



Affordable Care Act

Standards for Health Insurance Provider Networks: Examples from the States

As health plans explore how to control costs for themselves and their enrollees, they are experimenting with different ways of designing provider networks.

These evolving, sometimes narrower provider networks may result in lower-cost plan options for consumers. However, it is important that these networks still provide meaningful access to care for their enrollees.

To provide meaningful access, a provider network must be adequate, meaning it can deliver the right care at the right time, without enrollees having to travel unreasonably far. To ensure that all provider networks are adequate, states and the federal government can implement standards that create a baseline of consumer protections. It is especially important to enact these standards to ensure that plans sold in the health insurance marketplaces meet the Affordable Care Act's network adequacy requirements.¹

The laws, regulations, and guidance we profile in this brief are good examples of private insurance network adequacy or continuity of care protections from states across the country. These protections can serve as models for other states or for the federal government as they take steps to ensure that all health plan provider networks deliver meaningful access to care. The protections could be enacted through laws or regulations

at the state or federal level. Marketplaces, which have the authority to enact network adequacy and continuity of care standards for marketplace plans, can also consider implementing these model protections.

Examples from the States

The standards we've included in this brief address multiple concerns around provider networks and continuity of care. When enacted together, these standards can create a strong foundation of consumer protections for provider network adequacy.

It may be difficult to enact all of these protections at once. So, how does a state (or the federal government) decide which protections to pursue first?

The particular standards that each state or the federal government chooses to pursue should depend on the specific provider access concerns it most urgently needs to address. For example, states where consumers have been forced to travel unreasonable distances for in-network care may want to prioritize the enactment of travel time and distance standards (see "Adequate Geographic Distribution of Providers"). In states where networks seem to have too few providers to serve all of their enrollees, policy makers and advocates may want to prioritize enactment of standards for building up the number of in-network providers (see "Adequate Numbers of Providers").

When health plans design their provider networks, they need to ensure that these networks are adequate and provide meaningful access to care. That means their networks must be able to deliver the right care at the right time, without enrollees having to travel unreasonably far.

Many states have implemented network adequacy or continuity of care protections that serve as model standards that other states or the federal government can enact.

The protections we discuss

- 1 Accurate Information about Providers**
- 2 Timely Access to Care**
- 3 Adequate Numbers of Providers**
- 4 Adequate Types of Providers**
- 5 Inclusion of Essential Community Providers**
- 6 Adequate Geographic Distribution of Providers**
- 7 Access to Out-of-State Providers**
- 8 Accessible Hours**
- 9 Language-Accessible and Culturally-Competent Care**
- 10 Rights to Go Out of Network**
- 11 Continuity of Care**

For a more in-depth discussion of these protections, including what the Affordable Care Act requires, see our brief, *Improving Private Health Insurance Networks for Communities of Color*, at <http://familiesusa.org/product/improving-private-health-insurance-networks-communities-color>. You can also view our slideshow, *Network Adequacy 101: An Explainer*, online at <http://familiesusa.org/product/network-adequacy-101-explainer>.

1 Accurate Information about Providers

These states have implemented regulations that are designed to ensure that consumers can easily obtain accurate information about which providers are in a health plan's network.

New Jersey: The state has regulations requiring provider directories for managed care plans like HMOs (health maintenance organizations) and PPOs (preferred provider organizations) to include information such as providers' gender; whether providers are accepting new patients; and which languages providers speak other than English, if any.²

To help ensure that these directories are up to date, state regulations also require managed care plans to confirm the network participation of any provider who has not submitted a claim for 12 months or who has not otherwise communicated with the plan in a manner indicating an intention to continue participating in the network.

The process for confirming participation requires the insurer to contact the provider and request confirmation of the provider's intent to continue participating. The insurer must update its directories as necessary based on providers' responses. If a provider fails to respond, the insurer must mail a follow-up request by certified mail. If the provider fails to respond to the follow-up request within 30 days, the insurer must remove the provider from its directory.³

Washington: State regulations require health plans to update their provider directories monthly and to offer directories that accommodate individuals with limited English proficiency and people with disabilities. Directories must also provide information that includes but is not limited to the following:

- » The languages the provider speaks
- » The provider’s medical specialties
- » The provider’s institutional affiliations (such as hospital affiliations or provider groups of which they are a member)
- » Any interpreter services or communication and language assistance services that are available at the provider’s facilities, and information about how enrollees can obtain such services
- » The physical accessibility of the provider’s facilities
- » Specific descriptions of any available telemedicine services⁴

2 Timely Access to Care

These states have regulations that are designed to help make sure that health plan networks can provide enrollees with access to care in a timely manner.

California: State regulations require HMOs and many PPOs⁵ to ensure that enrollees are offered appointments within the following time frames:

- » Within 10 business days of a request for non-urgent primary care appointments
- » Within 15 business days of a request for an appointment with a specialist
- » Within 10 business days of a request for an appointment with a non-physician mental health care provider
- » Within 15 business days of a request for a non-urgent appointment for other (“ancillary”) services for the diagnosis or treatment of an injury, illness, or other health condition

These wait times may be shortened or extended as clinically appropriate based on the opinion of a qualified health care professional acting within the scope of his or her practice, consistent with professionally recognized standards of care. If the wait time is extended, it must be noted in the “relevant record” that a longer wait time will not have a detrimental impact on the health of the enrollee.⁶

Washington: The state has regulations that require health plans to demonstrate that enrollees can get appointments with primary care providers for non-preventive services within 10 business days of requesting them. When enrollees are referred to specialists, health plans must establish that enrollees can get appointments with those specialists within 15 business days for non-urgent services.⁷

Washington has regulations that require health plans to demonstrate that enrollees can get appointments with primary care providers for non-preventive services within 10 business days of requesting them.



3 Adequate Numbers of Providers

These states have enacted requirements that are designed to ensure that health plan networks have sufficient numbers of providers to meet enrollees' medical needs.

California: State regulations require that managed care plans provide one full-time-equivalent physician for every 1,200 enrollees, and approximately one full-time-equivalent primary care physician for every 2,000 enrollees.⁸

Delaware: In all plans sold in the marketplace, each primary care network must have at least one full-time-equivalent primary care provider for every 2,000 patients. Insurers must receive approval from the insurance commissioner for capacity changes that exceed 2,500 patients.⁹

4 Adequate Types of Providers

These states have regulations that are designed to ensure that health plan networks have a sufficient variety of types of providers to meet enrollees' medical needs.

New Hampshire: The state has enacted regulations that require managed care plans to have sufficient numbers of specific providers and facilities in their networks that include, but are not limited to:¹⁰

- » Primary care providers
- » Obstetricians/gynecologists
- » Oncologists
- » Allergists

- » Neurologists
- » Licensed renal dialysis providers
- » Psychiatrists
- » Inpatient psychiatric providers
- » Emergency mental health providers
- » Short-term facilities for substance use disorder treatment
- » Short-term care facilities for inpatient medical rehabilitation services

New Jersey: State regulations require managed care plans to have contracts or arrangements that allow enrollees to obtain covered services from certain types of facilities and providers at in-network costs. These providers and facilities include, but are not limited to:¹¹

- » Inpatient psychiatric facilities for adults, adolescents, and children
- » Outpatient therapy providers for mental health and substance use conditions
- » Emergency mental health service providers
- » Residential substance abuse treatment centers
- » Specialty outpatient centers for HIV/AIDS, sickle cell disease, and hemophilia
- » Comprehensive rehabilitation service providers
- » Licensed renal dialysis providers
- » A hospital that offers tertiary (highly specialized) pediatric services

New Jersey has also enacted additional regulations that apply only to HMOs. These regulations require HMO provider networks to have sufficient numbers of specific types of providers that include but are not limited to:¹²

- » Primary care providers, which can include physician assistants; certified nurse midwives; and nurse practitioners or clinical nurse specialists who are certified in advance practice categories that are comparable to family practice, internal medicine, general practice, obstetrics and gynecology, or pediatrics; and in hospitals or other facilities¹³
- » Obstetricians/gynecologists
- » Psychiatrists
- » Cardiologists
- » Neurologists
- » Oncologists

5 Inclusion of Essential Community Providers

Essential community providers serve predominantly low-income, medically underserved populations. These states have enacted requirements that are designed to help ensure that health plan networks provide sufficient access to essential community providers, as required by the Affordable Care Act.¹⁴

Connecticut: The state’s health insurance marketplace requires that by January 1, 2015, plans in the marketplace include in their networks 90 percent of the federally qualified health centers in the state, as well as 75 percent

of essential community providers that are not federally qualified health centers based on the marketplace’s list of essential community providers.¹⁵

The marketplace uses its own list of essential community providers instead of the database of essential community providers created by the U.S. Department of Health and Human Services (HHS)¹⁶ because it found that the HHS database does not include a sufficient number or sufficient geographic diversity of such providers in Connecticut. The marketplace also found that the database does not include sufficient essential community providers to deliver all of the essential health benefits that consumers are entitled to receive through their health coverage under the Affordable Care Act.¹⁷

Minnesota: Minnesota law requires health plans with 50,000 or more enrollees to offer a contract to any designated essential community provider located within the plan’s service area.

- » The plan may require that provider to “meet all data requirements, utilization review, and quality assurance requirements” that other in-network providers must meet.
- » The plan and the essential community provider may negotiate reimbursement rates for covered services, but these rates 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.”¹⁸

Minnesota law requires health plans with 50,000 or more enrollees to offer a contract to any designated essential community provider located within the plan’s service area.



6 Adequate Geographic Distribution of Providers

These states have enacted standards that are designed to ensure that health plan networks include providers and facilities that are geographically accessible to where enrollees live or work.

New Jersey: State regulations include geographic accessibility standards for the providers and facilities that all managed care plans must include in their networks, some of which are listed on page 5. For example:

- » Outpatient therapy for mental health and substance use conditions, emergency mental health services, and licensed renal dialysis providers must be “available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area.”
- » The other facilities and providers listed on page 5 that managed care plans must include in their networks must be “available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area.”

What is particularly important about these standards is that they are required to be modified to meet the needs of enrollees who rely on *public transportation*. Specifically, “in any county or approved service area in which 20 percent or more of a carrier’s [insurance

plan’s] projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times set forth in the specifications... above shall be based upon average transit time using public transportation.”¹⁹

In addition to the requirements for all managed care plans, state regulations include geographic accessibility standards that apply specifically to HMOs.

- » Primary care providers must be available within “10 miles or 30 minutes average driving time or public transit (if available), whichever is less, of 90 percent of the enrolled population.”
- » For the specialists for which only HMOs have specific provider inclusion standards (including obstetricians/gynecologists, psychiatrists, cardiologists, neurologists, and oncologists, as listed on page 6), HMOs must have a policy that assures access to these specialists “within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area.”²⁰

Vermont: Under state standards for marketplace plans and state regulations that cover all managed care plans, travel times for enrollees to reach in-network providers “under normal conditions from their residence or place of business, generally should not exceed the following:”

- » 30 minutes to a primary care provider
- » 30 minutes to routine, office-based mental health and substance abuse services

- » 60 minutes for outpatient physician specialty care; intensive outpatient, partial hospital, residential, or inpatient mental health and substance abuse services; laboratory services; pharmacy services; general optometry services; inpatient care; imaging services; and inpatient medical rehabilitation services
- » 90 minutes for kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery
- » The plans must also provide “reasonable accessibility for other specialty services.”

In addition, the requirements “shall not be construed as restricting or prohibiting a managed care plan from offering such services at so-called ‘centers of excellence’ inside or outside of the service area, as long as the selection of a center of excellence is based on objective quality of care indicators and as long as the benefits are such that it does not create foreseeable medical, practical or financial impediments for the member to be able to timely obtain access to related immediate, episodic and/or ongoing care.”²¹

7 Access to Out-of-State Providers

This state has a regulation that is designed to encourage health plan networks to include out-of-state providers to enhance their adequacy. This type of protection is especially important for plan enrollees who live near state borders and who may depend on providers located in an adjoining state for their care.


New Mexico: Under state regulations, “A [managed health care plan] is encouraged to enter into contracts or other arrangements with out-of-state providers in order to meet the access requirements [of the state’s network adequacy regulation].”²²

8 Accessible Hours

These states have enacted requirements that are designed to ensure that health plan networks can provide care at times that are convenient to enrollees who may be unable to obtain care during standard business hours (weekdays from 9:00 am to 5:00 pm).

California: State regulations that apply to some PPO plans and to certain other managed care plans require that basic health care services be available through a plan’s network not only during standard business hours, but also “until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday.”²³

Rhode Island: Guidance requires that of the primary care practices that health plans contract with in each county, at least 25 percent must be open at least one day per week for three hours beyond normal business hours (9:00 am to 5:00 pm) for routine visits, or the practices must have an agreement with another primary care practice to provide extended hours. These providers must be geographically distributed to ensure reasonable access based on where the health plan’s enrollees are located.²⁴



States have enacted requirements that are designed to ensure that health plan networks can provide care at times that are convenient to enrollees who may be unable to obtain care during standard business hours.

9 Language-Accessible and Culturally-Competent Care

These states have enacted requirements designed to ensure that health plan networks can provide language-accessible, culturally-competent care.

California: State laws require all health insurance plans to have language access programs that assess the language needs of their enrollees and that provide free interpreter services at all points of contact in the health plan, including with providers in the health plan’s network. Health plans must also provide enrollees with a notice about their right to receive these language services.²⁵

New Mexico: Regulations require that “managed health care plans must ensure that information and services are available in languages other than English, that services are provided in a manner that takes into account cultural aspects of the covered... population, and that accommodations are provided for covered persons with disabilities.”

To demonstrate compliance with these requirements, managed care plans must develop, implement, and maintain plans to address cultural and linguistic diversity that include the following elements:²⁶

- » A description of how the managed care plan will identify the language needs of enrollees
- » The measures the plan will take to ensure access for enrollees with limited English proficiency (LEP), including in encounters with providers

- » The steps the plan will take to ensure availability of adequate interpretation services within its network, including a description of the specific contracts or other arrangements for providing interpretation services for deaf enrollees
- » A description of whether interpretation services are available to enrollees on a 24-hour basis for emergency care
- » A description of how the plan will conduct outreach to ensure enrollees with particular cultural and linguistic needs are made aware of the services available to them to address these needs
- » A description of any guidelines on or training in the cultural and linguistic needs of enrollees that the plan will use with in-network providers
- » A description of the physical accessibility of the provider network for people with disabilities

10 Rights to Go Out of Network

Protections to ensure that provider networks are adequate to serve all populations are critical. However, it is just as important that consumers have the right to go out of network in instances when health plans do not have in-network providers who can meet enrollees’ medical needs in a reasonable and timely manner. These states provide models of such protections.

Delaware: If managed care plans have “an insufficient number of providers that are geographically accessible and available within a reasonable period of time to

provide covered health services to enrollees,” these plans must provide coverage for enrollees to see out-of-network providers for those services.²⁷ In addition, regulations require that managed care plans allow enrollees to see out-of-network providers “upon the request of a network provider, when medically necessary covered health services are not available through network providers, or the network providers are not available within a reasonable period of time.”

In both of these circumstances, the out-of-network provider may not “balance bill” the enrollee, meaning that the provider may not charge the enrollee extra if the provider does not believe the insurer is paying enough for the provider’s services.²⁸

New York: Under a 2014 law, enrollees in health plans that use provider networks may obtain referrals to or pre-authorizations for providers outside their plans’ networks when the networks do not have geographically accessible providers with the appropriate training and expertise to meet enrollees’ health care needs. In these situations, the enrollee will not have to pay the additional out-of-network expenses—the enrollee’s health plan will pay for all expenses other than the usual in-network cost-sharing.

If an enrollee and his or her health plan disagree on whether the plan has an appropriate in-network provider to address the enrollee’s medical needs, the enrollee has the right to appeal the plan’s decision through the state’s independent external review system. That system


will order the plan to allow the enrollee to see the out-of-network provider (without facing extra costs) if it finds that:

- » The health plan does not have an in-network provider with appropriate training and expertise, and
- » There is an out-of-network provider who does have that expertise and can treat the patient, and
- » The out-of-network provider’s services are likely to lead to a better clinical outcome.²⁹

11 Continuity of Care

These states have passed laws designed to ensure that consumers do not experience interruptions in necessary care if their providers leave their network or if consumers switch health plans.

California: State law requires managed care plans to allow enrollees to continue seeing providers who have left their plan’s network (as long as the provider’s termination was not due to “medical disciplinary cause or reason... or fraud or other criminal activity”) at the enrollee’s request, for select conditions or services for certain time frames. In these instances, the copayments, deductibles, and other cost-sharing the enrollee must pay for the terminated provider’s services would be the same as what the enrollee would pay if receiving care from an in-network provider.



States have passed laws designed to ensure that consumers do not experience interruptions in necessary care if their providers leave their network or if consumers switch health plans.

The conditions or services and the timeframes for which enrollees may see providers who have left their plan's network are as follows:

- » **Acute conditions:** Coverage is provided for the duration of the condition. (Acute conditions are medical conditions involving a sudden onset of symptoms that require prompt medical attention and that have a limited duration.)
- » **Serious chronic conditions:** Coverage is provided for the time period necessary to complete a course of treatment and arrange for a safe transfer to another provider (as determined by the plan in consultation with the enrollee and the terminated provider and consistent with good professional practice), not to exceed 12 months from the provider's contract termination date. (Serious chronic conditions are medical conditions that are serious in nature and that persist without a full cure, that worsen over an extended time period, or that require ongoing treatment to maintain remission or prevent deterioration.)
- » **Pregnancy:** Coverage is provided for the duration of the pregnancy (three trimesters and the immediate postpartum period).
- » **Terminal illnesses:** Coverage is provided for the duration of the illness, which may exceed 12 months from the provider's contract termination date. (Terminal illnesses are incurable or irreversible conditions that have a high probability of causing death within one year or less.)

- » **Care for children up to age three:** Coverage is provided for no longer than 12 months from the provider's contract termination date.

- » **Preauthorized surgeries or procedures that are part of a documented course of treatment:** Coverage is provided if documentation indicates that services were recommended to occur within 180 days of the provider's contract termination date.

The compensation rates for the terminated provider shall be similar to those the plan pays in-network providers who practice in the same or similar geographic areas unless the terminated provider and plan agree to a different rate.

Plans can also require terminated providers to agree to the same contractual terms and conditions that the plan imposed on the provider prior to termination. If these terms are not met, the plan is not required to continue the terminated provider's services.³⁰

Maryland: A 2013 law requires health plans that are sold or renewed on or after January 1, 2015, to allow new enrollees to continue to receive care from their former providers for certain conditions or services for certain amounts of time, even if those providers aren't in their new health plan's network. The law also requires plans to give new enrollees a notice of their rights to see their former providers in certain circumstances.

In instances where an enrollee is permitted to continue getting care from a former provider, the copayments, deductibles, or co-insurance the enrollee must pay for the former provider's services would be the same as the enrollee would pay if receiving care from an in-network provider. In addition, the former provider may not "balance bill" the enrollee.

Conditions or services for which enrollees may see their former providers are listed below. For each condition or service, unless otherwise noted, the enrollee will receive coverage for the lesser of the course of treatment or 90 days. At the end of that time, the health plan may elect to reassess the need for continued treatment and authorize continued coverage of services from the former provider.

Conditions and services that are eligible for continued coverage include the following:

- » Acute conditions, including acute dental conditions
- » Serious chronic conditions, including dental conditions
- » Pregnancy, for which coverage is provided throughout the duration of three trimesters and the initial postpartum visit
- » Mental health conditions and substance use disorders
- » Procedures, treatments, medications, or services covered by the enrollee's new plan and preauthorized by his or her former health plan, including Medicaid and the Children's Health Insurance Program (CHIP)


- » Any other condition on which the nonparticipating provider and the enrollee's new plan agree

The enrollee's new plan shall pay the former provider the rate it would normally pay in-network providers for similar services in the same or similar geographic area. The former provider may decline to accept the rate by giving 10 days' prior notice to the enrollee and the enrollee's new plan. In this case, the provider and plan may agree on an alternate rate, but if that is not possible and no agreement on compensation can be made, the provider is not required to continue care.³¹

Other Sources of Model Language on Provider Network Standards

There are additional sources that can serve as models for states and the federal government as they seek to strengthen network adequacy standards in the private insurance market. These include:

- » State network adequacy requirements for Medicaid managed care organizations
- » Network adequacy standards for private Medicare plans (Medicare Advantage plans)³²
- » In addition, the National Association of Insurance Commissioners is in the process of updating its Network Adequacy Model Act,³³ which is a source of consumer protection language and will hopefully be stronger once the update is complete.



The National Association of Insurance Commissioners is in the process of updating its Network Adequacy Model Act, which is a source of consumer protection language and will hopefully be stronger once the update is complete.

How can policy makers implement provider network standards?

As shown by the states we've featured, network adequacy and continuity of care protections may be implemented through multiple channels. These include legislation, the regulatory (and sub-regulatory guidance) authority of government agencies, and the authority of the health insurance marketplaces.

Although this brief focuses on examples of standards that have been enacted at the state level, policy makers can use these types of channels to implement stronger network adequacy and continuity of care protections at the federal level as well.

Advocating for Network Adequacy Standards

There are many influencers at the state and federal levels who have authority over which standards are in place to ensure that enrollees have meaningful access to the providers and facilities they need. We've divided these decision makers—and tips for reaching them—into two groups: state and federal.

Advocating for Standards at the State Level

Individuals who are interested in strengthening provider network standards in their state should reach out to the following decision makers:

- » State insurance regulators, often known as insurance departments³⁴

- » State legislators
- » Marketplace boards, directors, and staff in states with state-based marketplaces, or in states with federal marketplaces in which state agencies are partners or actively engaged in certain functions

When meeting with or contacting these decision makers, advocates and other stakeholders can discuss the provider network problems that consumers have encountered and can recommend standards the state should enact to ensure that networks can meet the needs of health plan enrollees.

Advocating for Standards at the Federal Level

Individuals who are interested in strengthening provider network standards that would apply nationwide—at least in all health insurance marketplace plans, or specifically in federally facilitated marketplace plans—should reach out to these federal decision makers about the standards that would best allow networks to meet the needs of health plan enrollees:

- » The applicable HHS regional director³⁵
- » HHS officials in Washington, DC, such as the HHS Secretary and officials at the Center for Consumer Information and Insurance Oversight (CCIIO), who have authority over insurance plan standards and the health insurance marketplaces

It is also important to respond to the relevant regulatory and sub-regulatory comment opportunities (sub-regulatory opportunities include opportunities to comment on guidance, letters from HHS, and other policy-setting documents that aren't regulations). Two important opportunities for responding are:

- » The annual Benefit and Payment Parameters Notice of Proposed Rulemaking, which updates standards relevant to plans that are sold both inside and outside the marketplaces³⁶
- » The Annual Draft Letter to Issuers in the Federally Facilitated Marketplaces, which outlines requirements for insurers seeking to sell coverage in these marketplaces, including requirements pertaining to network adequacy, provider directories, and essential community providers³⁷

As health plans continue to change how they design their provider networks, it's critical that these designs do not hamper consumers' ability to obtain the right care at the right time, without traveling too far. By enacting provider network and continuity of care standards, states and the federal government can safeguard consumers' rights to adequate access to care and create an environment where enrollees and health plans alike benefit from the cost savings produced by new network designs.

Endnotes

1 42 U.S. Code § 18031, “Affordable Choices of Health Benefit Plans”; 45 CFR § 156.230, “Network Adequacy Standards.” For an in-depth discussion of these requirements, see Claire McAndrew and Sinsi Hernández-Cancio, *Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color* (Washington: Families USA, August 2014), available online at <http://familiesusa.org/product/improving-private-health-insurance-networks-communities-color>.

2 N.J.A.C. 11:24C—4.5, “Content and Availability of Provider Network Directories.”

3 N.J.A.C. 11:24C—4.6, “Standards for Accuracy of Provider Directory Information.”

4 Washington State Office of the Insurance Commissioner, *Insurance Commissioner Matter No. R 2013-22* (Olympia: Washington State, April 26, 2014), available online at <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf>.

5 Health insurers in California may be regulated by one of two entities, either the Department of Managed Health Care or the California Department of Insurance. The rules for timely access to care referenced here apply to plans regulated by the Department of Managed Health Care, which include all HMOs in California, as well as many PPOs. For more information, see *Agencies that Oversee Health Plans*, available online at <http://www.dmhc.ca.gov/HealthPlansCoverage/ViewCompareHealthPlans/AgenciesThatOverseeHealthPlans.aspx#.U7GV37H5lff>.

6 28 CCR § 1300.672.2, “Timely Access to Non-Emergency Health Care Services,” implementing California law CA HLTH & S § 1367.03, “Regulations to Ensure Access to Needed Health Care Services in Timely Manner; Indicators and Considerations; Review and

Adoption of Standards; Contracts; Reports; Evaluating Compliance; Investigation and Enforcement.”

7 Washington State Office of the Insurance Commissioner, op. cit.

8 10 CCR § 2240.1, “Adequacy and Accessibility of Provider Services,” implementing California law CA INS § 10133.5, “Contracts with Providers for Alternative Rates; Regulations; Guidelines; Reports”; 28 CCR § 1300.672, “Accessibility of Services.”

9 Delaware Department of Insurance, *Delaware State-Specific Qualified Health Plan (QHP) Standards for Plan Year 2015* (Dover: State of Delaware, 2014), available online at <http://www.delawareinsurance.gov/health-reform/DE-QHP-Standards-PY2015-May2014-v1.pdf>.

10 N.H. Code Admin. R. Ins 2701.06, “Standards for Geographic Accessibility,” implementing New Hampshire law N.H. Rev. Stat. § 420-J:7, “Network Adequacy.” Specific geographic access standards also apply to these types of providers and facilities.

11 N.J.A.C. 11:24A—4.10, “Network Adequacy,” implementing New Jersey law N. J. S. A. 26:2S-18, “Enforcement; Adoption of Rules and Regulations.” Specific geographic access standards also apply to these types of providers and facilities, as listed on page 7.

12 N.J.A.C. 11:24—6.2, “Primary, Specialty and Ancillary Providers,” authorized under New Jersey law N.J.S.A.26:2J, “Health Maintenance Organizations.” Specific geographic access standards also apply to these types of providers and facilities, as described on page 7.

13 Non-HMO managed care plans also have to meet similar primary care provider standards if they require enrollees to have or select a primary care provider.

14 42 U.S. Code § 18031, “Affordable Choices of Health Benefit Plans”; 45 CFR § 156.235, “Essential Community Providers.” For an in-depth discussion of these requirements, see Claire McAndrew and Sinsi Hernández-Cancio, *Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color* (Washington: Families USA, August 2014), available online at <http://familiesusa.org/product/improving-private-health-insurance-networks-communities-color>.

15 Access Health CT, *Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace* (Hartford: Access Health CT, March 18, 2014), available online at http://www.ct.gov/hix/lib/hix/QHP_Solicitation_031814_Amended.pdf.

16 Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Non-Exhaustive HHS List of Essential Community Providers* (Washington: HHS, 2014), available online at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/non-exhaustive-list-essential-community-providers2015.xlsx>.

17 Connecticut Health Insurance Exchange Board of Directors, *Special Meeting Minutes* (Hartford: Access Health CT, June 26, 2013), available online at <http://www.ct.gov/hix/lib/hix/FinalMinutes62613.pdf>.

18 M.S.A. § 62Q.19, “Essential Community Providers.” This law predates the Affordable Care Act.

19 N.J.A.C. 11:24A—4.10, “Network Adequacy,” implementing New Jersey law N. J. S. A. 26:2S-18, “Enforcement; Adoption of Rules and Regulations.” In instances such as this where geographic access standards must be met for no less than a minimum share of enrollees, it is important to ensure that this share does not leave out individuals who live in communities of color or in other underserved areas.

20 N.J.A.C. 11:24—6.2, “Primary, Specialty, and Ancillary Providers,” authorized under New Jersey law N.J.S.A26:2], “Health Maintenance Organizations.” In instances such as this where geographic access standards must be met for no less than a minimum share of enrollees, it is important to ensure that this share does not leave out individuals who live in communities of color or in other underserved areas.

21 Vt. Admin. Code 4-5-3:10.500, “Additional Requirements If There Are Any Restrictions or Incentives Pertaining to Member Use of Contracted or Certain Other Providers”; Department of Vermont Health Access, *Vermont Health Connect Request for Proposals* (Montpelier: State of Vermont, amended December 21, 2012), available online at https://www.statereforum.org/system/files/vermont_ghp_rfp_amend_12_21_12.pdf.

22 N.M. Admin Code 13.10.22.8, “Managed Health Care Plan Compliance, Access to Health Care Services.”

23 10 CCR § 2240.1, “Adequacy and Accessibility of Provider Services,” implementing California law CA INS § 10133.5, “Contracts with Providers for Alternative Rates; Regulations; Guidelines; Reports.” Health insurers in California may be regulated by one of two entities, either the Department of Managed Health Care or the California Department of Insurance. The rules for accessible hours referenced here apply to plans regulated by the California Department of Insurance, which include some PPOs but no HMOs. For more information, see *Agencies that Oversee Health Plans*, available online at <http://www.dmhc.ca.gov/HealthPlansCoverage/ViewCompareHealthPlans/AgenciesThatOverseeHealthPlans.aspx#.U7GV37H51f>.

24 Rhode Island Department of Health, *Letter to Insurance Commissioner Koller and Exchange Director Ferguson on Network Adequacy* (Providence: State of Rhode Island, January, 11, 2013), available online at https://www.statereforum.org/sites/default/files/tr_network_adequacy_1-11-13.pdf.

25 CA INS § 10133.8, “Access to Translated Materials and Language Assistance; Regulations,” and corresponding regulations under 10 CCR § 2538.3, “Language Assistance Program”; CA HLTH & S § 1367.04, “Access to Language Assistance; Regulations and Standards; Assessment of Linguistic Needs of Enrollees; Biennial Reports,” and corresponding regulations under 28 CCR § 1300.67.04, “Language Assistance Programs.”

26 N.M. Admin Code 13.10.22.11, “Managed Health Care Plan Compliance: Cultural and Linguistic Diversity.”

27 18 Del. Admin. C. § 11.3.1.2.

28 18 Del. Admin. C. § 11.3.1.3; 18 Del. Admin. C. § 11.3.1.2.

29 New York Senate Bill 2914, 2014, available online at <http://stopsurprisemedicalbills.files.wordpress.com/2014/02/s-6914-a-2905-part-h.pdf>; Mark Scherzer, *New York’s New “Surprise Bill” Law Rolls Out New Health Insurance Protections for Consumers* (Washington: Families USA, April 10, 2014), available online at <http://familiesusa.org/blog/2014/04/new-york%E2%80%99s-new-surprise-bill-law-rolls-out-new-health-insurance-protections-consumers>.

30 CA HLTH & S § 1373.96, “Completion of Covered Services to Be Provided by Health Care Service Plan; Request of Enrollee; Covered Conditions; Compliance with Specified Terms and Conditions by Terminated Providers, or Nonparticipating Providers, Whose Services Are Continued; Payments”; CA INS § 10133.56, “Completion of Covered Services; Covered Conditions.” These laws also allowed enrollees in new plans to continue to receive care from their former providers if their former plan was canceled between December 1, 2013, and March 31, 2014.

31 MD Code, Insurance, § 15-140, “Continuity of Health Care during Transitions from One Carrier to Another.”

32 Centers for Medicare and Medicaid Services, *Calendar Year 2015 Medicare Advantage HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance* (Washington: CMS, 2014), available online at http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf.

33 National Association of Insurance Commissioners, *Managed Care Plan Network Adequacy Model Act* (Washington: NAIC, October 1996), available online at <http://www.naic.org/store/free/MDL-74.pdf>.

34 To locate your insurance regulator, visit this map from the National Association of Insurance Commissioners: http://www.naic.org/state_web_map.htm.

35 To locate your Regional Director, visit this map from HHS: <http://www.hhs.gov/iea/regional/>.

36 For an example, see Department of Health and Human Services, *Notice of Benefit and Payment Parameters for 2015; Proposed Rule* (Washington: HHS, December 2, 2013), available online at <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf>.

37 For an example see, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces* (Washington: HHS, February 4, 2014), available online at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf>.

A selected list of relevant publications to date:

Network Adequacy 101: An Explainer
(October 2014)

*Improving Private Health Insurance Networks
for Communities of Color* (August 2014)

For a more current list, visit:

www.familiesusa.org/publications

Publication ID: 000ACT110614

This publication was written by:

Claire McAndrew, Private Insurance Program
Director, Families USA

The following Families USA staff contributed to the
preparation of this material (listed alphabetically):

Evan Potler, Art Director

Carla Uriona, Director of Content Strategy

Ingrid VanTuinen, Director of Editorial

Alexandra Walker, Senior Web Editor

© Families USA 2014

FAMILIESUSA 
THE VOICE FOR HEALTH CARE CONSUMERS

1201 New York Avenue NW, Suite 1100

Washington, DC 20005

202-628-3030

info@familiesusa.org

www.FamiliesUSA.org

facebook / FamiliesUSA

twitter / @FamiliesUSA