State Health Reform Assistance Network
Charting the Road to Coverage

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# ACA Implications for State Network Adequacy Standards

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## Introduction

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all and other health care services included under the terms of the contract.[1] Taken together with the Essential Health Benefits (EHB) package, now required as a benefit level floor under the Affordable Care Act (ACA), network adequacy standards will determine what care is covered and how easily it can be obtained.[2]

States have taken different approaches in regulating the adequacy of health plan networks. The variation is due, in part, to the need for states to maintain robust health insurance markets by balancing access needs with the goals of controlling costs and attracting a healthy number of insurers.[3] In many states, network adequacy requirements have historically applied only to Health Maintenance Organizations (HMOs), and not to other managed-care products such as Preferred Provider Organizations (PPOs).[4] Because PPO products offer reimbursement for services obtained from both in-network and out-of-network providers, they present additional considerations and challenges. This brief explores some of the discrepancies that can arise with varying network adequacy standards and provides examples of how some states have resolved such issues.

[1] Texas Department of Insurance, Report of the Health Network Adequacy Advisory Committee Senate Bill 1731, Section 11 Eightieth Legislature, Regular Session, 2007 (January 2009) (p. 8).

[2] America Plasma Users Coalition, T*alking Points: How the Essential Health Benefits and Network Adequacy Work Together*, found at http://www.hemophilia.org/NHFWeb/Resource/StaticPages/menu0/menu4/menu306/EHBNATalkingPoints.pdf

[3] The District of Columbia Health Benefit Exchange Authority: Network Adequacy Working Group (explaining that "if network adequacy requirements do not reflect the actual availability of providers in a community, they could result in disqualifying plans from participating. For example, if there is a requirement that there be a physician to population ratio of 1:1000 and the actual physician to population ratio for a given area is 1:1500, the standard might have the effect of disqualifying all plans from participating because of the difficulty in meeting the standard."), found at http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/DC%20HBX%20Network%20Adequacy%20BackgroundPaper.pdf.

[4] See NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

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## Patient Protection and Affordable Care Act Network Adequacy Standards

### Sufficient Numbers and Types of Providers

The ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish criteria for the certification of health plans as Qualified Health Plans (QHPs) to be offered on a state's health insurance Exchange.[5] These criteria include requirements to:

- Ensure a sufficient choice of providers;
- Provide information to enrollees and prospective enrollees on the availability of both in-network and out-of-network providers; and
- Include within plan networks essential community providers, where available, that serve predominately low-income, medically-underserved individuals.[6]

Final rules published by HHS in 2012 elaborate on the minimum network adequacy requirements that a QHP must meet. A pertinent provision, at 45 CFR § 156.230, requires that a QHP issuer maintain a provider network that meets the following standards[7]:

- Includes essential community providers in accordance with 45 CFR § 156.235;
- Is sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay; and
- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.[8]

### Provider Directories

A QHP issuer must also make its QHP network provider directory available to the Exchange for publication online, in accordance with guidance from the Exchange, and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.[9] The Exchange final rule does not, however, include guidelines on how often a provider directory must be updated; rather, the rule suggests that Exchanges consider balancing consumer choice with the issuer's regulatory burden to comply.[10]

### Essential Community Providers (ECPs)

Conceptually, ECPs originated with the proposed 1993 Clinton health care reform plan as a term denoting "health care providers that, through legal obligation or mission, organizational and service structure, and patient population characteristics, play a significant role in health care for patients and populations at disparate risk for inadequate access."[11] The purpose of designating certain providers as ECPs was to assure that health insurance plans whose service areas included such providers (and therefore presumably included populations that depended on them) would not exclude them.[12] Although Clinton's 1993 plan ultimately failed to be enacted, the concept of ECPs gained traction later in the 1990s with the advent of Medicaid managed care. Medicaid administrators in several states were concerned about the potential exclusion of ECPs from provider networks and the resulting loss of patient access to care.[13]

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[5] PPACA §1311(c)(1).

[6] PPACA §1311(c)(1)(B) and (C).

[7] 45 CFR § 156.230(a).

[8] PHSA 2702 contains the requirement that health insurance be offered on a guaranteed issue basis. 2702(c) provides two exceptions to this requirement applicable to plans utilizing a network: (1) plans may limit coverage to eligible enrollees that live or work in the service area and (2) issuers may refuse to enroll new eligible employers or new eligible individuals if the issuer does not have the capacity to the meet the needs of existing enrollees and issue coverage to new enrollees.

[9] 45 CFR § 156.230(b).

[10] See, e.g., Reform Alert, Network Adequacy and Essential Community Providers, the Blues' Office of National Health Reform, July 9, 2012.

[11] Sara Rosenbaum, Essential Community Providers, Health Reform GPS, http://healthreformgps.org/resources/essential-community-providers/

[12] Id.

[13] Id.

The ACA requires that QHP issuers have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area. To comply with this requirement, an Exchange's network adequacy standards must include this criterion.[14]

## Comparison of Existing Network Adequacy Regulatory Structures

### National Association of Insurance Commissioners (NAIC) Model Law

The NAIC Managed Care Plan Network Adequacy Model Act #74 (the Model Act) has been adopted in some, but not all, states.[15] The Model Act applies to all managed care plans, broadly defined as any benefit plan that either requires, 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 insurance issuer.[16] The ACA and the Model Act, however, differ on what health plans are "covered," that is, subject to their requirements. The ACA applies only to QHPs; while the Model Act applies to managed health care plans generally. Further, some states that have adopted the Model Act only apply it to HMOs.[17]

As with the ACA's final rules, the Model Act requires covered health care plans to maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.[18] Neither the Model Act nor the ACA's final rules include specific requirements for minimum geographic distances or time frames for access to providers.[19]

The Model Act, like the final rules, allows state regulators flexibility to set network adequacy requirements that reflect the geographic variability and availability of health care providers in each state.[20] Unlike the final rules, the Model Act does not require health plans to offer contracts to ECPs within the plan's service area and does not address the updating of provider lists.

The NAIC's "Plan Management Function: Network Adequacy White Paper" provides a detailed analysis of the differences between the ACA final rules and the Managed Care Plan Network Adequacy Model Act #74.[21]

### States' Network Adequacy Standards

Appendix A is a chart that compares network adequacy standards and requirements found in the NAIC model law, the ACA final rule, guidance issued by HHS regarding its approach to network adequacy for the Federally Facilitated and Partnership Exchanges, and in statutes and regulations in 10 select states (California, Colorado, Delaware, Hawaii, Maryland, Minnesota, Montana, Texas, Vermont, and Washington). Comparisons are made in three broad areas: accessibility, ECPs, and transparency.

Appendix B includes narrative descriptions of the current network adequacy requirements in each of those 10 states, as well as HHS's approach to network adequacy in the Federally Facilitated and Partnership Exchanges.

[14] 45 CFR § 156.235(a).

[15] NAIC Model Laws, Regulations and Guidelines 74-1, State Adoption (listing 8 states as having adopted the model law and 12 states having adopted similar models and having related state activity); but see, The District of Columbia Health Benefit Exchange Authority: Network Adequacy Working Group (stating that most states (47) have some regulatory requirements for network adequacy for HMOs, including some that have adopted the NAIC model act or something similar. There are fewer states (27) that have requirements on non-HMOs related to network adequacy and even less standardization in the requirements as compared to HMOs).

[16] NAIC Model Laws, Regulations and Guidelines 74-3, § 4; See also NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[17] See NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[18] NAIC Model Laws, Regulations and Guidelines 74-4, § 5.

[19] NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[20] NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[21] NAIC's Plan Management Function: Network Adequacy White Paper, found at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

## Analysis

### Adopting Current Standards

When considering the adoption of market-wide network adequacy standards, states must consider a number of issues. For example, if a state's statutory or regulatory network adequacy standards apply only to HMOs, what are the advantages and disadvantages of extending those standards to apply market wide?

Among the advantages of adopting existing HMO standards to the entire market (both inside and outside the Exchange) are the minimization of adverse selection against the Exchange and ease of enforcement administration. Disadvantages involve problems that can arise from the different roles networks play in various types of managed care plans.

### Balance Billing

Balance billing occurs when a patient is billed for the difference between the medical service provider's actual charges and the amount that provider will be reimbursed from the patient's health plan. While network adequacy and balance billing are technically two separate issues, they are directly related because inadequate networks often result in an increase in balance billing.[22] One important distinction to note is the prevalence of balance billing issues in the PPO market as compared to the HMO market. In the HMO market, balance billing should rarely occur. An HMO provides or arranges to provide covered services for enrollees on a prepaid basis through a network of physicians and providers. At the time of service, the enrollee pays only a scheduled charge, usually a fixed co-payment. As long as the enrollee stays within the HMO network, no balance billing issues should arise. Providers participate in the HMO network by agreeing to accept the HMO's reimbursement for services.[23]

Developing PPO network adequacy standards involves different considerations than HMO standards because PPOs do not provide prepaid care. Instead, PPOs reimburse costs for care at different levels—in-network care is reimbursed at a higher level, and costs for care received from non-network providers are reimbursed at a lower level. Balance billing problems arise because non-network providers have not executed a contract with the issuer to accept specified reimbursement amounts and are, therefore, not obligated to accept the issuer's reimbursement as payment in full. As a result, when an enrollee who is unable to obtain services from an in-network health care provider seeks care from a non-network provider, and the enrollee's health insurance plan issuer pays only a portion of the out-of-network provider's charge, the provider may opt to bill the enrollee for the balance.[24] Therefore, it is equally important to have sufficient numbers of in-network providers in PPO networks as it is in HMO networks.

### Institutional Providers

Another issue to be considered when deciding whether to apply HMO network adequacy standards to PPO networks is the problem of enrollees being billed by providers affiliated with a particular institution (usually a hospital), such as anesthesiologists, radiologists, pathologists, and other providers that are often chosen with little or no input from the enrollee. The same balance billing problems as described previously sometimes exist for PPO enrollees when institutional providers are involved.

As shown in Appendix A, Texas addressed the PPO network balance billing issue when it enacted new network adequacy laws in 2011. Texas passed separate laws for HMOs and PPOs. The PPO law includes this accessibility requirement, and the HMO law does not:

"An insurer marketing a preferred provider benefit plan is required to contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities."

Colorado addressed balance billing by institutional providers by enacting legislation prohibiting out-of-network health care providers from charging consumers in managed care plans over and above the in-network benefit rate for services provided at in-network facilities.[25] However, "balance billing continues to stir controversy between providers and insurance carriers" in Colorado because some insurance carriers believe it puts them "at the mercy of providers who take the rule and charge exorbitant amounts, which are then cost shifted to the consumer in their premiums."[26]

[22] Texas Department of Insurance, Report of the Health Network Adequacy Advisory Committee, January 2009, pg. 8.

[23] Id. at 9.

[24] Id. at 8.

[25] CRS §10-16-704(3), See also Colorado Department of Regulatory Agencies, Report of the Insurance Commissioner to the Colorado General Assembly on §10-16-704(3), CRS, Consumer Protections Against Balance Billing, January 21, 2010.

[26] Id at 11

### Mileage and Wait Time Standards

If a state adopts mileage and wait time standards as part of its network adequacy rules, these standards will likely go beyond the ACA minimum requirements, which do not include such standards. One consideration is whether these standards are practical and valuable for PPO networks, or whether such standards are too prescriptive for PPOs, since PPO enrollees receive coverage for services delivered by providers outside the plan's network.

Although most states on the comparison chart have distance standards, it is not yet clear whether those states will adopt those standards as part of their QHP network adequacy standards. States such as Washington and Colorado have adopted the more flexible standard of "reasonable criteria established by the carrier" (WA), or "any reasonable requirement" (CO). With these more flexible standards, a state can assure network adequacy on the "back end" by including network adequacy as part of its market conduct examinations, or by investigating network adequacy in response to consumer complaints. To accomplish this approach, a state would want to include a review of a carrier's processes for assuring provider access as part of its periodic market conduct examinations. The following items could be considered when assessing a carrier's network adequacy:[27]

a. Carrier's network and type of network
    i. HMO, PPO, POS, EPO, etc.
    ii. Network institutions and their institution-based providers
b. Carrier's referral process
    i. Differences in in-network and out-network referral procedures
    ii. How clearly are the process and procedures conveyed to enrollees
c. Carrier's process for monitoring and updating network adequacy
d. Carrier's efforts to address enrollees with special needs
e. Carrier's methods to assess enrollee satisfaction
f. Carrier's system for assuring coordination and continuity of care
g. Carrier's procedures for enabling enrollees to change primary care physicians
h. Carrier's plan for providing continuity of care in the event of a contract termination
i. Provider selection standards, particularly for selection methods that would allow carriers to avoid providers serving high risk populations
j. Review of contracts for prohibitions against balance billing

### Essential Community Providers

The ACA final rules require that a QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.[28] ECPs serve predominantly low-income, medically underserved populations and include, but are not limited to, safety net providers who are eligible to participate in the 340B drug purchase program in these categories: Federally Qualified Health Centers (FQHCs), Ryan White providers, family planning providers, Indian providers, and specified hospitals.[29] While the ACA and its implementation regulations provide a framework for dealing with ECPs, several important questions regarding ECPs remain open, including which additional providers should be defined as ECPs and which minimum contracting standards should apply.[30] These issues are left to state regulators to resolve, implicitly recognizing that each state's demographics and geography are unique.[31]

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[27] NAIC's Plan Management Function: Network Adequacy White Paper.

[28] 45 CFR § 156.235(a)(1).

[29] 42 U.S.C. 256b; 45 CFR § 156.235; See also Essential Community Providers: Tips to Connect with Marketplace Plans, National Academy for State Health Policy, found at http://www.nashp.org/sites/default/files/ecp.tips.connect.marketplace.plans.pdf.

[30] See, e.g. North Carolina Department of Insurance Essential Community Provider (ECP) Workgroup Meeting,Thursday, August 30, 2012 (noting that "the terms 'low-income' and 'medically underserved' are not defined in the ACA but are critical to determining who should fall within the definition of ECPs in North Carolina. Similarly, 'generally applicable rate' is not defined and generally has been interpreted to mean whatever is generally paid in the marketplace. This rate could be based on the standard fee schedule; however, this may prove to be a point of contention when implementing the provision as small community providers typically do not have access to, and large health systems in the state are not on, the standard fee schedule.").

[31] Rosenbaum, supra note 10 (describing in detail questions left open regarding implementation of the network adequacy requirements relating to ECPs).

While Minnesota's pre-ACA network adequacy law requires issuers to offer to contract with all ECPs in a plan's service area, pre-ACA network adequacy laws in most states do not address ECPs at all. Essential Community Providers can also be proactive in seeking inclusion in networks. To do this, ECPs must identify insurers offering plans in their state's ACA marketplace and negotiate to be included.[32]

In response to the ACA, however, states have taken different approaches to address the ECPs requirement. Some states require QHPs to contract with a specific percentage of ECPs as a condition of offering coverage on the state's Exchange. California requires that QHP issuers contract with at least 15 percent of ECPs listed as 340B non-hospital and hospital entities.[33] Connecticut requires QHP networks to include 75 percent of ECPs and 90 percent of Federally Qualified Health Centers in any county.[34]

Others states require plans to self-certify that they comply with the network adequacy requirements under federal law. Maryland[35] and Vermont[36] have adopted this approach. Washington has taken the approach of conforming the state's existing filing guidance to meet ACA requirements. Pre-ACA Washington law required carriers to offer contracts to Indian Health Clinics (IHCs).[37] In addition to IHCs, the Washington Health Benefit Exchange has identified the Washington Association of Community & Migrant Health Centers (which includes 26 Federally Qualified Community Health Centers), as well as mental health and substance abuse providers as ECPs.[38]

### Transparency

The ACA requires that a QHP issuer provide the Exchange with its online provider directory and make a hard copy directory available to enrollees upon request. California and Texas are the only two states on the comparison chart that specify they require updating intervals, requiring the online provider directories be updated quarterly.

Additionally, Texas requires, in its PPO law only, that networks provide a method for enrollees to identify hospitals that have agreed to facilitate the use of in-network providers. The Texas PPO law also requires networks to provide a method for enrollees to identify in-network institutional physicians who provide services at in-network facilities.

## Conclusion

The ACA provides consumers, particularly those in the individual market, with significantly increased access to a wider range of health insurance benefits than has ever before been available. To make these reforms meaningful, however, health insurance issuers must provide networks that include a sufficient number of providers in locations that their enrollees can access. A network that falls short on either count will make it difficult or impossible for consumers to access the benefits promised to them. While the ACA provides a framework for addressing the adequacy of QHP networks, the law, and its implementing rule and guidance, makes the states responsible for assuring that network adequacy is achieved for the benefit of consumers.[39]

[32] Essential Community Providers: Tips to Connect with Marketplace Plans, National Academy for State Health Policy, found at http://www.nashp.org/sites/default/files/ecp.tips.connect.marketplace.plans.pdf.

[33] California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.

[34] Connecticut Health Insurance Exchange: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges. December 13, 2012.

[35] Maryland Health Benefit Exchange Board of Trustees Statement of Policy Regarding Essential Community Providers and Network Adequacy (stating that "the Maryland Health Benefit Exchange (MHBE) plans to closely monitor both access to care within Qualified Health Plans and the adequacy of provider networks, including engagement with essential community providers. MHBE will assess whether further action is needed to make sure participating Marylanders have meaningful access to needed health care).

[36] 33 V.S.A. § 1806; Department of Vermont Health Access, Vermont Health Connect Request for Proposals (amended December 21, 2012); Department of Banking, Insurance, Securities, and Health Care Administration, Rule H-2009-03: Consumer Protection and Quality Requirements for Managed Care Organizations (2009).

[37] Provider Contracting: Essential Community Providers & Indian Health Clinics (ACA #5), Office of Insurance Commissioner, American Indian Health Commission, (December 20, 2012).

[38] Id.

[39] Center for Consumer Information and Insurance Oversight Health Insurance Exchange System-Wide Meeting May 21-23, 2012, found at http://cciio.cms.gov/resources/files/hie-plan-management-in-the-ffe.pdf.

# Appendix A – Comparison of Network Adequacy Standards and Requirements

### Accessibility Standards

| State or Framework | Applicability | Regulatory Agency Responsible | Access Standard | Minimum Enrollee/ Provider Ratios | Maximum Travel Times/ Distances | Maximum Wait Times | Exemption Available |
|---|---|---|---|---|---|---|---|
| NAIC Model Law (#74) | Managed Care Plans | N/A | Sufficient in number and types of providers to assure that all services delivered to covered persons will be accessible without unreasonable delay. | No | No | No | No |
| ACA | Qualified Health Plans | N/A | Sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. | No | No | No | No |
| FFE and SPE | Qualified Health Plans | State Department of Insurance if "adequate;" if not, CCIIO | Sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. | No | No | No | No |
| CA HMO (California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.) | Managed Care Plans | Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) | Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition and consistent with good professional practice. | 1 physician per 1200 enrollees; 1 PCP per 2000 enrollees | 30 miles for primary care and 15 miles for hospitals | HMO only: 48-96 hours for urgent care; 10-15 days for non-urgent care | No |
| CO (25.5-5-403; 3 CCR 702-4) | Managed Care Plans | N/A | Sufficient in number and types of providers to assure that all services delivered to covered persons will be accessible without unreasonable delay. | Any reasonable requirement* | Any reasonable requirement* | Any reasonable requirement* | Yes, if out of network benefits offered, enrollee resides outside of a metropolitan area, and the carrier has no participating providers in such geographic area. |
| DE (18 Del. Admin. C. 13.1.3.1) | Qualified Health Plans and Managed Care Organizations | DOI | Adequate network of primary care providers, specialists, and other ancillary health care providers. | 1 PCP for every 2,000 patients | PCP within 30 minutes drive time or 20 miles | No | No |
| HI | N/A (pending legislation) | N/A | No | No | No | No | No |

| State or Framework | Applicability | Regulatory Agency Responsible | Access Standard | Minimum Enrollee/ Provider Ratios | Maximum Travel Times/ Distances | Maximum Wait Times | Exemption Available |
|---|---|---|---|---|---|---|---|
| MD* (Statutes of Maryland § 31-115; Exchange Carrier Reference Manual) | Qualified Health Plans | N/A | Sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. | No | No | No | No |
| MN (Minn. Stat. § 62D.09, Minn. Stat. § 62D.124) | HMOs only | Minnesota Department of Health (MDH) | Timely access to care. | No | 30 miles or 30 minutes for primary care.<br><br>60 miles or 60 minutes for specialty care. | No | Yes, if requirements are not feasible in a particular service area or part of a service area |
| MT (33-36-201; 37.108.215, 37.108.220 ) | Managed Care Plans | The Office of the Commissioner of Securities and Insurance | Yes | One mid-level PCP per 1,500 projected enrollees or one physician PCP per 2,500 projected enrollees | Primary care providers; a hospital, critical access hospital, or medical assistance facility; and a pharmacy that is located within a 30 mile radius | Urgent care 24 hrs.; routine care 10 to 45 days | Yes, for good cause |
| TX-HMO (28 TAC § 11.1607) | HMO | Texas Department of Insurance (TDI) | Each health benefit plan delivered or issued for delivery by an HMO must include an HMO delivery network which is adequate and complies with Insurance Code § 843.082. | No | 30 miles for primary care and general hospital care; and 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers | Urgent care 24 hrs.; routine care 2 weeks to 3 months | Yes, requires approved access plan |
| TX-PPO (28 TAC § 3.3704) | PPO | Texas Department of Insurance (TDI) | An insurer marketing a preferred provider benefit plan is required to contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage are provided in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. | No | 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and 75 miles for specialty care and specialty hospitals | Urgent care 24 hrs.; routine care 2 weeks to 3 months | Yes |
| VT (Rule H-2009-03) | Managed Care Organizations and Qualified Health Plans | Department of Financial Regulation, Insurance Division | Covered health services, either directly or through its provider contracts, to ensure that covered health care services are acceptable to members on a timely basis. | No | 30 minutes for primary care and mental health/ substance abuse services and 60 minutes maximum travel times for outpatient services | No | No |
| WA (WAC 284-43-200) | Market wide | Washington State Office of the Insurance Commissioner | Sufficient in number and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. | Reasonable criteria established by the carrier | Reasonable criteria established by the carrier | Reasonable criteria established by the carrier | No |

*MD insurance carriers issuing QHPs self-certify network adequacy requirements in 2014

## Essential Community Provider Standards

| State or Framework | Definition | Standard | Payment Rates Set in Statute/ Regulation |
|---|---|---|---|
| NAIC Model Law (#74) | Providers that serve predominantly low-income, medically underserved individuals | A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards | Nothing shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer |
| ACA | Health care provider that serves high-risk, special needs, and underserved individuals | Health plan companies must offer provider contracts to all designated ECPs in their service areas | The rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services |
| FFE and SPE | Health care provider that serves high-risk, special needs, and underserved individuals | Health plan companies must offer provider contracts to all designated ECPs in their service areas | The rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services |
| CA Explanation of Updated 340B Provider List | 340B list | QHPs must contract with at least 15% of the 340B providers | No |
| CO (25.5-5-403 C.R.S.) | Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations | Not applicable to private health insurance | N/A |
| DE (18 Del. Admin. C. 13.1.3.1) | Health care provider that serves high-risk, special needs, and underserved individuals | Health plan companies must offer provider contracts to all designated ECPs in their service areas | The rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services |
| HI | No | No | No |
| MD* (31-115; Carrier Reference Manual) | Health care provider that serves high-risk, special needs, and underserved individuals | Health plan companies must offer provider contracts to all designated ECPs in their service areas | The rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services |
| MN (Minn. Stat. § 62Q.19) | The commissioner designates essential community providers. Criteria defined in statute. | Health plans must offer contracts to all designated essential community providers within its service area | Rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services |
| MT (33-36-201; 37.108.215, 37.108.220) | No | No | No |
| TX-HMO | No | No | No |
| TX-PPO | No | No | No |
| VT (Rule H-2009-03) | No | No | No |
| WA | No | No | No |

*MD insurance carriers issuing QHPs self-certify network adequacy requirements in 2014

## Transparency Standards

| State or Framework | Provider Directory Hard Copy Available? | Provider Directory Available Online | Provider Directory Accepting New Patients Updates | Method for enrollees to identify those hospitals that have contractually agreed to use in-network providers | Method for enrollees to identify in network facility-based physicians |
|---|---|---|---|---|---|
| ACA | A QHP issuer must make its provider directory available to potential enrollees in hard copy upon request | A QHP issuer must make its provider directory available to the Exchange for publication online in accordance with guidance from the Exchange | Yes | No | No |
| FFE and SPE | A QHP issuer must make its provider directory available to potential enrollees in hard copy upon request | A QHP issuer must make its provider directory available to the Exchange for publication online in accordance with guidance from the Exchange | Yes | No | No |
| NAIC Model Law (#74) | No | No | No | No | No |
| CA HMO (California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.) | A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request | A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet website | Yes - updated at least quarterly. | No | No |
| CO (25.5-5-403; 3 CCR 702-4) | No | No | No | No | No |
| DE (18 Del. Admin. C. 13.1.3.1) | A QHP issuer must make its provider directory available to potential enrollees in hard copy upon request | A QHP issuer must make its provider directory available to the Exchange for publication online in accordance with guidance from the Exchange | Yes | No | No |
| HI | No | No | No | No | No |
| MD* (31-115; Carrier Reference Manual) | A QHP issuer must make its provider directory for a QHP available to potential enrollees in hard copy upon request | A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange | Yes | No | No |
| MN (Minn. Stat. § 62D.09) | HMOs shall provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without referral | No | No | No | No |
| MT (33-36-201; 37.108.215, 37.108.220) | No | No | No | No | No |
| TX-HMO | Yes - current list of physicians and providers, including behavioral health providers and substance abuse treatment providers updated on at least a quarterly basis | Yes | Yes - updated at least quarterly | No | No |
| TX-PPO | Current list of physicians and providers, including behavioral health providers and substance abuse treatment providers | Yes | Yes - updated at least quarterly | Yes | Yes |
| VT (Rule H-2009-03) | No | No | No | No | No |
| WA | No | No | No | No | No |

*MD insurance carriers issuing QHPs self-certify network adequacy requirements in 2014

## Appendix B – Narrative Descriptions of Network Adequacy Requirements

**Federally Facilitated and Partnership Exchanges**

Both Federally Facilitated Exchanges (FFE) and State Partnership Exchanges (SPE) will require Qualified Health Plan (QHP) issuer networks to meet Affordable Care Act (ACA) minimum standards. That is, networks must include sufficient numbers and types of providers (including providers that treat substance abuse and mental health conditions) to ensure that all services are available without unreasonable delay.[1]

In a FFE or a SPE the scope of Health and Human Service's (HHS) review of QHP issuer networks will depend on HHS's determination of whether or not the state has an effective network adequacy review process.[2] If HHS determines that a state has an effective network adequacy review process, HHS will merely confirm that the state has approved the issuer's network.

If HHS determines that a state does not have an effective network adequacy review process, HHS will accept the issuer's attestation alone if the issuer is accredited for an existing line of business (commercial or Medicaid) by an HHS-recognized accrediting entity. If the issuer is not accredited, HHS will require submission of an access plan from the QHP. HHS also will collect provider network data from a sampling of selected issuers following certification, and will monitor accessibility complaints from consumers.[3]

QHP issuers will be required to provide the Exchange with a link to the issuer's provider directory for display on the Exchange website.

A QHP network must also include sufficient numbers and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of ECPs.[4] HHS has developed a transitional policy for year one to determine whether or not a QHP issuer satisfies the requirements relating to ECPs in FFE and PE states. The transitional policy requires QHP issuers to, based on an HHS-developed ECP list, verify one of the following:[5]

- Issuer achieves at least 20 percent ECP participation in-network, in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers;
- Issuer achieves at least 10 percent ECP participation in-network, in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. Note, however, that justifications submitted by issuers that fail to achieve either standard will undergo stricter review by CMS.

A QHP issuer that provides a majority of covered services through employed physicians or a single contracted medical group is held to an alternate standard.[6] To comply with the alternate standard the QHP issuer must do one of the following:[7]

- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 20 percent of available ECPs in the service area;[8]

[1] 45 CFR § 156.230.

[2] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange* (stating that HHS would determine whether a state has an effective network adequacy review based upon whether the state has statutory authority to review issuers' networks, and whether the authority allows the state to determine whether the issuer/health plan maintains a network sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay), January 3, 2013; *See also*, Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges*, May 16, 2012.

[3] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange*, January 3, 2013; *See also*, Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges*, May 16, 2012.

[4] 45 CFR § 156.235.

[5] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange*, January 3, 2013; *See also*, Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges*, May 16, 2012.

[6] 45 CFR § 156.235(b).

[7] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange*, January 3, 2013; *See also*, Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges*, May 16, 2012.

[8] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on the State Partnership Exchange*, (stating that HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the Federal Poverty Limit.); January 3, 2013; *See also*, Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges, May 16, 2012*.

- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10 percent of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application.

**California**

California has a bifurcated regulatory process in which California's Department of Managed Health Care (DMHC) is responsible for regulating the adequacy of Health Management Organizations (HMO) networks and the California Department of Insurance (CDI) is responsible for other issuers utilizing provider networks.[9] Both require issuers to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition and consistent with good professional practice. Regulations set out maximum travel times and distances, maximum wait times, and minimum provider to enrollee ratios. QHP insurers must also submit provider contracts to the California Health Benefit Exchange (CBHX) to have their networks evaluated. In addition to submitting provider contracts, plans must attest that they meet DMHC and CDI regulations. Issuers are required to provide their enrollees access to a provider directory, updated quarterly.[10] CBHX also requires QHP issuers to contract with at least 15 percent of ECPs that were listed on the Health Resources and Services Administration's (HRSA's) 340B non-hospital and hospital entities list as of November 9, 2012. Although HRSA's list includes single-service as well as full-service sites, CHBX removed single-service sites from the updated 340B list to encourage contracting with health centers that provide comprehensive services to the low-income and under-served population. A QHP issuer may, however, contract with a single-service 340B provider that the Exchange has removed from the 340B list if the issuer can demonstrate and attest that the 340B entity provides comprehensive services.[11]

QHP issuers are required to maintain the same provider network across all tiers of coverage. QHPs are expected to "hold harmless" enrollees receiving health care from an out-of-network provider (such as an anesthesiologist, pathologist, radiologist, etc.) while in an in-network hospital.[12]

**Colorado**

Colorado closely follows the NAIC's model law approach.[13] The state does not set defined provider radii, ratios, or wait times in statute or regulation. Rather, Colorado requires all carriers utilizing a managed care plan to demonstrate that their network is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay based on any reasonable criteria established by the carrier.[14] This approach allows carriers and regulators maximum flexibility to establish networks that meet the needs of diverse geographic areas by reviewing each network based on its unique design and circumstances.

An exemption to the network adequacy requirements is available for carriers offering plans with out-of-network benefits to enrollees residing outside of a metropolitan area in the event that the carrier is able to contract with participating providers in particular geographic areas.[15]

In 2006, Colorado enacted legislation prohibiting out-of-network health care providers from charging consumers in managed care plans over and above the in-network benefit rate for services provided at in-network facilities.[16] The legislation addressed consumer concerns regarding out-of-network doctors and providers working at in-network facilities, who balance billed patients for any amount not paid by the patient's managed care plan. In these instances, the prohibition protects consumers when they are receiving

[9] California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.

[10] California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.

[11] California Health & Safety Code §1367, 1367.03, California Insurance Code §10133.5, and California Code of Regulations §§2240.1 et seq, 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2.

[12] California Health Benefit Exchange Board, Qualified Health Plan Policies and Strategies to Improve Care, Prevention, and Affordability: Discussion Draft – Options and Recommendations (Sacramento: State of California, July 16, 2012), available online at http://www.healthexchange.ca.gov/BoardMeetings/Documents/July_19_2012/CHBE-QHP_Discussion_Draft_7162012.pdf.

[13] NAIC Model Laws, Regulations and Guidelines 74-1, State Adoption (listing Colorado as having adopted the model law).

[14] CRS § 25.5-5-403; 3 CCR 702-4.

[15] CRS § 25.5-5-403; 3 CCR 702-4.

[16] CRS §10-16-704(3), http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Consumer+Protections+Against+Balance+Billing+2010.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251822199740&ssbinary=true

services in an in-network facility and expect to pay in-network reimbursement rates where they believe they have followed the rules of their managed care plan by seeking care at in-network facilities.[17] According to an April 2009 report by the California HealthCare Foundation, only nine states have laws protecting consumers from balance billing, including Colorado, Delaware, Florida, Indiana, Maryland, New York, Rhode Island, West Virginia and Wisconsin.[18]

**Delaware**

Delaware requires that Managed Care Organizations (MCOs) maintain an adequate network of primary care providers, specialists, and other ancillary health care professionals.[19] A MCO must submit evidence of network adequacy upon request from the Department of Insurance.[20] If a health plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, the MCO is required to cover services obtained from non-network providers, and must prohibit balance billing.[21] A MCO also must allow referrals to non-network providers, upon request by a network provider, when medically necessary covered health services are not available through network providers. Non-network referrals also are required when the network providers are not available within a reasonable period of time. In these instances, the MCO must make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing.[22]

The Delaware Health Exchange (DEX) requires QHP issuers to meet additional standards.[23] QHP network arrangements must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence. Each primary care network must have at least one (1) full time equivalent PCP for every 2,000 patients. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2500 patients. QHP issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply with Network Standards.[24]

The Delaware Exchange requires that each health plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(I)(2)(B) of the Social Security Act (42 USC 1369d(I)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse such centers for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act.[25]

**Hawaii**

While there is no express network adequacy standard currently in the Hawaii Revised Statutes (HRS) or the Hawaii Administrative Rules (HAR) regarding network adequacy or ECPs,[26] managed care plans must demonstrate that the plans provide adequate access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay.[27] The State Insurance Commissioner has requested an amendment to pending legislation, which would grant the authority to the state to review health plans for network adequacy, and has informed the Hawaii Connector that it is the Connector's obligation to review network adequacy as part of the certification process.[28]

The Connector's position is, "should the State choose to regulate network adequacy, the State should be encouraged to secure its authority to regulate network adequacy through State legislation rather than through delegation from the Connector. This would assure that network adequacy standards would apply to the entire insurance market both inside and outside of the Exchange."[29]

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[17] CRS §10-16-704(3), http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Consumer+Protections+Against+Balance+Billing+2010.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251822199740&ssbinary=true

[18] http://www.chcf.org/topics/healthinsurance/. LINK NOT FOUND

[19] 18 Del. Admin. C. § 11.3.1.1.

[20] 18 Del. Admin. C. § 11.3.1.4.

[21] 18 Del. Admin. C. § 11.3.1.2.

[22] 18 Del. Admin. C. § 11.3.1.3.

[23] Delaware Department of Insurance, Request for Letter of Intent to Participate on Delaware Health Benefit Exchange, December 27, 2012.

[24] Id.

[25] Id.

[26] See Hawaii Health Connector Power Point, March 22, 2013.

[27] HRS §432E-3

[28] See Hawaii Health Connector Power Point, March 22, 2013

[29] Id.

### Maryland

Maryland does not have market-wide network adequacy standards. HMOs are required to ensure that all covered services, including any services for which the health maintenance organization has contracted, are reasonably accessible to enrollees.[30]

For 2014, Maryland is requiring QHP carriers to self-certify that they are maintaining provider networks sufficient in numbers and types of providers and ECPs, as required under federal law, to ensure that all services will be accessible without unreasonable delay.[31] By January 1, 2013, carriers were to provide the Maryland Health Benefit Exchange (MHBE) with an explanation of 2014 network adequacy standards for review and approval as a condition of certification. Beginning July 1, 2013, MHBE will require quarterly reports to demonstrate network adequacy.[32]

To meet the ACA requirements regarding the availability and content of provider directories, carriers will be required to submit provider data to the State Health Information Exchange that is being managed by Chesapeake Regional Information System for Maryland's Patients Provider Information Management system.[33]

For the 2015 benefit plan year, MHBE will determine if standardized network adequacy requirements across all carriers are appropriate.[34] In addition, MHBE will determine if expanded categories of ECPs (beyond the federal definition) will be allowed and if standardized ECP adequacy requirements across all carriers are appropriate.[35] The MHBE will utilize network adequacy software to monitor networks, compare networks across carriers, and publicly report on accessibility of providers.[36]

### Minnesota

The Minnesota Department of Health (MDH) reviews and approves HMO network adequacy standards in the state. MDH's HMO network adequacy rules do not currently extend to other managed health care products (e.g. PPOs).

HMO networks must be sufficient to provide timely access to care.[37] Minnesota uses statutorily defined travel times and distances to define timely access to care. Primary care must be available within 30 miles or 30 minutes of travel time. Specialty care must be available within 60 miles or 60 minutes.[38] HMO networks that are unable to satisfy these requirements may apply for an exemption from MDH by providing data demonstrating that the requirement is unfeasible in some portion of the service area.[39] Criteria for granting an exemption include utilization and referral patterns and the ability to pay for non-contracted providers.[40]

Minnesota requires health plans to offer contracts to all MDH designated ECPs within the plan's service area.[41] Under Minnesota law, ECPs must have a demonstrated ability to integrate appropriate and stabilizing services, such as transportation and child care, with medical services for underserved, high-risk, and special needs populations.[42] Providers must also demonstrate a commitment to serve low-income, underserved populations and may not restrict access to services because of a client's financial situation.[43]

Minnesota requires HMOs to provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without a referral.[44]

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[30] Md. HEALTH-GENERAL Code Ann. § 19-705.1(b)(1)(i)(2).

[31] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf.

[32] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf.

[33] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf.

[34] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf.

[35] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf.

[36] Id.

[37] Minn. Stat. § 62D.124, Subd.1 and 2.

[38] Minn. Stat. § 62D.124, Subd.1 and 2.

[39] Minn. Stat. § 62D.124, Subd.3.

[40] MN Rules 4685.1010.

[41] Minn. Stat. § 62Q.19 Subd. 3.

[42] Minn. Stat. § 62Q.19 Subd. 1(a).

[43] Minn. Stat. § 62Q.19 Subd. 1(a).

[44] Minn. Stat. § 62Q.19

### Montana

The Office of the Commissioner of Securities and Insurance oversees HMO network adequacy in Montana. HMOs are required to provide or arrange for the provision of covered health care services in a timely manner. Montana statutes set out maximum travel times and distances, maximum wait times, and minimum provider to enrollee ratios.[45] Montana does not, however, appear to review the adequacy of PPO networks.[46]

### Texas

The Texas Department of Insurance reviews network adequacy standards in the state. Texas requires both HMOs and PPOs to have a network that is adequate to meet the needs of covered individuals in a geographic area. Texas's network adequacy requirements have evolved, in part, due to consumer concerns revolving around inadequate networks and balance billing.[47] Unlike Colorado's approach (prohibiting balance billing at in-network facilities), Texas has attempted to address this problem though increased transparency requirements. The criteria for adequate PPO networks are similar to the requirements imposed upon HMO networks. For both HMOs and PPOs, networks must now contain enough doctors, hospitals and other providers to provide the full array of plan benefits within a prescribed drive time.[48]

An adequate network is required to be sufficiently accessible in number, size, and geographic distribution to be capable of furnishing the health care services covered by the insurance contract within the issuer's designated service area. The standard takes into account the number of covered individuals, their characteristics, and their medical and health care needs.[49] "Sufficiently accessible" for primary care and general hospital care means that the distance from any point in the insurer's designated service area to a point of service is not greater than 30 miles in non-rural areas and 60 miles in rural areas. For specialty care and specialty hospitals, the maximum distance is 75 miles.[50] In addition to the distance standards, HMO and PPO issuers must also ensure that preventive health services are available from preferred providers within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and within three months for an adult.[51]

Under the new transparency requirements, PPOs must also provide:

- Consumer notices when out-of-network referrals are made;
- Consumer information about network facilities, including the likelihood of balance billing occurring at such facilities;
- Disclosure of how out-of-network claim payments are calculated and disclosure of the carrier's average negotiated rates; and
- Real time estimates of payments to out-of-network providers.[52]

HMOs are required to maintain a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, and must update the list at least quarterly. The list must include the information necessary to fully inform prospective or current enrollees about the network, including names and locations of physicians and providers, a statement of any limitations on accessibility and referrals to specialists, including any limitations imposed by a limited provider network, and a disclosure of which physicians and providers will not accept new enrollees and which providers participate in closed provider networks serving only certain enrollees.[53]

[45] 33-36-201; 37.108.215, 37.108.220.

[46] Montana Commissioner of Securities and Insurance, *Affordable Care Act Update and the Federally Facilitated Exchange*, February 24, 2012, found at http://sao.mt.gov/health/exchange/docs/pdf/02242012_CSI_ExSICPresentation.pdf

[47] *See* http://www.tdi.texas.gov/hprovider/index.html; *See also* Report of the Health Network Adequacy Advisory Committee Senate Bill 1731, Section 11 Eightieth Legislature, Regular Session, 2007 (January 2009).

[48] http://www.tdi.texas.gov/hprovider/index.html.

[49] 28 TAC § 3.3704 (e)(1); 28 TAC § 11.1607.

[50] 28 TAC § 3.3704(e)(8); 28 TAC § 3.3704 (e)(1); 28 TAC § 11.1607.

[51] 28 TAC § 3.3704(e)(11); 28 TAC § 3.3704 (e)(1); 28 TAC § 11.1607.

[52] http://www.tdi.texas.gov/hprovider/index.html.

[53] 28 TAC § 11.1600(b)(11).

PPO provider listing requirements are outlined in regulations. These include requirements that:

- Issuers provide notice to enrollees at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis;[54]
- All electronic or non-electronic listings of preferred providers must be made available and updated at least every three months;[55]
- The provider information must include a method for enrollees to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers;[56]
- The provider information must indicate whether each preferred provider is accepting new patients;[57] and
- The provider information must provide a method by which enrollees may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.[58]

**Vermont**

Vermont requires managed care organizations (MCOs), either directly or through its provider contracts, to ensure that covered health care services are accessible to members on a timely basis.[59] Each MCO must contract with sufficient numbers and types of providers to ensure that all covered health care services will be delivered without delay when there are restrictions or incentives for members to use contracted or certain other providers.[60] Vermont outlines general travel standards in its regulation, including: 30 minutes maximum travel time for primary care; 30 minutes maximum for routine, office-based, mental health and substance abuse services; and, 60 minutes maximum for outpatient services.[61] Vermont Health Access requires that QHPs certify compliance with network adequacy requirements applicable to MCOs.

**Washington**

Washington's network adequacy standards closely follow the NAIC's model law approach and they apply market wide.[62] Washington does not set defined provider radii, ratios, or wait times in statute or regulation. Rather, Washington requires all carriers utilizing a managed care plan to have a network that is sufficient in numbers and types of providers and facilities to ensure that all health plan services offered to covered persons will be accessible without unreasonable delay. Carriers may demonstrate adequacy based on any reasonable criteria established by the carrier.[63] As previously stated, this approach allows carriers and regulators maximum flexibility to establish networks that cover diverse geographic areas by reviewing each network based on its unique design and circumstances.

Washington does not currently require carriers to offer contracts to essential community providers, except that all health insurance issuers are required to contract with Indian Health Services.[64] In addition to contracting with Indian Health Centers, the Washington Health Benefit Exchange also has identified the Washington Association of Community & Migrant Health Centers (WACMHC) which includes 26 Federally Qualified Community Health Centers and Mental Health and Substance Abuse providers as ECPs.[65]

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[54] 28 TAC § 3.3705(h)

[55] 28 TAC § 3.3705(i).

[56] 28 TAC § 3.3705(l)(1).

[57] 28 TAC § 3.3705(l)(4),

[58] 28 TAC § 3.3705(l)(7).

[59] Rule H-2009-03, Consumer Protection and Quality Requirements for Managed Care Organizations.

[60] Id.

[61] Id.

[62] NAIC Model Laws, Regulations and Guidelines 74-1, State Adoption (listing Washington as having adopted the model law).

[63] WA (WAC 284-43-200).

[64] WAC 284-43-200 (7).

[65] Washington State Office of the Insurance Commissioner, *Provider Contracting: Essential Community Providers & Indian Health Clinics (ACA #5)*, December 20, 2012.