

PROVISION TITLE: Network Adequacy Standards

CITATION: PHSA §2702 (c) & §156.230

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must meet minimum criteria for adequacy of provider networks delivering covered services to covered persons.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs),

The purpose of the network adequacy provisions of the federal Affordable Care Act is to assure the adequacy, accessibility, transparency and quality of health care services provided to covered individuals in individual and group market health insurance network plans. Pursuant to 45 C.F.R. 156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.

This provision applies to all health carriers in the individual market and to group plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for guidance.

NOTES:

STANDARDS NETWORK ADEQUACY

Standard 1

A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay.

Apply to: All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

- _____ Health carrier policies and procedures related to network adequacy and plan design
- _____ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria
- _____ Documents related to physician recruitment
- _____ Provider directory/listing
- _____ Health carrier policy/plan design for in network/out of network coverage levels
- _____ Provider/member location reports (e.g. by ZIP code)
- _____ List of providers by specialty
- _____ Any policies or incentives that restrict access to subsets of network specialists
- _____ Electronic tools used to assess the health carrier's network adequacy (e.g. GeoAccess®)
- _____ Complaint register/logs/files regarding inadequate networks and out of network service denials
- _____ Health carrier complaint records concerning network adequacy and plan design (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- _____ Health carrier marketing and sales policies and procedures' references to network adequacy and plan design

_____ Health carrier communication and educational materials related to network adequacy and plan design provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding network adequacy and plan design of individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults will be accessible without unreasonable travel or delay, in compliance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to give particular attention 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. Examiners need to carefully review health carrier network 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.

A state insurance commissioner determines network sufficiency in accordance with applicable state statutes, rules and regulations. Note: With regard to conflict of network adequacy provisions in state statutes, rules and regulations with final guidance on network adequacy set forth by HHS, the DOL and the Treasury, examiners may need to consult with state insurance department legal staff, regarding whether state provisions add to or create a more generous benefit than the network adequacy health reform requirements in final regulations established by HHS, the DOL and the Treasury, and are thus not preempted, as set forth in federal law.

Verify that the health carrier has established and implemented written policies and procedures to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the insurance commissioner of the applicable state, when:

- The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or
- The health carrier has an insufficient number or insufficient type of participating provider (e.g. specialists) available to provide the covered benefit to the covered person without unreasonable travel or delay.

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider when:

- The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
- The health carrier:
 - Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - Cannot provide reasonable access to a participating 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 travel or delay.

Verify that with regard to the process in which a covered person may use to request access to obtain a covered benefit from a non-participating provider, the health carrier addresses requests to obtain a covered benefit from a non-participating provider in a timely fashion appropriate to the covered person's condition. In order to determine what may be considered "in a timely fashion," examiners may wish to review the timeframes and notification requirements in applicable state statutes, rules and regulations regarding utilization review.

Verify that the health carrier treats the health care services the covered person receives from a non-participating provider as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request.

Note: Examiners need to be aware that the process which a covered person uses to request access to obtain a covered benefit from a non-participating provider is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with applicable state statutes, rules and regulations, 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. A covered person is not precluded from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Verify that the health carrier establishes and maintains adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the insurance commissioner of the applicable state may give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

Verify that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to network adequacy and plan design.

Review complaint records to verify that if the health carrier has not met minimum network adequacy standards or has improperly applied network adequacy standards, the health carrier has taken appropriate corrective action/adjustments regarding the removal of network adequacy limitations for the covered person(s) in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about network adequacy.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network adequacy.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network adequacy.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

DRAFT

STANDARDS NETWORK ADEQUACY

Standard 2

A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.

Apply to: All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier policies and procedures related to content of access plans

_____ Health carrier policies and procedures related to filing of access plans and material changes to access plans

_____ Copy of access plan filed in the applicable state and copy of access plan in use by health carrier

_____ Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network, with the insurance commissioner of the applicable state, for individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that a health carrier files with the insurance commissioner of the applicable state for review (or for approval) prior to or at the time it files a newly offered network, in a manner and form defined by rule of the insurance commissioner, an access plan meeting the requirements of applicable state statutes, rules and regulations regarding network adequacy.

Note: Examiners need to be aware that requirements for access plans will vary by state. A state may require that a health carrier file access plans with the insurance commissioner of the applicable state for approval before use, or a state may require a health carrier to file access plans with the insurance commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In addition, a health carrier may request an insurance commissioner to deem sections of an access plan as [proprietary, competitive or trade secret] information that shall not be made public. Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request. Information is considered [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information. Applicable state statutes, rules and regulations should be reviewed to determine which term "proprietary," "competitive" or "trade secret" is being used in the applicable state.

Verify that when a health carrier prepares an access plan prior to offering a new network plan, the health carrier notifies the insurance commissioner of the applicable state of any material change to any existing network plan within fifteen (15) business days after the change occurs. Verify that the notice to the insurance commissioner provided by the health carrier includes a reasonable timeframe within which the health carrier will submit to the insurance commissioner, for approval or file with the insurance commissioner, as appropriate, an update to an existing access plan.

Note: Examiners need to be aware that the definition of "material change" will vary by state. For example, a "material change" may be a certain percentage change, as determined by a state, in the health 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 or it may be any change that renders the health carrier's network noncompliant with one or more network adequacy standards.

Verify that the health carrier's access plan describes or contains at least the following:

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

- The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;
- 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;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;
- The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:
 - The plan's grievance and appeals procedures;
 - Its process for choosing and changing providers;
 - Its process for updating its provider directories for each of its network plans;
 - A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
 - Its procedures for covering and approving emergency, urgent and specialty care, if applicable (Note: Examiners need to be aware that a state may have an existing definition of "urgent" care in applicable state statutes, laws and regulations.)
- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
 - For covered persons referred to specialty physicians; and
 - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- 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 transitioned to other providers in a timely manner;
- 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 the health carrier's participating hospitals. (Note: Examiners need to be aware that if a limited scope dental and/or vision uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with applicable state statutes, rules and regulations regarding network adequacy pertaining to hospitals and/or other type of facility); and
- Any other information required by the insurance commissioner of the applicable state to determine compliance with applicable state statutes, rules and regulations regarding network adequacy.

Note: Examiners need to be aware that for dental network plans, some states 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. Examiners, however, need to be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term “access plan.”

General Review Procedures and Criteria

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network access plans.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network access plans.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network access plans.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network access plans.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

STANDARDS NETWORK ADEQUACY

Standard 3

A health carrier’s contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes, rules and regulations.

Apply to: All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier policies and procedures related to contractual arrangements between health carriers and participating providers

_____ Provider contracts

_____ Network plans

_____ Complaint register/logs/files relating to administrative, payment or other complaints/disputes made by participating providers relating to health carrier/participating provider contractual arrangements

_____ Health carrier complaint records concerning health carrier/participating provider contractual arrangements (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response/resolution)

_____ Health carrier communication and educational materials related to health carrier/participating provider contractual arrangements provided to participating providers

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with requirements relating to health carrier/participating provider contractual arrangements, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established a mechanism by which a participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons. This requirement can be met by including a provision within the contract, 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.”

Verify that contracts between the health carrier and a participating provider 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 without balance billing will continue until the earlier of:

- 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 an active course of treatment or totally disabled. (Note: Examiners need to be aware that the reference to termination may encompass all the circumstances in which a covered person’s coverage can be terminated, e.g. nonpayment of premium, fraud or intentional misrepresentation of material fact in connection with the coverage); or

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

Note: Examiners need to be aware that contractual arrangements between health carriers and providers that satisfy the above requirements (1) are to be construed in favor of the covered person, (2) shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and (3) 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 as set forth in the above standards relating to health carrier/provider contractual requirements. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except in the event that a network relationship is extended to provide continuity of care.

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting and tiering, as applicable, of participating providers. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts. Verify that the selection standards meet the requirements of applicable state statutes, rules and regulations equivalent to the Health Care Professional Credentialing Verification Model Act.

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

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

Verify that the health carrier's selection criteria does not discriminate, with respect to 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. Note: Examiners need to be aware that a health carrier is not prohibited from declining to select a provider who fails to meet other legitimate selection criteria of the health carrier. The provisions of applicable state statutes, rules and regulations regarding network adequacy do not require a health carrier, its intermediaries or the provider networks with which they contract (1) to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or (2) to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network.

Verify that the health carrier makes its standards for selection and tiering, as applicable, of participating providers available for review [and approval] by the insurance commissioner of the applicable state.

Verify that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, is made available to the public.

Note: Examiners need to review how a health carrier markets or represents its network plans to consumers, particularly for those network plans that health 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, examiners also need to 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.

Verify that the health carrier notifies 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.

Verify that the health carrier does not offer an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does 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 health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state or federal law.

Verify that contracts between a health carrier and a participating provider 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 applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

Verify that for providers who have asked to be removed from the network, the health carrier maintains and can provide examiners with such notices received from the provider.

With regard to providers who have been asked by the health carrier to no longer be part of the network, verify that the health carrier maintains and can provide to the examiner the notices it sent to the provider.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

When a provider who is a primary care professional is being removed or is leaving the provider network, verify that the health carrier's contract with the participating provider requires the provider to provide the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice to all covered persons who are patients of that primary care professional. .

When a covered person's provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures to transition a covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

Verify that the health carrier makes 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 continuity of care.

Verify that the health carrier's procedures outlining how a covered person may request continuity of care provide that:

- Any request for continuity of care can be made to the health carrier by the covered person or the covered person's authorized representative;
- 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 "active course of treatment," "life-threatening health condition," and "serious acute condition" as defined in applicable state statutes, rules and regulations, 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;
- 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
- The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:
 - The termination of the course of treatment by the covered person or the treating provider;
 - [Ninety (90) days] unless the health carrier's medical director determines that a longer period is necessary;
 - The date that care is successfully transitioned to a participating provider;
 - Benefit limitations under the plan are met or exceeded; or
 - Care is not medically necessary.

Note: Examiners need to be aware that while ninety (90) days is the current accreditation standard for the length of a continuity of care period, a state, when determining the length of time for the continuity of care period, may take into consideration the number of providers, especially specialty providers who are available to treat serious health conditions within the state.

- In addition to the above-referenced continuity of care provisions, a continuity of care request may only be granted when:
 - The provider agrees in writing to accept the same payment 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
 - 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.

Review health carrier contractual arrangements with participating providers to verify that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

Verify that the health carrier has written policies and procedures in place to ensure 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.

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

Verify that a health carrier does 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.

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the network plan and/or the requirements of applicable state statutes, rules and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the health carrier and, if appropriate, an intermediary, notifies a participating provider, in a timely manner, of all provisions and other documents incorporated by reference into the contract. The language of the contract shall define what is to be considered timely notice.

Verify that, while a contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints/disputes made by participating providers relating to health carrier/participating provider contractual arrangements.

Review complaint/dispute records to verify that if the health carrier has not complied with the contractual provisions of, or fulfilled its obligations contained within the health carrier/participating provider contract, the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

Verify that the health carrier has established training programs designed to inform its employees about HHS, the DOL and the Treasury provisions and final regulations pertaining to health carrier/participating provider contractual arrangements.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to health carrier/participating provider contractual arrangements.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

STANDARDS NETWORK ADEQUACY

Standard 4

A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes, rules and regulations.

Apply to: Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant)

Priority: Essential

Documents to be Reviewed

- _____ Health carrier policyholder service policies and procedures related to balance billing
- _____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.
- _____ Non-emergency out-of-network services written disclosures issued by facility-based providers
- _____ Out-of-network emergency services billing notices issued by facility-based providers
- _____ Non-participating facility-based provider-issued payment responsibility notices/billing statements
- _____ Health carrier's provider mediation process (policy and procedures)
- _____ Records of requests for provider mediation
- _____ Records of open and completed provider mediations
- _____ Complaint register/logs/files
- _____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- _____ Health carrier communication and educational materials related to balance billing provided to applicants, enrollees, policyholders, certificateholders and beneficiaries
- _____ Training materials
- _____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Review Procedures and Criteria

Note: Examiners need to be aware that for purposes of this examination standard, “facility-based provider” means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other 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. Examiners need to review the applicable state’s definition of “facility-based provider” to make sure it includes any provider who may bill separately from the facility for health care services provided in an in-patient or ambulatory facility setting.

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with requirements set forth in applicable state statutes, rules and regulations regarding balance billing.

With regard to non-emergency out-of-network services, 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:

- That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;
- 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;
- That the service(s) therefore will be provided on an out-of-network basis;
- A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;
- 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; and
- A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, a facility shall provide a covered person with the written disclosure, as outlined above, 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.

With regard to out-of-network emergency services, a non-participating facility-based provider shall include a statement on any billing notice sent to a 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 bill to their health carrier for consideration under the provider mediation process described below if the difference in the billed charge and the plan's allowable amount is more than \$500.00. Note: Examiners need to be aware that the applicable dollar amount threshold may vary by state. A covered person is not precluded from agreeing to accept and pay the charges for the out-of-network service(s) and not using the provider mediation process described below.

In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice below. 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 a non-participating provider 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, 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 more than [\$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by applicable state statutes, rules and regulations; OR 3) you may rely on other rights and remedies that may be available in your state.”

Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined above, may not balance bill the covered person.

A covered person is not precluded from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the provider mediation process described below.

Regarding health carrier out-of-network facility-based provider payments:

- Health carriers shall develop a program for payment of non-participating facility-based provider bills;

- Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes, rules and regulations;
- Non-participating facility-based providers who object to the payment(s) made in accordance with the above may elect the provider mediation process described in applicable state statutes, rules and regulations; and
- This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment 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. Note: Examiners need to be aware that a state may use a percentage of the Medicare payment that a state considers appropriate. A state may alternatively use as a benchmark some percentage of a public, independent, database of charges 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.

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes, rules and regulations. The health carrier's provider mediation process shall be established in accordance with one of the following recognized mediation standards:

- The Uniform Mediation Act;
- Mediation.org, a division of the American Arbitration Association;
- The Association for Conflict Resolution (ACR);
- The American Bar Association Dispute Resolution Section; or
- The applicable state dispute resolution, mediation or arbitration section.

Verify that following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

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

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner of the applicable state in the format specified by the insurance commissioner.

The rights and remedies set forth in applicable state statutes, rules and regulations regarding balance billing shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

With regard to enforcement of state-specific requirements regarding balance billing, the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general and the applicable state insurance department shall be responsible for enforcement of the requirements of applicable state statutes, rules and regulations pertaining to balance billing.

Note: Examiners need to be aware that state-specific requirements regarding balance billing 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 applicable state 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 insurance commissioner of the applicable state 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.

Balance billing requirements do not apply to providers or covered persons using the process set forth in applicable state statutes, rules and regulations to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or makes other arrangements acceptable to the insurance commissioner of the applicable state.

The requirements set forth in applicable state statutes, rules and regulations regarding balance billing 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.

The insurance commissioner of the applicable state and the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general may, after notice and hearing, promulgate reasonable regulations to carry out the provisions set forth in applicable state statutes regarding balance billing. The regulations shall be subject to review in accordance with the applicable state statutory citation providing for administrative rulemaking and review of regulations.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to balance billing.

Review complaint records to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, the above reasons for noncompliance notwithstanding, the non-participating facility-based provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to balance billing.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

DRAFT

STANDARDS NETWORK ADEQUACY

Standard 5

A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes, rules and regulations.

Apply to: Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant)

Priority: Essential

Documents to be Reviewed

- _____ Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing
- _____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.
- _____ Out-of-network services written disclosures provided by health carriers
- _____ Non-emergency services written disclosures provided by facility-based providers
- _____ Complaint register/logs/files
- _____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- _____ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to applicants, enrollees, policyholders, certificateholders and beneficiaries
- _____ Training materials
- _____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing, in compliance with requirements set forth in applicable state statutes, rules and regulations.

Verify that the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's 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 as the covered person's network.

Verify that the health carrier's disclosure or notice indicates 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. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops 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 as the covered person's network.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to content and issuance of written notices or disclosures regarding balance billing.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state statutes, rules and regulations, has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations regarding content and issuance of written notices or disclosures pertaining to balance billing.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to content and issuance of written notices or disclosures pertaining to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

DRAFT

STANDARDS NETWORK ADEQUACY

Standard 6

A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes, rules and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.

Apply to: All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier policies and procedures related to provider directories

_____ Files and supporting documentation regarding frequency of provider directory revisions and updates

_____ Provider directory (print copy provided to covered persons)

_____ Web-based provider directory

_____ Health carrier self-audit of provider directory

_____ Complaint register/logs/files regarding inaccessibility, inaccuracy and incompleteness of provider directories

_____ Health carrier complaint records concerning provider directories (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures' references to provider directories

_____ Health carrier communication and educational materials related to provider directories provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with provider directory requirements in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, to include the following information in a searchable format:

- For health care professionals:
 - Name;
 - Gender;
 - Participating office location(s);
 - Specialty, if applicable;
 - Medical group affiliations, if applicable;
 - Facility affiliations, if applicable;
 - Participating facility affiliations, if applicable;
 - Languages spoken other than English, if applicable; and
 - Whether accepting new patients.
- For hospitals:
 - Hospital name;
 - Hospital type (i.e. acute, rehabilitation, children's, cancer);
 - Participating hospital location; and
 - Hospital accreditation status; and
- For facilities, other than hospitals, by type:
 - Facility name;
 - Facility type;
 - Types of services performed; and
 - Participating facility location(s).

In addition, for electronic provider directories, for each network plan, verify that the health carrier makes available the following information in addition to all of the information above:

- For health care professionals:
 - Contact information;
 - Board certification(s); and
 - Languages spoken other than English by clinical staff, if applicable.
- For hospitals: telephone number; and
- For facilities other than hospitals: telephone number.

Verify that in making the directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan via a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

Verify that the health carrier updates each network plan provider directory at least monthly.

Verify that the health carrier periodically audits 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 insurance commissioner of the applicable state upon request.

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with the information listed below, upon request of a covered person or a prospective covered person.

- For health care professionals:
 - Name;
 - Gender;
 - Participating office location(s);
 - Specialty, if applicable;
 - Medical group affiliations, if applicable;
 - Facility affiliations, if applicable;
 - Participating facility affiliations, if applicable;
 - Languages spoken other than English, if applicable; and
 - Whether accepting new patients.
- For hospitals:
 - Hospital name;
 - Hospital type (i.e. acute, rehabilitation, children's, cancer);
 - Participating hospital location; and
 - Hospital accreditation status; and
- For facilities, other than hospitals, by type:
 - Facility name;
 - Facility type;
 - Types of services performed; and
 - Participating facility location(s).

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, the following general information:

- In plain language, a description of the criteria the health carrier has used to build its provider network;
- If applicable, in plain language, a description of the criteria the health carrier has used to tier providers;
- If applicable, in plain language, how the health 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 placed, 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
- If applicable, note that authorization or referral may be required to access some providers.

Verify that the health carrier makes 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.

Verify that the health carrier includes 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.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency.

Verify that the health carrier makes available in print, upon request, the following provider directory information for the applicable network plan:

- For health care professionals:
 - Name;
 - Contact information;
 - Participating office location(s);
 - Specialty, if applicable;
 - Languages spoken other than English, if applicable; and
 - Whether accepting new patients.
- For hospitals:
 - Hospital name;
 - Hospital type (i.e. acute, rehabilitation, children's, cancer); and
 - Participating hospital location and telephone number; and
- For facilities, other than hospitals, by type:
 - Facility name;
 - Facility type;
 - Types of services performed; and
 - Participating facility location(s) and telephone number.

Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to inaccessibility, inaccuracy and incompleteness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state statutes, rules and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to content, accessibility, transparency, accuracy, and completeness of provider directories.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law. G:\MKTREG\DATA\D Working Groups\D WG 2016 MCES (PCW)\Docs_WG Calls 2016\Network Adequacy\Current Exposure Draft\Network Adequacy Exam Standards 4-26-16.docx

Conference Calls

STANDARDIZED DATA REQUEST (D) SUBGROUP

April 13, 2016 / March 16, 2016

Summary Report

The Standardized Data Request (D) Subgroup met April 13 and March 16, 2016. The meetings were held in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During these meetings, the Subgroup:

1. Discussed potential updates to the Advertising and Complaints section of the producer, commission and complaint standardized data request.
2. Agreed to continue reviewing the producer, commission and complaint standardized data request and next meet in May.

G:\MKTREG\DATA\D Working Groups\D WG 2016 MCES (PCW)\SDR Subgroup\Summaries To MCES WG\5-04 Summary To Working Group.Docx