WYOMING LEGISLATIVE SERVICE OFFICE

RESEARCH MEMORANDUM

Date: February 7, 2020

From: Karla Smith, Senior Program Evaluator

Subject: Compelling Insurance Coverage

QUESTION:

How do other states address a health insurance providers' lack of nearby in-network providers?

ANSWER:

Ensuring access to care is a significant challenge in rural America where the healthcare workforce supply is smaller and the healthcare needs are greater.[1] Employer-provided (group) and Individual insurance health plans develop provider networks – which include the set of hospitals, physicians, dentists, mental health services, and other providers who deliver care under the terms of the insurance contract. The size and composition of the network can influence an enrollee's ability to access care (primary as well as specialty care) in a sufficient number and in a timely fashion (network adequacy).

In order to balance access to providers with costs, health insurance plans often define and adjust the number, qualifications, and quality of providers in their networks.[2] Health insurance plans may also limit the number of providers in their networks as a means of conserving costs or coordinating care. As a result of rising insurance costs, consumers have been increasingly drawn to less expensive plans, creating a market for inexpensive, overly narrow networks, also known as "skinny networks."[3] This may narrow the provider network to the extent that the enrollees in the

[1] Michelle Casey, MS, et.al., *Regulating Network Adequacy for Rural Populations: Perspectives of Five States*, University of Minnesota Rural Health Research Center - Policy Brief. August 2017, 1.
[2] Jolie H. Matthews, Senior Health Policy Advisor and Counsel, NAIC Center for Insurance Policy and Research (CIPR), Last updated 4/18/19.
[3] Leah Selby Gray, *An Elegant Solution to Network Inadequacy: How to Better Protect Patients from Inadequate Health Networks and Surprise Balance Billing*, 70 Hastings L.J. 1639 (2019), 1644.

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plan may have extremely limited options in choosing providers. Often there are financial implications associated if the enrollee opts for an out-of-network provider.[4]

While there is no single solution to address the specific issue of geographical access coverage and cost, to varying degrees, states have used one or more of the following approaches:

Network Adequacy

Provisions to assist enrollees in plans with very limited options in choosing healthcare providers as well as efforts to ensure sufficient quality care is available within a reasonable distance.

Any Willing Provider

Provisions to address limited healthcare networks by requiring health insurers and other health care plans to allow willing health care providers to become members of an insurer's network if certain conditions are met.

Surprise Billing/Balanced Billing.

Provisions alleviating out-of-pocket costs when consumers receive medical bills from health providers outside their insurance plan's network.

NETWORK ADEQUACY

Network adequacy refers to a healthcare plan's ability to deliver the benefits promised under the terms of the contract by providing reasonable access to a sufficient number of in-network primary care, specialty physicians, and health services.[5] State and federal regulators use various quantitative and qualitative network adequacy standards to ensure an appropriate number of providers within each network to meet the needs of those patients.[6] Qualitative standards set a general benchmark that insurers must meet for their participating provider networks. These are often used to regulate "narrow network" plans.[7] The following three quantitative standards provide more precise benchmarks for regulating networks:

- Minimum provider-to-enrollee ratios
- Minimum time or distance to travel to certain providers
- Maximum wait times

In 2013, a task force conducted a regulatory review of the National Association of Insurance Commissioners (NAIC) existing models related to health insurance. The task force concluded that

[4] Matthews, NAIC Center for Insurance Policy and Research (CIPR), Last updated 4/18/19.
[5] Ibid.
[6] Leah, *An Elegant Solution to Network Inadequacy: How to Better Protect Patients from Inadequate Health Networks and Surprise Balance Billing*, 1652.
[7] Jack Pistor, National Conference of State Legislators. January 2020.

"network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions" while balancing the "competing policy goals and considerations that come into play with examinations of network adequacy."[8] Revisions to the model were adopted in 2015 with Model #74, now called the *Health Benefit Plan Network Access and Adequacy Model Act*.[9] These revisions include a number of enhancements such as more specific requirements for network adequacy concerning network sufficiency, how network sufficiency is to be determined, and who is to determine network sufficiency.[10]

In October of 2016, the university of Maryland School of Law published a fifty-state survey of network Adequacy Quantitative Standards in conjunction with their study on the State Opioid Treatment Program. This survey provides an overview of the various approaches adopted by states addressing network adequacy, with geographic criteria as the predominate approach. See **Attachment C** for the survey responses by state (note Wyoming is absent in this survey).[11]

State Approaches to Network Adequacy Laws

While some states will only use one of the quantitative measures to evaluate network adequacy, some states, such as California, use all three: provider-to-enrollee ratios, travel and distance time, and maximum wait times. This "timely access" approach is considered the most effective way to use quantitative measures as it allows regulators to see the broader picture from multiple viewpoints. California's timely access laws attempt to ensure patients can obtain necessary services in a reasonable amount of time. Health insurance plans in California must provide a certain number of doctors per insured in the area few standards exist, however, for how far away providers can be and the hours per week during which emergency and non-emergency providers must be available. One condition which may be noteworthy as relevant to Wyoming, is that California includes a provision stating "networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year."[12]

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[8] *Plan Management Function: Network Adequacy White Paper*, NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012. Based on: Federal Register, final rules, "Exchange Establishment Standards and Other Related Standards under the Affordable Care Act.", March 2012. https://www.govinfo.gov/content/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

[9] Matthews, NAIC Center for Insurance Policy and Research (CIPR).

[10] The revisions also addresses a narrow aspect of the so-called "surprise bill" issue by establishing a mechanism for consumers to deal with bills they received for services provided by out-of-network facility-based providers while receiving treatment at an in-network facility. Section 7 also includes a provider mediation process for payment of out-of-network facility-based provider remittances for those providers who object to the amount of the payment they received for the out-of-network services they provided using the established payment rate.

[11] Ellen Weber, Esq. Professor of Law, Drug Policy and Public Strategies Clinic, University of Maryland, Francis King Carey School of Law, Update to the *Fifty-state Survey : Network Adequacy Quantitative Standards, and summary of survey results,* October 18, 2016.

[12] Michelle Casey, MS, et.al., *Regulating Network Adequacy for Rural Populations: Perspectives of Five States*, University of Minnesota Rural Health Research Center - Policy Brief. August 2017.

Similarly, managed care plans in California must also have providers within a reasonable distance who can adequately serve enrolled patients. The corresponding regulations require health plans to ensure a certain number of providers for enrollees, a certain number of hours of provider availability per week, and timelines for when a patient must receive different types of appointment after requesting one. The requirements differ for emergency and non-emergency care, but not for specialties.[13] If plans in California cannot comply with these timely access laws, they cannot sell plans in the state.

Drawbacks to California's timely access requirements include "arduous reporting standards" for the health plans and insurers and a heavy regulatory burden on state regulatory agencies. Insurers and health plans must constantly file reports on network adequacy requiring review, investigation, and enforcement. California's Department of Insurance and Department of Managed Health Care regulate the largest market in the country and is the only state which has full-time staff devoted solely to evaluating network adequacy.[14]

A University of Minnesota Rural Health Research Center study provides an overview of rural-specific network adequacy standards in five different states—California, Kentucky, Montana, Texas and Wisconsin. The study concludes that regulatory "agencies face a complex and ongoing challenge to encourage insurers to offer plans in rural areas (perhaps by offering more flexible standards in rural areas) while still guaranteeing that rural residents will have adequate provider networks with any insurer they join."[15] Telemedicine is another option being proposed as a potential tool to help insurers meet network adequacy standards in rural areas lacking a sufficient supply of providers.[16]

Wyoming Network Adequacy

In Wyoming, relevant network adequacy laws are W.S. §26-34-108 *Quality Assurance Program*, and W.S. §26-18-302(a)(vii) *Sale of Health Insurance Policies Approved in Other States*. See **Attachment A**. In a 2014 Wyoming Department of Insurance Report to the Joint Labor, Health and Social Services Interim Committee,[17] the Department addressed the issue of Network Adequacy:

[13] Emergency care as well as specialty care maybe treated different from primary care.
[14] Mark A. Hall & Paul B. Ginsburg, *A Better Approach to Regulating Provider network Adequacy*, USC-Brookings Schaeffer Initiative for Health Policy ed., 2017. As of this article, sixteen states have quantitative standards that apply to all plans, eleven states have quantitative standards that apply only to plans such as HMOs, and the remaining twenty-three states do not use quantitative measures of network adequacy.
[15] Casey, *Regulating Network Adequacy for Rural Populations: Perspectives of Five States*, University of Minnesota Rural Health Research Center - Policy Brief. August 2017, 4.
[16] Ibid.
[17] Wyoming Department of Insurance, *Wyoming Health Insurance Topics*. Report to the Joint Labor, Health and Social Services Interim Committee, October 16, 2014.

> The ACA requires that Qualified Health Plan (QHP) networks be sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services covered under the QHP will be accessible without unreasonable delay. While the ACA provides a general framework to address the adequacy of QHP networks, the law and its implementing rule and guidance make the states responsible for assuring that network adequacy is achieved for the benefit of consumers. States, in turn, take different approaches in regulating the adequacy of health plan networks, at least in part due 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.
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> 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). This is the case in Wyoming where HMOs are required to comply with "reasonable standards of medical practice" which include availability and accessibility of care, but there are no similar state requirements for non-HMO insurers. [18]

In the case of out-of-state health insurance policies sold in Wyoming, the Wyoming Commissioner of Insurance has the authority to review network requirements and require modifications if the network lacks a sufficient number of providers.[19]

ANY WILLING PROVIDER

"Any Willing Provider" statutes, sometimes referred to as "Any Authorized Provider," are laws that require health insurance carriers to allow health care providers to become members of the 'carriers' networks of providers if certain conditions are met. The idea behind Any Willing Provider laws is more providers included in an insurance network may bolster access to care. Such statutes prohibit insurance carriers from limiting membership within their provider networks based upon geography or other characteristics, so long as a provider is willing and able to meet the conditions of network membership set by the carrier. These statutes can be broad in scope and apply to many providers, including physicians, facilities (e.g. hospitals), pharmacists and other providers. Other Any Willing Provider statutes are more limited and often apply only to pharmacies and pharmacists. See **Attachment B**, for surrounding states legislation[20] regarding Any Willing Provider laws with the emphasis on pharmacy benefits.

[18] Ibid, 12.
[19] Ibid, 12.
[20] PBM Watch, *A Listing of State Any Willing Provider Laws*, The Pharmacy Benefit Manager Network on-line news source, (Undated).

Criticisms of Any Willing Provider laws are that while the laws may limit plans from using narrow (skinny) networks, the laws may also prevent insurance companies from negotiating lower prices with providers and facilities. As such, insurance companies may be less able to contain costs for enrollees and unable to disqualify providers based on quality.[21] Any Willing Provider legislation alone is considered an insufficient solution to the problem of overly narrow networks due to its failure to reduce costs for consumers, inability to guarantee that additional providers will ask to join networks, companies' inability to control the quality of providers with whom they contract. [22]

SURPRISE BILLING AND BALANCE BILLING

Surprise medical bills are medical services bills resulting from out-of-network physicians that patients had no role in choosing. Surprise medical bills primarily come from hospitals, particularly the emergency department, or when a patient receives medical procedures from an in-network hospital facility but from providers at that facility who are out-of-network. For example, a consumer may select a surgeon at facility in-network, but discover that other providers, such an anesthesiologist or surgical assistant, are out-of-network.[23] This results in the practice also known as balance billing; referring to a physician's ability to bill the patient for an "outstanding balance after the insurance company submits its portion of the bill. Out-of-network physicians are not bound by contractual, in-network rates agreements, and therefore have the ability to bill patients for the entire remaining balance."[24]

Out-of-network bills are a source of concern to consumers. A "2018 study indicates that approximately 20 percent of hospital visits among patients with large group coverage resulted in this form of bill."[25] In the case of medical emergencies, the ACA requires that out-of-network care is reimbursed at *in-network* rates, although depending on state law, providers may still "balance bill" patients. This is especially true of consumers with plans in the individual and small group markets as they are considered to have a high level of exposure to these charges. Skinny or narrow networks increase the likelihood that providers are out-of-network. Many plans do not have *any* out-of-network coverage at all, and for those that do, the coverage tends to be very minimal.[26]

> The share of plans with out-of-network benefits has declined, and so has the comprehensiveness of those benefits that are offered. In about 95 percent of individual and small group plans with out-of-network benefits, the deductible must

[21] Hall & Ginsburg, at 5-6, Baiker & Levy, 2.
[22] Katherine Baicker, PhD, and Helen Levy, PhD, How Narrow a Network is Too Narrow? JAMA Intern. Med., January 2015.
[23] Jack Hoadley, Kevin Lucia, and Maanasa Kona, *State Efforts to Protect Consumers from Balance Billing*, To the Point: The Commonwealth Fund, January 2019.
[24] Brooke Murphy, *20 things to know about balance billing*, Becker's Hospital Review, February 2016, 1.
[25] K. Hempstead, *Percent of Plans with Out-of-Network Benefits*, Marketplace Pulse, Robert Wood Johnson Foundation, October 2018.
[26] Ibid.

> be met before there is any cost-sharing. Out-of-network deductibles are generally high, particularly in the individual market, where the median out-of-network deductible is approximately $12,000. In about 30 percent of individual market plans with out-of-network coverage, the deductible is greater than $20,000. The small group market is quite different, with a median deductible of about $6,000 and virtually no deductibles higher than $20,000.[27]

Balanced Billing and State Legislation

According to experts, because a federal policy solution may prove difficult, some states have stepped in to protect consumers from balance billing.[28] Based on a study by Georgetown University: of the 21 states with laws protecting consumers from balance billing by an out-of-network provider for care delivered in an emergency department or in-network hospital, only 6 have a comprehensive approach to safeguarding consumers for both.[29] As of 2017, there are 15 states with partial protections and the remaining 29 (plus D.C.) states are without protections. States without formal protections usually rely on market forces to minimize balance billing or they rely on regulators to pressure insurance providers to moderate effects on consumers.[30] Of the 21 states with consumer protection laws for balance billing, the methods vary and some states use more than one form of protection, including:

- Prohibiting balance billing by providers.
- Requiring insurers to hold enrollees harmless from balance billing charges by paying the entire charge (beyond what the health plan pays) if necessary.
- Requiring insurers guarantee that the consumer is held harmless from, and is not liable for, balance-billing charges.
- Laws including payment standards to ensure that providers are compensated fairly. Such as requiring insurers to pay out-of-network providers at a set percentage of Medicare rates or at "usual and customary" rates.
- Require providers and insurers to engage in dispute resolution process for settling payment rate issues, with some holding the enrollee be held harmless.[31]

The study further cites New York as an example of successfully providing adequate protection.

> [P]lans must establish a reasonable payment amount and disclose their method for determining it. Plans also must show how that amount compares to usual and customary rates, defined as the 80th percentile of all charges for a health care

[27] Ibid.
[28] Kevin Lucia, J.D., M.H. P., Jack Hoadley, Ph.D., M.A., and Ashley William, J.D., *Balance Billing by Health Care Providers: Assessing Consumer Protections Across Sates, Issue Brief*, The Commonwealth Foundation, June 2017.
[29] Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy, Georgetown University.
[30] Ibid. 2-3.
[31] Ibid, 3.

> service made available by FAIR Health, an independent entity that maintains a medical bill database. Any party that is not satisfied with the amount paid can appeal through a state-created independent dispute resolution process.[32]

Aside from New York, and despite states providing legal safeguards, consumers are not protected in all situations. **Table 1** below provides a state-by-state approach to balance-billing protection. According to this study, Wyoming is one of the 29 states without legal protections.

[32] Ibid, 4.

Table 1.

State Balance-Billing Protections

	Setting		Type of managed care plan		Type of protection		State-specific method for payment	
	Emergency department	Nonemergency care in network hospital	HMO	PPO	Hold harm-less	Provider prohibition	Payment standard	Dispute resolution process
States with a comprehensive approach								
California	✓	✓	✓	✓[a]	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓	✓	✓	✓	
Florida	✓	✓	✓	✓	✓	✓	✓[b]	✓
Illinois	✓	✓	✓	✓	✓[c]	✓[d]		✓
Maryland	✓	✓	✓	✓	✓[e]	✓[d]	✓[e]	
New York	✓	✓	✓	✓	✓	✓[d]	✓	✓
States with a limited approach								
Colorado	✓	✓	✓	✓	✓			
Delaware	✓[f]		✓	✓	✓	✓		✓
Indiana	✓		✓		✓	✓		
Iowa	✓		✓	✓	✓			
Massachusetts		✓	✓	✓	✓			
Mississippi	✓	✓	✓	✓	✓	✓[d]		
New Hampshire	✓	✓	✓		✓			
New Jersey	✓	✓	✓	✓	✓			
New Mexico	✓		✓	✓	✓			
North Carolina	✓		✓	✓	✓			
Pennsylvania	✓		✓	✓[g]	✓			
Rhode Island	✓	✓	✓		✓			
Texas	✓	✓	✓[h]		✓			
Vermont	✓		✓	✓	✓			
West Virginia	✓		✓		✓			

Note: See glossary for full definitions of the terms used in the column headers.
a Protections in emergency department setting apply only to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.
b Payment standards apply only for nonnetwork providers of emergency services for HMOs.
c Protections apply only to facility-based providers.
d Protections attach when consumer assigns the benefit to provider. Linkages to assignment in Maryland apply only to PPOs and in New York only to in-network hospitals.
e Hold harmless and payment standards for PPOs apply only to on-call physicians and hospital-based physicians who obtain assignment of benefits; they apply to HMO providers in all situations.
f Protections for emergency department care also apply to services originating in hospital emergency facility or comparable facility following treatment or stabilization of emergency medical condition, as approved by insurer with respect to services performed by nonnetwork providers. Insurer is required to approve or disapprove coverage of post-stabilization care.
g Emergency service balance-billing protections apply only to HMOs and PPOs that require gatekeepers.
h HMO members must be held harmless, but those in PPOs may be balance-billed. State law requires PPOs to disclose possibility of balance billing to consumers and allows consumers to pursue dispute resolution for amounts of $500 or greater. PPOs must base payments on usual and customary billed charges in emergency settings or those where no in-network provider is reasonably available. This minimum payment amount is designed to minimize use of balance billing.

Source: Georgetown University Center on Health Insurance Reforms, Health Policy Institute, McCourt Scholl of Public Policy.

If you have any further questions, please do not hesitate to contact LSO Research at 777-7881.

Attachment A

WYOMING STATUTES PERTAINING TO NETWORK ADEQUACY

§26-34-108. **Quality assurance program**

(a) The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

(b) The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(i) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(ii) A written quality assurance plan which describes the following:

(A) The health maintenance organization's scope and purpose in quality assurance;

(B) The organizational structure responsible for quality assurance activities;

(C) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(D) Confidentiality policies and procedures;

(E) A system of ongoing evaluation activities;

(F) A system of focused evaluation activities;

(G) A system for credentialing providers and performing peer review activities; and

(H) Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(iii) A written statement describing the system of ongoing quality assurance activities including:

(A) Problem assessment, identification, selection and study;

(B) Corrective action, monitoring, evaluation and reassessment; and

(C) Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(iv) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(v) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard care or services have been provided, or care or services which should have been furnished have not been provided.

(c) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the administrator. Contents of the minutes shall be confidential to the extent confidentiality is provided under the provisions of W.S. 16-4-203(d)(i) and (vii), 26-34-129, 26-34-130, 35-2-605 through 35-2-617, 35-2-910 or 35-17-105.

(d) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the administrator or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the administrator.

(f) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

§26-18-302(a)(vii). **Sale of health insurance policies approved in other states.**

(a) The insurance commissioner shall approve for sale in Wyoming any individual or small employer health insurance policy or high deductible health plan that is currently approved for issuance in another state where the insurer or the insurer's affiliate or subsidiary is authorized to transact insurance, subject to the following:

(vii) The commissioner shall review any provider network requirements in the policy and may require modification of those requirements if the insurer lacks sufficient within network providers in Wyoming;

42 CFR 438.68 **Kid Care CHIP Provider Network Adequacy Standards for the Contractor**[33]

The State of Wyoming is requiring a distance standard of 150 miles or a time standards of 2 ½ hours for the following provider types:

- Primary care, pediatric
- OB/GYN
- Behavior Health (mental health and substance use disorder), pediatric
- Specialist, pediatric
- Hospital
- Pharmacy
- Pediatric Dental

[33] Per Wyoming Department of Health.

Attachment B

SURROUNDING STATES WITH ANY WILLING PROVIDER LAWS

State	Legislation	Provision
Colorado	Section 10-16-122	Any PBM/intermediary (pharmacy benefit manager) whose contract with a carrier includes an open network must allow all area pharmacy providers to participate if they agree to the terms and conditions of the contract. PBms/Intermediaries may contract with exclusive pharmacy networks if a 60-day notice is given before the termination or the effective date of such contract by publication in a newspaper of general circulation.
Idaho	Section 215-5/370h	Insurers/administrators must be willing to enter into agreements with any non-institutional providers who meet the established terms and conditions. The terms and conditions may not discriminate unreasonably against or among non-institutional providers.
	Section 215-134/72(a)	A plan may not refuse to contract with a pharmacy provider that meets the terms and conditions established by the plan.
Montana	Section 33-22-1704	A preferred provider agreement must provide all providers with the opportunity to participate on the basis of a competitive bid.
Nebraska	Section 44-513.02	Beneficiaries shall not be required to obtain pharmaceutical services from mail-order in order to obtain reimbursement.
	Section 44-313(2)	...an insurer may contract with a licensed pharmacist for pharmacist professional services. Nothing in this section shall prohibit an insurer from contracting with a licensed pharmacist who is not employed or associated with a pharmacy. Nothing in this section shall require a licensed pharmacist to contract with an insurer for pharmacist professional services.
New Mexico	Section16.19.6.7(f)	"Point of care vendor" means an entity contracted with a prescriber to generate or transmit electronic prescriptions authorized by a practitioner directly to a pharmacy or to a "contracted" intermediary or "network vendor", who will ultimately transmit the prescription order to a patient's pharmacy of choice. Vendor must provide an unbiased listing of provider pharmacies and not use pop-ups or other paid advertisements to influence the prescriber's choice of therapy or to interfere with patient's freedom of choice of pharmacy. Presentation of drug formulary information, including preferred and non-preferred drugs and co-pay information if available, is allowed.

North Dakota	Section 26.1-36-12.2	Beneficiaries may choose any licensed pharmacy/pharmacist to provide services. Benefit differentials are prohibited. Licensed pharmacists who accept the terms may participate in the plan.
South Dakota	Section 58-18-37	Group health insurance policies may not refuse to accept licensed pharmacies/pharmacists as participating providers if they agree to the same terms and conditions offered to other providers of pharmacy services under the policy.
Utah	Section 31A-22-617	Insurers must allow providers to apply for and be designated as preferred providers if they agree to meet established terms and conditions. "Reasonable limitations" may be placed on the number of designated preferred providers.
Wyoming	Section 26-22-503	Any provider willing to meet the established requirements has the right to enter into contracts relating to health care services.
	Section 26-34-134	Providers willing to meet an HMO's established terms shall not be denied the right to contract. An HMO may not discriminate against a provider on the basis of the provider's academic degree.

Source: PBMWatch.com, the online publication for Pharmacy Benefit Managers.

Attachment C

FIFTY-STATE SURVEY: NETWORK ADEQUACY QUANTITATIVE STANDARDS

Fifty-State Survey
Network Adequacy Quantitative Standards:
Geographic Criteria, Appointment Wait Times & Provider/Enrollee Ratios
Current through August 2016

Quantitative Standards in Commercial Insurance Plans:

- Twenty-three (23) states and Medicare Advantage have adopted one or more of the quantitative standards included in this survey to measure network adequacy in commercial insurance plans: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Louisiana, Maine, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Texas (HMO & PPO), Vermont, and Washington.
    - Nevada requires health plans to meet Federally-Facilitated Marketplaces (FFM) standards issued by CMS.
- Five (5) states require health plans to meet NCQA and/or other national accreditation standards:[1] Connecticut, Idaho, Indiana (HMO), Louisiana and New Hampshire (for wait time standards).
- An additional six (6) states have adopted quantitative standards to measure network adequacy for emergency services only: Michigan, Mississippi, Nebraska, North Dakota (HMO), South Dakota, and Virginia (HMO).

Appointment Wait Times:

- Twelve (12) states have established appointment wait time standards: Arizona, California, Colorado, Florida (HMO), Maine, Missouri (HMO), Montana, New Jersey, New Mexico, Texas (HMO & PPO), Vermont, and Washington.
    - Five (5) states have specific wait time standards for mental health and substance use disorder providers: California, Colorado, Maine, Texas (HMO and PPO), and Vermont.
    - An additional five (5) states require that plans satisfy NCQA appointment time standards for mental health and substance use disorder health visits: Connecticut, Idaho, Indiana (HMO), Louisiana, and New Hampshire.
- Eleven (11) states have adopted both wait time and geographic standards: Arizona, California, Colorado, Florida (HMO), Missouri (HMO), Montana, New Jersey, New Mexico, Texas (HMO & PPO), Vermont, and Washington.

Geographic Standards:

- Twenty-one (21) states have adopted or require geographic standards of network adequacy: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Texas (HMO & PPO), Vermont, and Washington.

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[1] NCQA requires carriers to establish quantitative standards to measure the availability and accessibility of primary care and specialty care. Carriers may also determine which medical specialties are subject to these quantitative standards. NCQA has established appointment wait time standards for behavioral health care.

- Eleven (11) states and Medicare Advantage have adopted or require geographic standards that account for population density: Arizona, Colorado, Delaware, Kentucky, Missouri (HMO), Nevada (FFM), New Mexico, New York, Pennsylvania, Texas (PPO), and Washington.
    - Colorado and Nevada (FFM) have adopted the population categories used by Medicare Advantage: Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC).
- Twenty-one (21) states and Medicare Advantage have adopted or require time and/or distance criteria for their geographic standards.
    - Twelve (12) states have adopted or require both time and distance geographic requirements: Arizona, California, Kentucky, Minnesota, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Washington.
    - Seven (7) states have adopted only distance requirements: Alabama (HMO), Arkansas, Colorado, Delaware, Missouri (HMO), Montana, and Texas (HMO & PPO).
    - Two (2) states have adopted only travel time requirements: Florida (HMO) and Vermont.
- Twenty (20) states and Medicare Advantage have adopted or require geographic criteria that vary by provider and/or facility-type: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Tennessee, Texas (HMO & PPO), Vermont, and Washington.
    - Ten (10) states and Medicare Advantage have adopted or require geographic criteria specific to mental health and substance use disorder providers: California, Colorado, Delaware, Minnesota, Missouri (HMO), Nevada (FFM), New Hampshire, New Jersey, Vermont, and Washington.
- Six (6) states require a targeted percentage of members (90% unless otherwise designated) whose geographic access must meet the designated services: Nevada (FFM), New Hampshire, New Jersey, New Mexico, Pennsylvania, and Washington (80%).

Provider/Enrollee Ratio or Minimum Number of Providers:

- Nine (9) states and Medicare Advantage have adopted provider/enrollee ratios or a standard to determine the minimum number of providers available: California, Colorado, Delaware, Maine, Montana, New Jersey, New Mexico, New York, and Washington.
- Four (4) states require plans to meet the NCQA and/or other national accreditation requirement to measure the provider/enrollee ratio: Connecticut, Idaho, Indiana (HMO), and Louisiana.

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State[2]	Source	Geographic Criteria[3]	Appointment Wait Times	Provider/Enrollee Ratio
Alabama *(Standards apply to Health Maintenance Organizations)*	ALA. ADMIN. CODE R. 420-5-6-.06 (1999)	• The distance from the health maintenance organization's geographic service area boundary to the nearest primary care delivery site and the nearest institutional service site shall be a radius of no more than 30 miles. • Frequently utilized specialty services shall be within a radius of no more than 60 miles.	• Providers must have policies regarding emergency telephone consultation on a 24-hour per day, 7-day per week basis including qualified physician coverage for emergency services.	• No quantitative criteria provided.
Arizona *(Standards apply to Health Care Service Organizations)*	ARIZ. ADMIN. CODE § R20-6-1901 to 20-6-1921 (2005); Regulatory Bulletin 2006-07 (2006)[4]	• HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. • Urban areas: 1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home; 2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and 3. Inpatient care in a contracted general hospital, or contracted special hospital, within	• Preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule. • Routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request or sooner if medically necessary. • For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary. • In-area urgent care services from a contracted provider 7 days per week.	• No quantitative criteria provided.

[2] States not identified have no quantitative standards for the network adequacy metrics included in this survey.
[3] Note that 3 states (Arizona, Arkansas, and New Hampshire) provide standards regarding the type, format, or level of detail required of maps that must be submitted to show compliance with geographic criteria.
[4] https://insurance.az.gov/sites/default/files/documents/files/2006-07.pdf

		25 miles or 75 minutes of the enrollee's home. • Suburban areas: 1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home; 2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and 3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home. • Rural areas: Primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.	• Timely non-emergency inpatient care services from a contracted facility. • Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.	
Arkansas *(Standards apply to health benefit plans)*	054-00 ARK. CODE R. §§ 077 (2014)	• Emergency services within a 30 mile radius of residence. • Primary care professional – at least one within 30 mile radius of residence. • Specialty care services within 60 mile radius of residence. • For QHPs: at least 1 essential community provider within a 30 mile radius of residence.	• Access to emergency services 24 hours per day, 7 days per week.	• No quantitative criteria provided.
California *(Standards apply to health insurance policies)*	CAL. CODE REGS. TIT. 10, § 2240.1 to 2240.15 (2016)	• Facilities used by providers to render health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible, both	• Health care services available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.	• At least 1 full-time physician per 1,200 covered persons and at least the equivalent of 1 full-time primary care physician per 2,000 covered persons.

		physically and in terms of provision of service, to covered persons with disabilities. • Max travel time for PCP 30 minutes or max travel distance 15 miles from insured's residence or workplace. • Max travel time for specialists 60 minutes or max travel distance 30 miles from insured's residence or workplace. • Max travel time for MH/SUD professionals 30 minutes or max travel distance 15 miles from insured's residence or workplace. • Max travel time for hospital 30 minutes or max travel distance of 15 miles from insured's residence or workplace. • Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.	• Emergency health care services are available and accessible within the service area at all times. • <u>Appointments meet the following timeframes</u>: ○ Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, ○ Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment ○ Non-urgent appointments for primary care: within 10 business days of the request for appointment ○ Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment ○ Non-urgent appointments with a non-physician mental health or substance use disorder provider: within 10 business days of the request for appointment • Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment.	
Colorado	CO Bulletin No. B-4.89 (2016);	• <u>Primary Care, OB/GYN, Pediatric Primary Care</u> ○ Large Metro – within 5 miles	• Emergency Care (Medical, Behavioral, Substance Abuse) – 24 hours per day, 7 days per	• 1:1000 for large metro, metro, and micro areas (primary care,

(Standards apply to health benefit plans)	CO Bulletin No. B-4.90 (2016); CO Bulletin No. B-4.91 (2016); CO Proposed Reg. 4-2-53 (2017)	○ Metro – within 10 miles ○ Micro – within 20 miles ○ Rural – within 30 miles ○ CEAC - within 60 miles • <u>Mental Health and Substance Use Disorder (Licensed Clinical Social Worker, Psychiatrist, Psychologist)</u> ○ Large Metro –10 miles ○ Metro – 30 miles ○ Micro – 45 miles ○ Rural – 60 miles ○ CEAC – 100 miles • <u>Specialty Care (see specific specialty)</u> ○ Large Metro – ranges from 10 to 15 miles, based on specialty ○ Metro – ranges from 20 to 40 miles, based on specialty ○ Micro – ranges from 35 to 75 miles, based on specialty ○ Rural – ranges from 60 to 90 miles, depending on specialty ○ CEAC – ranges from 85 to 130 miles, depending on specialty • <u>Other Medical Providers (Includes other MH/SUD providers):</u> ○ Large Metro – within 15 miles ○ Metro – within 40 miles ○ Micro - within 75 miles ○ Rural – within 90 miles ○ CEAC – within 130 miles • Facilities (see specific facility type) ○ Large Metro – ranges from 5 to 15 miles, depending on facility type ○ Metro – ranges from 10 to 45 miles, depending on facility type	week, with time-frame met 100% of the time • Urgent Care (Medical, Behavioral, Mental Health and Substance Abuse) - Within 24 hours, with time-frame met 100% of the time • Behavioral Health, Mental Health and Substance Abuse Care (Routine, non-urgent, non-emergency) - Within 7 calendar days, with timeframe met ≥ 90% of the time. • PCP: Within 7 calendar days, with goal met ≥ 90% of the time; • Prenatal Care: Within 7 calendar days, with goal met ≥ 90% of the time; • Primary Care Access to after-hours care: Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician, with goal met ≥ 90% of the time; • Preventive visit/well visits: Within 30 calendar days, with goal met ≥ 90% of the time; • Specialty Care: Within 60 calendar days, with goal met ≥ 90% of the time	pediatrics, OB/GYN, Mental health, behavioral health and SUD care providers)

		○ Micro – ranges from 20 to 120 miles, depending on facility type ○ Rural – ranges from 30 to 120 miles, depending on facility type ○ CEAC – ranges from 60 to 140 miles, depending on facility type • Other Facilities (see specific facility type): ○ Large Metro – within 15 miles ○ Metro – within 40 miles ○ Micro - within 120 miles ○ Rural – within 120 miles ○ CEAC – within 140 miles • In some circumstances, access may require crossing of county or state lines.		
Connecticut *(Standards apply to health insurance policies)*	2016 CONN. LEGIS. SERV. P.A. 16-205 (S.B. 433) (WEST) (2016)	• Must maintain a network consistent with NCQA or URAC requirements.	• Must maintain a network consistent with NCQA or URAC requirements • Covered persons shall have access to emergency services 24 hours per day, 7 days per week.	• Must maintain a network consistent with NCQA or URAC requirements
Delaware *(Separate standards apply to Managed Care Organizations and Qualified Health Plans)*	MCO: 18-1400-1403 DEL. CODE REGS. § 1.0 (2007); QHP: Delaware QHP Guidance Document[5] (2014)	MCO: • No quantitative criteria provided. QHP: • PCP: 15 miles in Urban/Suburban area, 25 miles in rural area • OB/GYN: 15 miles in Urban/Suburban area, 25 miles in rural area • Pediatrician: 15 miles in Urban/Suburban area, 25 miles in rural area	MCO: • Health care services shall be available 24 hours per day and 7 days per week for urgent or emergency conditions. QHP: • No quantitative criteria provided.	MCO: • No quantitative criteria provided. QHP: • PCP: 1:2,000 patients. • Behavioral health practitioner or mid-level professional (licensed psychologists, psychiatric nurse specialists, Licensed

[5] http://dhss.delaware.gov/dhcc/files/ChooseDE.pdf

		• Specialty Care Providers: 35 miles in Urban/Suburban area, 45 miles in rural area • Behavioral Health/Mental Health/Substance Abuse Providers: 35 miles in Urban/Suburban area, 45 miles in rural area • Acute-care hospitals: 15 miles in Urban/Suburban area, 25 miles in rural area • Psychiatric hospitals: 35 miles in an Urban/Suburban area, 45 miles in a rural area • Dental: 35 miles in Urban/Suburban area; 45 miles in rural area		Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists) supervised by an advanced-degree behavioral health practitioner: 1:2,000
Florida *(Standards apply to Health Maintenance Organizations and Prepaid Health Clinics)*	FLA. ADMIN. CODE ANN. R. 59A-12.006 (2003)	• Average travel time from the HMO geographic services area boundary to the nearest primary care delivery site and to the nearest general hospital no longer than 30 minutes under normal circumstances. • Average travel time from the HMO geographic services area boundary to the nearest provider of specialty physician services, ancillary services, specialty inpatient hospital services and all other health services of no longer than 60 minutes under normal circumstances.	• Emergencies will be seen immediately • Urgent cases will be seen within 24 hours; • Routine symptomatic cases will be seen within 2 weeks; and • Routine non-symptomatic cases will be seen as soon as possible. • Patients with appointments should have a professional evaluation within one hour of scheduled appointment time. If a delay is unavoidable, patient shall be informed and provided an alternative	• No quantitative criteria provided.
Idaho *(Standards apply to*	IDAHO ADMIN. CODE R 41-3915 (2015); 2016 QHP Standards	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.

Qualified Health Plans)	Guidance Document[6]			
Indiana *(Standards apply to Health Maintenance Organizations)*	IND. CODE ANN. § 27-13-36-2 to IC 27-13-36-12 (Burns) (1999)	• Must comply with standards developed by NCQA or a successor organization.	• Must comply with standards developed by NCQA or a successor organization.	• Must comply with standards developed by NCQA or a successor organization.
Kentucky *(Standards apply to Qualified Health Plans and Managed Care Plans)*	KY. REV. STAT. § 304.17A-515 (West 2016); 900 KY. ADMIN. REGS. 10:010 (2015)	• Urban areas: a provider network that is available to all persons enrolled in the plan within 30 miles or 30 minutes of each person's place of residence or work, to the extent that services are available; or • Non-urban areas: primary care physician services, hospital services, and pharmacy services within 30 minutes or 30 miles of each enrollee's place of residence or work, to the extent those services are available. • Non-urban areas: all other providers within 50 minutes or 50 miles of each enrollee's place of residence or work, to the extent those services are available.	• No quantitative criteria provided.	• No quantitative criteria provided.
Louisiana *(Standards apply to Health Benefit Plans)*	LA. REV. STAT. ANN. § 22:1019.2 (2013)	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation.	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation. • Emergency services and ancillary emergency health care services	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation.

[6] http://doi.idaho.gov/Consumer/HCReform/2016QHPStandardsforYHI215.pdf

			shall be available 24 hours per day and 7 days per week.	• PCP: minimum ratio of 1 full-time equivalent primary care provider to 2000 enrollees.
Maine *(Standards apply to Health Maintenance Organizations, Managed Care Plans, and health plans)*	850 ME. CODE R. §02-031 (2012	• Carriers must define high-volume specialty care and behavioral health practitioners and establish quantifiable and measurable standards for the geographic distribution of each type of practitioner	• Behavioral Health: o Care for non-life-threatening emergencies within 6 hours; o urgent care within 48 hours; and o an appointment for a routine office visit within 10 business days • Managed care plans must provide access to emergency services at all times.	• PCPs: 1:2000 • Carriers must define high-volume specialty care and behavioral health practitioners and establish quantifiable and measurable standards for the number of each type of practitioner
Michigan *(Standards apply to health insurance issuers, including Health Maintenance Organizations)*	MICH. COMP. LAWS SERV. § 500.221 (2016); Michigan Network Adequacy Guidance Document[7]	• No quantitative criteria provided.	• Services available and accessible to covered persons 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.	• No quantitative criteria provided.
Minnesota *(Standards apply to health carriers)*	MINN. STAT. ANN. § 62K.10 (2013); MINN. STAT. ANN. § 62Q.19 (2013)	• Primary care services, mental health services, and general hospital services: maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider. • Specialty physician services, ancillary services, specialized hospital services, and all other health	• PCP services are available and accessible 24 hours per day, seven days per week, within the network area	• No quantitative criteria provided.

[7] https://www.michigan.gov/documents/difs/Network_Adequacy_Guidelines_415418_7.pdf

		services: maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider.		
Mississippi *(Standards apply to Managed Care Plans)*	MISS. ADMIN. CODE R. 19-3:14.05 (2014); MS Bulletin No. 2015-4 (MS INS BUL) (2015)	• No quantitative criteria provided.	• Emergency facility services shall provide access 24 hours/day and 7 days/week.	• No quantitative criteria provided.
Missouri *(Standards apply to Health Maintenance Organizations offering Managed Care Plans)*	MO. REV. STAT. § 354.603 (2007); MO. CODE REGS. ANN. tit. 20, § 400-7.095 (2007)	• PCPs: within 10 miles in urban areas; 20 miles in basic areas; 30 miles in rural areas • OB/GYN: within 15 miles in urban areas; 30 miles in basic areas; 60 miles in rural areas • Specialists: within 25 miles in urban areas; 50 miles in basic areas; 100 miles in rural areas • Basic hospital, physical and speech therapy: 30 miles in urban, basic and rural areas • Psychiatrist-Adult/General: within 15 miles in urban areas; 40 miles in basic areas; 80 miles in rural areas • Psychiatrist-Child/Adolescent: within 22 miles in urban areas; 45 miles in basic areas; 90 miles in rural areas • Psychologists/Other Therapists: within 10 miles in urban areas; 20 miles in basic areas; 40 miles in rural areas	• Routine care, without symptoms— within 30 days from the time the enrollee contacts the provider; • Routine care, with symptoms—within 5 business days from the time the enrollee contacts the provider; • Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies: within 24 hours from the time the enrollee contacts the provider; • Emergency care—a provider or emergency care facility shall be available 24 hours per day, 7 days per week for enrollees who require emergency care; • Obstetrical care—within 1 week for enrollees in the first or second trimester of pregnancy; within 3 days for enrollees in the third trimester. Emergency obstetrical	• No quantitative criteria provided.

		• Inpatient mental health treatment facility: within 25 miles in urban areas; 40 miles in basic areas; 75 miles in rural areas • Ambulatory mental health treatment providers: within 15 miles in urban areas; 25 miles in basic areas; 45 miles in rural areas • Residential mental health treatment providers: within 20 miles in urban areas; 30 miles in basic areas; 50 miles in rural areas (Not full list) Exhibit A[8]	care is subject to the same standards as emergency care, except that an obstetrician must be available 24 hours per day, 7 days per week for enrollees who require emergency obstetrical care; and • Mental health care – telephone access to licensed therapist shall be available 24 hours/day and 7 days/week.	
Montana *(Standards apply to Managed Care Plans)*	MONT. CODE ANN. § 33-36-201 (2003); MONT. ADMIN. R. 37.108.201 to 37.108.241 (2003)	• Carrier must have an adequate network of primary care providers; a hospital, critical access hospital, or medical assistance facility; and a pharmacy that is located within a 30 mile radius of each enrollee's residence or place of work, unless: o the usual and customary travel pattern of the general population within the service area to reach health care providers is further, and if the fact that the usual and customary travel pattern exists is documented by the health carrier; or o the provider is available but does not meet the health carrier's reasonable credentialing requirements; and	• Emergency services must be available and accessible at all times; • Urgent care appointments must be available within 24 hours; • Non-urgent care with symptoms appointments must be available within 10 calendar days; • Immunization appointments must be available within 21 calendar days; and • Routine or preventive care appointments for must be available within 45 calendar days.	• Must include 1 mid-level PCP per 1,500 projected enrollees or 1 physician PCP per 2,500 projected enrollees.

[8]https://1.next.westlaw.com/Document/N3CCEA04817E94397B6AFE13132B8D4AF/View/FullText.html?navigationPath=%2FRelatedInfo%2Fv1%2FkcCitingReferences%2Fnav%3FdocGuid%3DNCBA45B3049A111DB9A80B90E4B840C8B%26midlineIndex%3D24%26warningFlag%3DN%26planIcons%3DNO%26skipOutOfPlan%3DNO%26sort%3Ddatedesc%26category%3DkcCitingReferences%26origDocSource%3D45a534b8961245069c4697aa0cf40369&listSource=RelatedInfo&list=CitingReferences&rank=24&originationContext=citingreferences&transitionType=CitingReferencesItem&contextData=%28sc.Default%29

		○ if no qualified provider for a service covered by the plan exists within a 30 mile radius of an enrollee's residence or place of work, the health carrier must document how covered services will be provided at no additional charge to enrollees through referrals to qualified providers outside the 30 mile radius. • At the time of initial selection or the renewal of a managed care plan, the maximum number of eligible employees residing and working outside the 30 mile radius of the primary place of work may not exceed the following: ○ for groups with 2 to 5 employees, 1; ○ for groups with 6 to 15 employees, 2; ○ for groups with 16 to 30 employees, 3, and ○ for groups with 30 or more employees, 10% of the employees.		
Nebraska *(Standards apply to Managed Care Plans)*	NEB. REV. STAT. ANN § 44-7105 (1998)	• No quantitative criteria provided.	• Emergency facility services: access 24 hours per day, 7 days per week.	• No quantitative criteria provided.
Nevada *(Standards apply to Health Benefit Plans)*	NEV. REV. STAT. § 57-687B.490 (2014); NEV. ADMIN. CODE § 687B.xxx(9) (2015)	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter provides the following standards: • Primary Care	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter does not provide quantitative standards.	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter does not provide quantitative standards.

		○ Large Metro – within 10 minutes/5 miles ○ Metro – within 15 minutes/10 miles ○ Micro – within 30 minutes/20 miles ○ Rural – within 40 minutes/30 miles ○ CEAC - within 70 minutes/60 miles • <u>Mental Health (Including Substance Use Disorder)</u> ○ Large Metro – within 20 minutes/10 miles ○ Metro – within 45 minutes/30 miles ○ Micro – within 60 minutes/45 miles ○ Rural – within 75 minutes/60 miles ○ CEAC – within 110 minutes/100 miles • <u>Other Specialty Care</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 45 to 60 minutes or 30 to 40 miles, based on specialty ○ Micro – ranges from 60 to 100 minutes or 45 to 75 miles, based on specialty ○ Rural – ranges from 75 to 110 minutes or 60 to 90 miles , depending on specialty ○ CEAC – ranges from 110 to 145 minutes or 100 to 130 minutes, depending on specialty • Plans must provide access to at least one provider in each of the above-listed provider types for at least 90% of enrollees.		

New Hampshire *(Standards apply to Managed Care Plans)*	N.H. CODE ADMIN. R. INS 2701.04 to 2701.10 (2010)	• PCPs: At least 2 open panel primary care providers within 15 miles or 40 minutes average driving time of at least 90 percent of the enrolled population within each county or hospital service area. • Key Specialists (list includes psychiatrists): Within 45 miles or 60 minutes travel time for at least 90 percent of the enrolled population within each county or hospital service area. • Pharmacy shall be 15 miles or 45 minutes travel time; • Provider of outpatient mental health services shall be 25 miles or 45 minutes travel time; • The travel time interval for the following list of services shall be 45 miles or 60 minutes o Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services; o Surgical facilities associated with acute care hospital services; o General inpatient psychiatric; o Emergency mental health provider; o Short term care facility for involuntary psychiatric admissions; o Short term care facility for substance abuse treatment; and o Short term care facility for inpatient medical rehabilitation services.	• Standard waiting times for appointments shall be measured from the initial request for an appointment and shall meet NCQA requirements.	• No quantitative criteria provided.

New Jersey *(Standards apply to Managed Care Plans)*	N.J. ADMIN. CODE § 11:24A-4.10 (2011)	• PCPs – at least 2 within 10 miles or 30 minutes driving time or public transit time (if available), whichever is less, of 90 percent of the carrier's covered persons. Medical specialist access within 45 miles or one hour driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area. • Institutional providers - maintain geographic accessibility of the services subject to no less than the following: o At least one licensed acute care hospital with licensed medical-surgical, pediatric, obstetrical and critical care services in any county or service area that is no greater than 20 miles or 30 minutes driving time, whichever is less, from 90% covered persons within county/service area o Surgical facilities, including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices available in each county or service area that are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90% covered persons o Specialized services 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:	• Emergencies shall be triaged immediately through the PCP or by a hospital emergency department through medical screening or evaluation; • Urgent care shall be provided within 24 hours of notification of the PCP or carrier; and • In both emergent and urgent care, PCPs shall be required to provide 24 hour per day, 7days per week access to triage services; • Routine appointments can be scheduled within at least 2 weeks; and • Routine physical exams can be scheduled within at least 4 months.	• The carrier shall demonstrate sufficiency of network PCPs to meet the adult, pediatric and primary ob/gyn needs of the current and/or projected number of covered persons by assuming:(1) 4 primary care visits per year per member, averaging one hour per year per member; and(2) 4 patient visits per hour per PCP. To demonstrate PCP availability, a carrier shall verify that the PCP has committed to providing a specific number of hours for new patients that cumulatively add up to projected clinic hour needs of the projected number of covered persons by county or service area.

		▪ Hospital providing regional perinatal services and tertiary pediatric services ▪ In-patient psychiatric services for adults, adolescents and children; ▪ Residential substance abuse treatment centers; ▪ Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies; and ▪ Comprehensive rehabilitation services. o Services will 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: ▪ Emergency mental health service, including a short term care facility for involuntary psychiatric admissions; ▪ Outpatient therapy for mental health and substance abuse conditions; ▪ Licensed long-term care facility, therapeutic radiations, MRI, diagnostic radiology, renal dialysis ▪ In any county or approved service area in which 20 percent or more of a carrier'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, and the carrier shall demonstrate how it will meet the requirements in its application.		
New Mexico *(Standards apply to Managed health care plans)*	N. M. STAT. ANN. § 59A-57-4 (1998); N.M. CODE § 13.10.22 (1998)	• In population areas of 50,000 or more residents, 2 PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, 2 PCPs are available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care. • Attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population. • In population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a	• Emergency care is immediately available without prior authorization requirements. The medical needs of covered persons are met 24 hours per day, seven days per week. • Urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case; • For emergent and urgent care, triage services by PCP 7 days per week and 24 hours per day • Routine appointments scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice; • Routine physical exams shall be scheduled within 4 months; • All appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.	• Must have a sufficient number of PCPs to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each covered person will have four primary care visits annually, averaging a total of one hour; 2) that each PCP will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 covered persons.

		minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.		
New York *(Standards apply to issuers of health insurance contracts or policies)*	N.Y. INS. LAW § 3241 (2015); Standards Guidance Document[9]	• Must be geographically accessible (i.e., meeting time/distance standards) and be accessiblefor people with disabilities. • PCPs: ○ Metropolitan Areas: 30 minutes by public transportation. ○ Non-Metropolitan Areas: 30 minutes or 30 miles by public transportation or by car. ○ In rural areas, transportation may exceed these standards if justified.	• No quantitative criteria provided.	• A choice of 3 PCPs in each county, and potentially more based on enrollment and geographic accessibility; and • At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility. • Carrier must offer insureds a choice of 2

[9] http://www.dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance.pdf

		• Providers other than PCPs: It is preferred that an insurer meet the 30 minute or 30 mile standard. • At least one hospital in each county and at least 3 hospitals for Erie, Monroe, Nassau, Suffolk,Westchester, Bronx, Kings, New York and Queens Counties.		primary dentists in their service area and achieve a ratio of at least 1 primary care dentist for each 2,000 insureds. • Networks must include at least 2 orthodontists, 1 pedodontist and 1 oral surgeon.
North Dakota *(Standards apply to Health Maintenance Organizations)*	N.D. ADMIN. CODE 45-06-07-06 (1994)	• No quantitative criteria provided.	• Emergency Services available and accessible 24 hours/day and 7 days/week.	• No quantitative criteria provided.
Pennsylvania *(Standards apply to Managed Care Plans)*	28 PA. CODE § 9.679 (2001)	• Plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county. Standard applies to primary care, specialty care and other health care facilities and services necessary to provide covered benefits. Standards also apply to prescription drugs, vision, dental and DME, to extent provided.	• No quantitative criteria provided.	• No quantitative criteria provided.

South Dakota *(Standards apply to Managed Care Plans)*	S.D. CODIFIED LAWS § 58-17F-5 to 58-17F-9 (2011); S.D. ADMIN. R. 20:06:33:04 (2011)	• No quantitative criteria provided.	• Emergency services available twenty-four hours a day, seven days a week.	• No quantitative criteria provided.
Tennessee *(Standards apply to Health Maintenance Organizations and Managed Care Plans)*	TENN. CODE ANN. § 56-7-2356 (1998); TENN. COMP. R. & REGS. 1200-8-33-.06 (2003)	• Managed health insurance issuer and HMOs shall demonstrate the following: o An adequate number of acute care hospital services, within a reasonable distance or travel time; o An adequate number of primary care providers and hospitals within not more than 30 miles distance or 30 minutes travel time at a reasonable speed; o An adequate number of specialists and subspecialists, within a reasonable distance or travel time. • Point of service providers shall see patients on a timely basis.	• Access to emergency services 24 hours per day, 7 days per week. • For HMOs, the hours of operation and service availability for behavioral health care must reflect the needs of members needing behavioral health care.	• No quantitative criteria provided.
Texas *(Separate standards apply to Health Maintenance Organizations and Preferred Provider Organizations)*	HMO: 28 TEX. ADMIN. CODE § 11.1607 (2006); PPO: 28 TEX. ADMIN. CODE § 3.3704 (2013)	HMO: • 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. PPO: • Provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the	HMO: • Emergency care, general, special, and psychiatric hospital care available and accessible 24 hours per day, 7 days per week, within the HMO's service area. • Urgent care shall be available: o medical, dental and behavioral health conditions within 24 hours; • Routine care shall be available: o medical conditions within 3 weeks ;	HMO: • No quantitative criteria provided. PPO: • No quantitative criteria provided

		insurer's designated service area to a point of service is not greater than: ○ Primary care and general hospital care - 30 miles in non-rural areas and 60 miles in rural areas ; and ○ Specialty care and specialty hospitals - 75 miles.	○ behavioral health conditions within 2 weeks ○ dental conditions within 8 weeks ; and • Preventive health services shall be available: ○ within 2 months for a child; ○ within 3 months for an adult; and ○ within 4 months for dental services. PPO: • Emergency care available 24 hours/day and 7 days/week • Urgent care for medical and behavioral health conditions available and accessible within designated service area within 24 hours • Routine care: ○ within 3 weeks for medical conditions; and ○ within 2 weeks for behavioral health conditions; • Preventive health services: • within 2 months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and within 3 months for an adult.	
Vermont *(Standards apply to*	21-040-010 VT. CODE R. § 1 (2009)	• Travel times from residence or place of business, generally should not exceed: ○ Primary care provider - 30 minutes ;	• Immediate access to emergency care • Urgent care - 24 hours or a time frame consistent with the medical	• No quantitative criteria provided

Managed Care Organizations)		○ Mental health and substance abuse services routine, office-based services - 30 minutes ; ○ Outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services - 60 minutes; ○ Kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery -- 90 minutes; and ○ Reasonable accessibility for other specialty services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care.	exigencies of the case for urgent care • Outpatient mental health and substance abuse care designated by the member or provider as non-urgent is not considered to be urgent care; • Non-emergency, non-urgent care - 2 weeks ; • Preventive care, including routine physical examinations, - 90 days; and ○ Routine laboratory, imaging, general optometry, and all other routine services - 30 days.	
Virginia *(Standards apply to Health Maintenance Organizations)*	VA. CODE ANN. § 38.2-4312.3 (2011)	○ No quantitative criteria provided.	• Emergency medical care available on a 24-hour basis: ○ access to medical care or • access by telephone to a physician or licensed health care professional with appropriate medical training.	• No quantitative criteria provided.
Washington *(Standards apply to Essential Health Benefit Services)*	WASH. ADMIN. CODE § 284-170-200 (2016)	• Hospitals and Emergency Services: Each enrollee access within 30 minutes in urban area and 60 minutes in a rural area from either residence or workplace	• Emergency services are accessible 24 hours per day, 7 days per week. • EHB services: Urgent appointments without prior authorization within 48 hours, or	• PCP: the ratio of primary care providers to enrollees within the issuer's service area as a whole must meet or exceed the average ratio

		• PCP: 80% of enrollees within the service area are within 30 miles of a sufficient number of primary care providers in an urban area and within 60 miles of a sufficient number of primary care providers in a rural area from either their residence or work. • Mental health and substance use disorder providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, 80% of the enrollees in the service area have access to a mental health provider within 30 miles in an urban area and 60 miles in a rural area from either their residence or workplace. • For specialty mental health providers and substance use disorder providers, 80% of the enrollees must access to the following types of service provider or facility: evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy.	with prior authorization, within 96 hours of the provider's referral. • PCP: Non- preventive services within 10 business days of request. • Specialists: Non-urgent services - within 15 business days of referral. ○ Preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, scheduling in advance, consistent with professionally recognized standards of practice.	for Washington State for the prior plan year.
Medicare Advantage *(Standards apply to Medicare*	Centers for Medicare & Medicaid Services 2017 Letter to Issuers in the Federally-	• <u>Primary Care</u> ○ Large Metro – within 10 minutes/5 miles ○ Metro – within 15 minutes/10 miles ○ Micro – within 30 minutes/20 miles ○ Rural – within 40 minutes/30 miles ○ CEAC – within 70 minutes/60 miles	• No quantitative criteria provided.	• <u>Primary Care</u> ○ Large Metro – 1.67 ratio ○ Metro – 1.67 ratio ○ Micro – 1.42 ratio ○ Rural – 1.42 ratio ○ CEAC – 1.42 ratio

Advantage Organizations)	facilitated Marketplaces;[10] CMS 2017 HSD Reference File[11]	• Specialty Care (see specific specialty) ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 30 to 60 minutes or 20 to 40 miles, based on specialty ○ Micro – ranges from 50 to 100 minutes or 35 to 75 miles, based on specialty ○ Rural – ranges from75 to 110 minutes or 60 to 90 miles, depending on specialty ○ CEAC – ranges from 95 to 145 minutes or 85 to 130 miles, depending on specialty • Facilities (see specific facility type) ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, depending on facility type ○ Metro – ranges from 45 to 70 minutes or 30 to 45 miles, depending on facility type ○ Micro – ranges from 80 to 160 minutes or 60 to 120 miles, depending on facility type ○ Rural – ranges from 75 to 145 minutes or 60 to 120 miles, depending on facility type • CEAC – ranges from 110 to 155 minutes or 100 to 140 miles, depending on facility type		• Specialty Care (see specific specialty) ○ Large Metro – ranges from 0.01 to 0.27 ratio, based on specialty ○ Metro – ranges from 0.01 to 0.28 ratio, based on specialty ○ Micro – ranges from 0.01 to 0.24 ratio, based on specialty ○ Rural – ranges from 0.01 to 0.24 ratio, depending on specialty • CEAC – ranges from 0.01 to 0.24 ratio, depending on specialty • MAOs must have at least one of each HSD facility type. • Must have a minimum of 12.2 inpatient hospital beds per 1,000 beneficiaries required to cover for that county. • Provider/enrollee and facility ratios vary based on type of provider or facility and on the geographic category.

[10] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF
[11] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Reference_File.zip

		• At least 90% of have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. • Specialized, long-term care, and pediatric/children's hospitals as well as providers/facilities contracted with the MAO only for its commercial, Medicaid, or other products do not count toward meeting HSD criteria.		
National Committee for Quality Assurance (NCQA) *(Standards apply to NCQA Accredited Health Plans)*	Health Plan Accreditation 2016 and Additional Accreditation and Certification Product Updates Overview[12]; 2016 NCQA Health Plan Accreditation Requirements[13]	• Organizations must analyze access, availability and member experience to ensure that all services are accessible without an unreasonable delay. • Carriers must set quantitative standards for availability and accessibility of primary care providers and specialty care. The carrier determines which specialties these standards must apply to based on claim volume.	• NCQA has set appointment time standards for behavioral health and requires carriers to measure these for each type of behavioral health professional meeting NCQA's credentialing standards (e.g., psychologists, psychiatrists, licensed clinical social workers...). • Organizations must currently assess access for "routine" behavioral health visits within 10 business days.	• Plans must have enough in-network hospitals and doctors available to members so that all services will be accessible without an unreasonable delay. • Organizations currently must identify specialties considered high volume, which at a minimum must include obstetrics/gynecology.
Federally-Facilitated Marketplaces	2017 Letter to Issuers in the Federally-facilitated Marketplaces[14]	• Primary Care o Large Metro – within 10 minutes/5 miles o Metro – within 15 minutes/10 miles o Micro – within 30 minutes/20 miles	• No quantitative criteria provided.	• No quantitative criteria provided.

[12]https://www.ncqa.org/Portals/0/PublicComment/HPA2016/Health%20Plan%20Accreditation%202016%20and%20Additional%20Accreditation%20%26%20Certification%20Product%20Updates%20Overview.pdf

[13] https://www.ncqa.org/Portals/0/Programs/Accreditation/2016_HPA_SGs.pdf

[14] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf

(Standards apply to Qualified Health Plans in Federally-Facilitated Marketplaces)		○ Rural – within 40 minutes/30 miles ○ CEAC - within 70 minutes/60 miles • <u>Mental Health (Including Substance Use Disorder)</u> ○ Large Metro – within 20 minutes/10 miles ○ Metro – within 45 minutes/30 miles ○ Micro – within 60 minutes/45 miles ○ Rural – within 75 minutes/60 miles ○ CEAC – within 110 minutes/100 miles • <u>Other Specialty Care</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 45 to 60 minutes or 30 to 40 miles, based on specialty ○ Micro – ranges from 60 to 100 minutes or 45 to 75 miles, based on specialty ○ Rural – ranges from 75 to 110 minutes or 60 to 90 miles , depending on specialty ○ CEAC – ranges from 110 to 145 minutes or 100 to 130 minutes, depending on specialty • Plans must provide access to at least one provider in each of the above-listed provider types for at least 90% of enrollees.		