benefits plan shall comply with the Act’s requirements pertaining to hospitals and/or other type of facility.
Section 9. Provider Directories

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

   (b) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) (a) The health carrier shall update each network plan provider directory at least monthly.

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 participating 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; and 2) establish a method or process, such as market conduct oversight, to closely monitor consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating that the provider is a participating provider, state insurance regulators should refer the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

   (b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

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

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

   (a) In consumer-friendly language, a description of the criteria the carrier has used to build its provider network;

   (b) If applicable, in consumer-friendly language, a description of the criteria the carrier has used to tier providers;

   (c) If applicable, in clear language, how the carrier designates the different provider tiers or levels in the network, and identifies for each specific provider, hospital or other type of facility in the network which tier each is in — for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier, and

   (d) If applicable, note that authorization or referral may be required to access some providers.

(5) (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

   (b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.
(6) For the pieces of information in a provider directory in Subsections B, C and D, about a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in searchable format or in print, upon request, the following provider directory information for each network plan:

(1) For health care professionals:
   (a) Name;
   (b) Gender;
   (c) Contact information;
   (d) Participating office location(s);
   (e) Specialty, if applicable;
   (f) Medical group affiliation, if applicable;
   (g) Facility affiliations, if applicable;
   (h) Languages spoken other than English, if applicable; and
   (i) Whether accepting new patients.

(2) For hospitals:
   (a) Hospital name;
   (b) Hospital type (i.e. acute, rehabilitation, children’s, cancer);
   (c) Participating hospital location and telephone number; and
   (d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:
   (a) Facility name;
   (b) Facility type;
   (c) Types of services performed; and
   (d) Participating facility location(s) and telephone number.

C. For the electronic provider directories, for each network plan, a health carrier shall include the information under Subsection B, for each category in Paragraphs (1) through (3), that includes search functions and additionally include, make available the following information, in addition to all of the information available under Subsection B:

(1) For health care professionals, information such as:

Comment [K38]: We agree with the consumer reps on their proposed revisions to subsections B and C, including the addition of a new subsection D. These changes will make it clearer which information needs to be available electronically, in searchable format, and in print upon request.
D. The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) For health care professionals:
   (a) Name;  
   (b) Contact information;  
   (c) Participating office location(s);  
   (d) Specialty, if applicable;  
   (e) Languages spoken other than English, if applicable; and  
   (f) Whether accepting new patients.

(2) For hospitals:
   (a) Hospital name;  
   (b) Hospital type (i.e., acute, rehabilitation, children’s, cancer); and  
   (c) Participating hospital location and telephone number; and

(3) For facilities other than hospitals:
   (a) Facility name;  
   (b) Facility type;  
   (c) Types of services performed; and  
   (d) Facility location(s).

Comment [JK39]: We recommend that “clinical” be changed to “medical” to clarify that the staff should be those who are providing medical care to the covered person, rather than anyone who works in the office.
(a) Facility name;
(b) Facility type;
(c) Types of services performed; and
Participating facility location(s) and telephone number.

Drafting Note: In addition to the information provided in Subsections B and C, and D, health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination and diagnostic equipment and availability of programmatic accessibility.

Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision benefits plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision benefits plans.

Section 710. 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. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

I. Notwithstanding any other provision of this section, the health carrier shall retain full responsibility for the intermediary’s compliance with the requirements of this Act.
Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

### Section 811. Filing Requirements and State Administration

A. **Beginning [insert effective date]** At the time a health carrier files its access plan, the health carrier shall file [for approval] 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 Act or implementing regulations to the commissioner [for approval] at least [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.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file contracts and material changes 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 contract or a material change to a contract by a health carrier, the contract or 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 912. 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 1013. Enforcement

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

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

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

### Section 1414. 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 1415. Penalties

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

### Section 1416. 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 1417. 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].

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].

D. Transition period for compliance with amended Section 5 of this Act.

Option 1.

For states with access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.
Option 2.

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