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January 12, 2015

Mr. J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Network Adequacy Model Review (B) Subgroup
c/o 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 on NAIC's Proposed Revisions to the Managed Care Plan
Network Adequacy Model Act (#74)**

Dear Ms. Matthews:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments to the National Association of Insurance Commissioners' (NAIC) Regulatory Framework (B) Task Force's Network Adequacy Model Review (B) Subgroup's proposed revisions to the Managed Care Plan Network Adequacy Model Act (#74).

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society (ACS), supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Approximately 1.66 million new cases of cancer are expected to be diagnosed in the United States in 2015.¹ Cancer patients – including those who are newly diagnosed, in active treatment, and survivors – often need access to specialists (e.g., oncologist, surgeon, radiologist – including subspecialists). Even short gaps in coverage – or delayed access to care – can lead to significant disruptions in care for individuals with cancer and can result in negative health outcomes. That is why it is so critical that issuers offer robust networks of providers and for issuers to allow individuals access to out-of-network services, when medically appropriate. ACS operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals whose cancer treatments are delayed due to problems associated with their health insurance coverage – in particular, problems accessing needed specialist.

Cancer treatments can be very expensive and cancer patients incur significantly more out-of-pocket costs compared to individuals with no history of cancer. The average annual out-of-pocket costs (excluding health insurance premiums) for an adult under age 65 without a history of cancer is \$590. An individual who is recently

¹ American Cancer Society, Cancer Facts and Figures 2015, available at <http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044552.pdf>.

diagnosed with cancer will spend an average of \$1,463 in out-of-pocket costs (excluding premiums) and an individual who previously was diagnosed with cancer will spend an average of \$1,182 in out-of-pocket costs (excluding premiums).²

ACS CAN supports the NAIC's efforts to revise and update its Network Adequacy Model Act to ensure that consumers have access to the providers, products, and services they need when medically necessary. We join other groups in offering revisions designed to improve the Model Act to be more consumer-friendly. Our red-lined comments are attached to this letter. The following summarizes our red-lined comments on the revised Network Adequacy Model Act:

Network Adequacy

ACS CAN applauds the NAIC for requiring plans to maintain a network that is sufficient to provide enrollees with access to a sufficient number and type of providers (including primary, specialty, and subspecialty providers) to meet the needs of the enrollees.

Tiered networks: As more health plans adopt tiered networking arrangements, it is important that state laws and regulations reflect this fact. Many plans utilize a tiered network for providers. Cancer patients often need to utilize providers in higher network tiers – like cancer centers of excellence or specialized oncologists – but are unable to do so due to the higher cost-sharing associated with higher tiers. We urge the NAIC to encourage states to review a plan's tiered network to ensure that the plan is not discouraging individuals with certain diseases or conditions, like cancer, from enrolling in a plan by placing access to all specialized providers in the highest tier.

Sufficiency of the network: ACS CAN urges the NAIC to adopt quantitative criteria to ensure that a plan's network meets a minimum sufficiency standard. Specifically, ACS CAN recommends the NAIC include a minimum ratio of providers to covered persons for primary care physicians and specialists (including subspecialists); minimum number of full-time providers to meet the needs of individuals with limited English proficiency; and, a maximum time and distance standard to access hospital, emergency care, diagnostic and ancillary services. Individuals who enroll in a health plan must be ensured that their plan provides basic coverage for their health care needs – including access to oncology services, if necessary.

Access plans: ACS CAN urges the NAIC to include in its Model Act requirements that plans must submit to a state insurance commissioner an access plan that stipulates how the plan intends to meet the network adequacy requirements. Plans should be required to provide this information on a prospective basis and require the insurance commissioner's prior approval of the access plan (Option One). ACS CAN urges the NAIC to remove its proposal (Option Two) to allow states to permit a health plan to simply maintain an access plan on file and make the plan available to the insurance commissioner if requested.

Out-Of-Network Services

Cancer patients often need to access out-of-network specialized providers for their cancer treatment. However, many health plans do not provide any coverage for out-of-network services, making it difficult for cancer patients to access specialized out-of-network services without significant out-of-pocket costs. Last year ACS CAN conducted an analysis to determine the extent to which qualified health plans (QHPs) offered in the Marketplace provided adequate provider networks for oncologist services and the availability of out-of-network coverage.³ Our analysis revealed that overall 43 percent of the unique silver QHPs available through the federally-facilitated

² Guy GP, Ekwueme DU, Yabroff KR, et al. Economic burden of cancer survivorship among adults in the United States. *J Clin Oncol* 31:3749-3757, 2013.

marketplace on healthcare.gov, Covered California, and NY State of Health did not offer any out-of-network coverage.

We support the NAIC's proposed revisions to require that plans maintain a process to allow plan enrollees the ability to obtain a covered benefit from a non-participating out-of-network provider. We urge the NAIC to clarify that, in these instances, individuals should have their cost-sharing count toward their maximum out-of-pocket limit.

Balance billing: We are concerned that individuals who utilize out-of-network services are subject to balance billing, which occurs when the out-of-network provider's costs exceed the issuer's in-network payment rate, leaving the individual responsible for the difference (in addition to any cost-sharing required by the insurer). Balance billing charges can be quite significant – particularly if the issuer provides no or nominal reimbursement for a service, leaving the enrollee to essentially cover the entire cost of the service. We urge the NAIC to require that a facility that is designated as being in-network be prohibited from balance billing for any services provided by an out-of-network health care professional employed or contracted by the facility.

Second opinions: For serious conditions like cancer, individuals often need access to a second opinion regarding their treatment options. We urge the NAIC to require that in such instances enrollees be permitted to obtain a second opinion from an out-of-network provider for the price of in-network cost-sharing if no alternative in-network provider is available, qualified, or within a reasonable distance. If the first and second opinions are in conflict, the carrier should be required to cover a third option.

Appeals

Some individuals with rare conditions – like some cancers – need access to specific specialized providers, who may not be included in a plan's network. ACS CAN urges the NAIC to include in its Model Act an appeals mechanism to allow consumers the ability to access providers – including specialist care and subspecialty care if needed. The appeals provisions should contain requirements by which the plan must act on any appeals request, including an expedited appeals process requiring the carrier to notify the provider and enrollee of its decision within 24 hours in cases where the enrollee has an emergency medical condition.

Plans should be required to keep a log of any appeals filed by an enrollee. We note that similar provisions exist in the Medicare program. States should review this log as a check and balance on the adequacy of a plan's network.

Continuity of Care

Cancer patients rely on the expertise of a specialized provider (e.g., an oncologist, radiation oncologist, and surgeon) throughout their cancer journey (from point of diagnosis, through active treatment, to survivorship). Switching providers during the course of active treatment can disrupt a patient's care and could jeopardize the outcome. We urge the NAIC to provide additional safeguards to ensure that individuals with serious medical conditions, like cancer, who are currently in active treatment have access to their provider throughout the course of their treatment.

Provider Directories

ACS CAN supports provisions that require plans to provide accurate and current provider directories. These directories should provide consumers – both current enrollees in the plan as well as prospective enrollees – with

³ American Cancer Society Cancer Action Network, [Cancer Care and the Adequacy of Provider Networks Under the ACA Marketplace Plans](http://www.acscan.org/content/wp-content/uploads/2014/07/ACS-CAN-Cancer-providers-and-QHP-Networks.pdf), (June 2014), available at <http://www.acscan.org/content/wp-content/uploads/2014/07/ACS-CAN-Cancer-providers-and-QHP-Networks.pdf>.

information they need to determine what providers are covered by the plan, including whether a provider is accepting new patients. Simply listing that a provider is included in the plan's network is insufficient.

Plans directories should be written in plain language so that the average consumer is able to determine which providers are included in the plan's network. We have heard from individuals who have expressed frustration that the provider directories contain inaccurate information. In one instance, an individual specifically chose a plan based in part on the hospital covered by the plan. This individual (and the hospital) believed the hospital to be included in the plan's network. After the individual underwent a procedure she was informed that the hospital was not included in the plan's network and thus the individual was assessed thousands of dollars in out-of-pocket costs. In this case, the provider directory for the plan listed fewer providers (including the specific hospital) depending on whether the individual logged into the site as a member versus visiting the site as a guest.

In addition, plans should list specialty and subspecialty of each provider, if applicable. Earlier this year, ACS CAN conducted an analysis to determine the extent to which cancer patients could obtain information regarding whether a plan contracted with a particular oncologist.⁴ Our analysis revealed that in general plans provided coverage of oncologists, but that it was often difficult to determine the number and range of oncology-related providers included in a plan's network.

Disclosure and Notice Requirements

The revised Model Act requires issuers to provide written disclosure or notice for a covered benefit that is provided at an in-network hospital when there is the possibility that the covered person could be treated by a provider that is not included in the hospital's network. While we support the NAIC's notice and disclosure requirement, we urge the NAIC also to consider requiring issuers to notify consumers of any options available to them for access to an in-network provider. Simply informing the consumer that s/he may be liable for significant charges for anesthesia services, for example, fails to provide appropriate consumer protections.

In addition, we urge the NAIC to require that States actively monitor the extent to which carriers are issuing written disclosures or notices. States should take this information into account when determining whether a plan meets the network adequacy requirements.

⁴ Id.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the Regulatory Framework (B) Task Force's Network Adequacy Model Review (B) Subgroup's proposed revisions to the Managed Care Plan Network Adequacy Model Act (#74). If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

A handwritten signature in cursive script that reads "Dick Woodruff".

Dick Woodruff
Vice President, Federal Relations and Strategic Alliances
American Cancer Society Cancer Action Network

Draft: 11/12/14
Model#74

**MANAGED-CAREHEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY
MODEL ACT**

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Section 1. Title

This Act shall be known and may be cited as the Managed-CareHealth 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:

- and
- A. establish~~Establish~~ standards for the creation and maintenance of networks by health carriers;
 - B. to assure~~Assure~~ the adequacy, accessibility, transparency and quality of health care services offered under a managed-care~~network~~ plan by;

(1) ~~establishing~~Establishing requirements for written agreements between health carriers offering ~~managed-care~~network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide ~~services~~covered benefits to covered persons; and

(2) Requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks.

NOTE TO SUBGROUP: SUBGROUP AGREED TO RETURN TO THIS SECTION TO CONSIDER POSSIBLE ADDITIONAL REVISIONS.

Drafting Note: In states that regulate prepaid health services, this ~~model~~Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to ~~enrollees~~covered persons.

Section 3. Definitions

For purposes of this Act:

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

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

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

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

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

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

by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect, in the absence of immediate medical attention, to result in:

- (1) Placing the individual's health or, with respect to a pregnant woman, the woman's or her unborn child's health in serious jeopardy;
- (2) Serious impairment to a bodily function;
- (3) Serious impairment of any bodily organ or part; or
- (4) With respect to a pregnant woman who is having contractions:
 - (a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - (b) That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

- (1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and
- (2) Any further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

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

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

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

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

HJ. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

IJ. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate “persons.”

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

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

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

LM. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the Public Health Service Act (PHSA) defines the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” above is consistent with the definition of “health insurance issuer” in Section 2791(b)(2) of the PHSA.

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

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

NO. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

~~Q. “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.~~

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

~~Q. “Network plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.~~

~~**Drafting Note:** The definition of “network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs and including accountable care organizations (ACOs) and other models of health care delivery systems. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the difference between in-network and out-of-network cost-sharing or the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.~~

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

~~Q. “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.~~

R. “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.

- S. "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.
- T. "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.
- U. "Specialty provider" means a provider who provides specialized services. The term can be used to describe a physician or health care professional (e.g., surgeon) as defined by the American Board of Medical Specialties list of approved medical boards. The term also can be used to describe a facility offering specialized services (e.g., cancer center).
- V. "Telemedicine" or "Telehealth" means covered benefits provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology.
- ∇W. "Tiered provider network" or "tiered network" means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered person or provider behavior."
- WX. "To stabilize" means with respect to an emergency medical condition, as defined in Subsection E, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in Subsection E(4), to deliver, including the placenta.
- WXY. "Transfer" means, for purposes of Subsection V, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:
- (1) Has been declared dead; or
 - (2) Leaves the facility without the permission of any such person.

GENERAL NOTE: DURING ITS DISCUSSIONS ON REVISIONS TO THIS SECTION, THE SUBGROUP CONSIDERED INCLUDING AND DEFINING THE TERMS "ANCILLARY SERVICES," "PREFERRED PROVIDER," "PROVIDER CONTRACT," "SERVICE AREA," AND "TIERED PROVIDER NETWORK." THESE TERMS ARE NOT INCLUDED IN THIS REVISED SECTION BECAUSE EITHER THEY WERE NOT USED IN THE SUBSTANTIVE PROVISIONS OF THE REVISED

MODEL ACT OR DID NOT NEED TO BE DEFINED. HOWEVER, ANYONE MAY SUBMIT ADDITIONAL COMMENTS ON WHETHER THESE TERMS SHOULD BE INCLUDED AND DEFINED.

Section 4. Applicability and Scope

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

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

Section 5. Network Adequacy

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

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

Drafting Note: States ~~may want to~~should pay particular attention to network sufficiency, marketing and disclosure issues that may arise with respect to certain health carrier network designs, such as so-called "tiered networks." Tiered networks may be designed, marketed and sold in different ways. Regulators should review what information carriers are providing to consumers on a particular tiered network at the time of sale. In some cases, the network may be designed such that not all covered services are provided in every tier. Regulators should pay close attention to ensuring that the benefits promised to the consumer by the carrier can be accessed without unreasonable travel or delay through a provider in the lowest cost-sharing tier. States could consider a variety of regulatory options including taking no additional action, requiring additional disclosures or requiring additional scrutiny of tiered networks.

B. (1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: Such requirements must include quantitative criteria and any other requirements that the commissioner deems appropriate. When developing its quantitative criteria, the commissioner must incorporate the following:

- (1) ~~provider covered~~ Provider covered person ratios by specialty;
- ~~primary~~ Primary care provider covered person ratios;
- (3) ~~geographic~~ Geographic accessibility;
- (4) ~~Geographic population dispersion;~~
- (5) ~~waiting~~ Waiting times for appointments visits with participating providers;
- (6) ~~hours~~ Hours of operation;
- (7) ~~New health care service delivery system options, such as telemedicine or telehealth;~~
and
- (8) ~~the~~ The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

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

(2) The Department shall consider the following factors in the access standards identified in Section 5(B)(1):

- (a) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.
- (b) Maximum allowable wait times for an appointment with a primary care physician, specialist, and other health care provider.

- (c) Regular assessment of provider capacity, including the availability of providers to accept new patients.
- (d) The breadth of hours of operation for network providers.
- (e) The quality measures used to evaluate providers for network inclusion.
- (f) The ability of physicians to admit patients to in-network hospitals.

(3) All requirements of the regulations to be issued under Section 5(A)-(B) shall be applied to the lowest cost-sharing tier of any tiered network.

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

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

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

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

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

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

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

- (b) The health carrier:
- (i) Does not have a network provider of the required specialty or subspecialty with the professional training and expertise and experience to treat or provide health care services for the condition or disease; or
 - (ii) Cannot provide reasonable access to a network provider with the professional training and expertise and experience to treat or provide health care services for the condition or disease without unreasonable delay.
- (3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider, including by counting the covered person's cost-sharing toward the maximum out-of-pocket limit.
- (4) (a) The process described in C(1) and C(2) of this section must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person's life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.
- (b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list:
- (i) all such requests;
 - (ii) the name of the covered person involved;
 - (iii) the name and address of the provider making the request;
 - (iv) whether the request or was approved or denied;
 - (v) the date of approval or denial; and,
 - (vi) the relevant authorization number, if the request was approved.
- (5) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person's request to access an out-of-network provider using the alternate process is denied by the carrier.

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

monitoring consider how often the alternate process is being used as a potential indicator of an inadequate network.

D. ~~(2)~~(1) ~~The~~A health carrier shall establish and maintain adequate arrangements to ensure reasonable ~~proximity~~access of participating providers to the business or personal residence of covered persons. In determining whether ~~at~~the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

~~(3)~~(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

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

~~EF.~~ Option 1. ~~_____~~ Prior Approval of Access Plan

(1) ~~_____~~ Beginning [insert effective date], a health carrier shall ~~file with~~submit to the commissioner for approval prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the ~~managed care network~~ plans ~~that~~ the carrier offers in this state.

Drafting Note: States will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to submit the access plan to the insurance commissioner for prior approval. Some states may prefer that a health carrier file the access plan with the insurance commissioner, but not require that the insurance commissioner take any action on the plan. This is Option 2 of Paragraph (1) below. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

Option 2. ~~_____~~ Filing of Access Plan

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

Drafting Note: States will establish different requirements for the access plan. Option 2 of Paragraph (1) above requires a health carrier to file the access plan with the insurance commissioner, but does not require the commissioner to take action on the plan. Some states may want require the commissioner's approval of access plans, which is in Option 1 of Paragraph (1). Other states may prefer that a health carrier not file the access plan with the insurance commissioner but, instead maintain the plan on file at the health carrier's place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, ~~or competitive~~ or trade secret] information that shall not be made public. ~~For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information.~~ The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, on its business premises and shall provide them to any ~~interested party~~person upon request.

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

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

(3) The carrier shall prepare an access plan prior to offering a new ~~managed care~~network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The health carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an updated an existing access plan ~~whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:~~

Drafting Note: States may want to consider defining "material change" for purposes of Paragraph (3) above as "a change in the composition of a health carrier's provider network (including any changes to tiering structure, if applicable) and/or any change that renders the health carrier's network non-compliant with one or more of the network adequacy standards set forth in Section 5 of this Act or any rules adopted or promulgated pursuant to that section.

Drafting Note: ~~Different states will set different requirements for the access plan. This model requires a health carrier to file the plan with the insurance commissioner but does not require the commissioner to take action on the plan. Some states may want to require the commissioner's approval of access plans; other states may prefer that a health carrier not file the access plan with the commissioner but instead maintain the plan on file at the carrier's place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.~~

Drafting Note: States should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

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

- (1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards;
- (2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;
- (3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed-care network plans;
- (4) The health carrier's process for making available in consumer-friendly language the criteria it has used to build its provider network (including information about the breadth of the network and the criteria used to select and/or tier how it selects/tiers providers), which must be made available through the health carrier's on-line and in-print provider directories;
- ~~(4)~~(5) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- ~~(5)~~(6) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- ~~(6)~~(7) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, its process for updating its provider directories for each of its network plans, a statement of services offered, including those services offered through the preventative care benefit, if applicable, and its procedures for providing and approving emergency and specialty care;
- ~~(7)~~(8) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- ~~(8)~~(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- ~~(9)~~(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers,

or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

~~(10)~~(11) Any other information required by the commissioner to determine compliance with the provisions of this Act.

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

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. A health carrier shall ensure via contract with a facility that is a network provider that a covered person will not be subject to balance billing for health care services provided in that facility by an out-of-network health care professional employed by or under contract with the facility.

- ED. (1) Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered ~~services~~benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater.
- (2) ~~After the period for which premium has been paid, Covered~~covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the earlier of:
- (a) The effective date of new health benefit plan coverage; or
- (b) Their discharge from the inpatient facility because their continued confinement in ~~an~~the inpatient facility is no longer medically necessary.

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

- ED. 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~~benefits provisions required by Subsections B and C of this section.
- EF. 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.
- FG. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for ~~primary care professionals~~providers and each health care professional specialty.
- (2) (a) The standards shall be used in determining the selection or tiering of ~~health care professionals~~providers by the health carrier, and its intermediaries ~~and any provider networks~~ with which it contracts.
- (b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].
- (3) Selection or tiering criteria shall not be established in a manner:

- (a) That would allow a health carrier to ~~avoid discriminate against~~ high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; ~~or~~
 - (b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or
 - (c) That fails to take into account provider performance on quality metrics and patient outcomes.
- (2)(4) Paragraphs ~~(1)(a) and (1)(b)(3)~~ shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.
- (3)(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers ~~or types of providers acting within the scope of their license or certification under applicable state law~~ that may meet their selection criteria, or to contract with or retain more providers ~~or types of providers acting within the scope of their license or certification under applicable state law~~ than are necessary to maintain ~~an adequate~~ 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 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.

- GH. A health carrier shall make its ~~selection~~ standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner and available to the public on its website.

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.~~

- HJ. 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.
- IJ. A health carrier shall not offer an inducement or penalty under the managed care plan to a provider to provide less than medically necessary services to a covered person.
- JK. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier.

Drafting Note: States should be aware that the term "participating provider" is meant to include providers who may not be in the typical physician office setting or hospital setting, such as patient care coordinators.

- KL. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.
- LM. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.

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

(b) The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working~~thirty (30)~~ days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

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

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

~~(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has a limited duration.”~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(ii) The contract termination was not "for cause."~~

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

~~(i) The next plan renewal date; or~~

~~(ii) The course of treatment ends.~~

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

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

MN. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

Drafting Note: In order to assure continued provider participation, a state may wish to restrict the right of a health carrier to assign or delegate its contract with a provider without prior written notice to the provider.

NO. 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.

- OP. 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.
- PQ. 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.
- QR. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person an individual is covered by the carrier.
- RS. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.
- ST. 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.
- TU. A health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions at the time the contract is executed and of any material changes in the contract.

Section 7. Disclosure and Notice Requirements

- A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. Such disclosure shall include whether a health care provider scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount of cost-sharing (including deductibles, copayments, and coinsurance) that the covered person would be required to pay under his or her plan with respect to the furnishing of a specific item or service (including out-of-network services).
- B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person's network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. Such disclosure shall include an estimate of

the approximate charges that may be billed to the covered person for services provided by a non-participating provider.

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

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to hospital-based providers who are not in the same network as the in-network hospital. States should actively monitor the extent to which carriers are issuing written disclosures and notices and take this information into account when determining the adequacy of a plan's network.

Section 8. Provider Directories

- A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. In making a directory available online, the carrier shall do so in a manner that:
- (a) Makes it clear what provider directory applies to which network plan to the maximum extent possible; and
 - (b) Does not require a covered person or prospective covered person to log in or enter a policy number in order to access the applicable provider directory.
- (2) The health carrier shall update each network plan provider directory at least monthly and it shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.
- (3) A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.
- (4) For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory, the following general information:
- (a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;
 - (b) The methodology used, if any, for determining the payment amount for out-of-network services and the covered person's liability for additional costs;
 - (c) The breadth of the network;

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

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

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

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

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Contact information;

(d) Specialty (including subspecialty, if applicable); and

(e) Network tier to which the professional is assigned, if applicable; and,

(f) Whether accepting new patients (and if the provider has multiple locations, whether new patients are only accepted at specific locations).

(2) For hospitals:

(a) Hospital name;

(b) Hospital location and telephone number; and

(c) Hospital accreditation status; and

(d) Network tier to which the hospital is assigned, if applicable.

(3) Except hospitals, other facilities by type:

- (a) Facility name;
- (b) Facility type;
- (c) Procedures performed; ~~and~~

- (d) Network tier to which the facility is assigned, if applicable; and
- (~~e~~) Facility location and telephone number.

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

- (1) The health care professional information in Subsection B(1) that includes search functions and instructions for accessing additional information on the health care professional, such as:
 - (a) Hospital affiliations;
 - (b) Medical group affiliations;
 - (c) Board certification(s);
 - (d) Languages spoken by the health care professional or clinical staff; and
 - (e) Office location(s);
- (2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:
 - (a) Hospital name; and
 - (b) Hospital location; and
- (3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:
 - (a) Facility name;
 - (b) Facility type;
 - (c) Procedures performed; and
 - (d) Facility location.

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

D. In any instance in which a covered person receives covered benefits from a non-participating provider due to a material inaccuracy in the provider directory indicating that the provider is a participating provider, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider.

Section 79. Intermediaries

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

- A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.
- B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
- C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.
- E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.
- F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

- G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.
- H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

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

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

Section 810. Filing Requirements and State Administration

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

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

- B. A health carrier shall submit material changes to a contract that would affect a provision required ~~by this statute~~under this Act or implementing regulations to the commissioner for [filing] [approval within [cite period of time in the form approval statute]] within [x] days prior to use. ~~Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.~~

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

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

- C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.
- D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies

to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 911. Contracting

- A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.
- B. All contracts shall be in writing and subject to review.

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

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

Section 1012. Enforcement

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

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

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

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

| **Section ~~11~~13. Regulations**

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

| **Section ~~12~~14. Penalties**

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

| **Section ~~13~~15. Separability**

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

| **Section ~~14~~16. Effective Date**

This Act shall be effective [insert date].

- A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.
- B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.
- C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].