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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2015

A N A C T

RELATING TO INSURANCE -- HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT

Introduced By: Senators Goldin, Ottiano, Nesselbush, and Miller

Date Introduced: February 25, 2015

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 81

THE HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT

27-81-1. Title. -- This chapter shall be known and may be cited as the "Health Benefit Plan Network Access and Adequacy Act."

27-81-2. Purpose. -- The purpose and intent of this chapter is to:

(1) Establish standards for the creation and maintenance of networks by health carriers; and

(2) Assure the adequacy, accessibility, and transparency of health care services offered under a network plan by:

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

(ii) Requiring network plans to have and maintain publicly available access plans consistent with § 27-81-5(b) that consist of policies and procedures for assuring the ongoing sufficiency of provider networks.

27-81-3. Definitions. -- For purposes of this chapter:

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

(2) "Commissioner" means the Rhode Island office of the health insurance commissioner.

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

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

(5) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(i) Placing the individual's health or, with respect to a pregnant woman, the woman or her unborn fetus in serious jeopardy;

(ii) Serious impairment to a bodily function;

(iii) Serious impairment of any bodily organ or part; or

(iv) With respect to a pregnant woman who is having contractions:

(A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(B) That transfer to another hospital may pose a threat to the health or safety of the woman or fetus.

(6) "Emergency services" means, with respect to an emergency medical condition, as defined in subsection (5) of this section:

(i) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(ii) Any further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

(7) "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical centers, nursing homes, hospices, home health agencies, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

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

(9) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(10) "Health care provider" or "provider" means a health care professional or a facility.

(11) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

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

(13) "Health maintenance organization" means a health maintenance organization as defined in chapter 41 of this title.

(14) "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

(15) "Material change" is a change in the composition or structure of a health carrier's provider network or a change in the size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier's network non-compliant with one or more of the network adequacy standards set forth in § 27-81-5 or rules adopted pursuant to that section.

(16) "Network" means the group of participating providers providing services to a network plan.

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

(18) "Nonprofit service corporation" means a nonprofit hospital service corporation as defined in chapter 19 of this title or a nonprofit medical service corporation as defined in chapter 20 of this title.

(19) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

(20) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any

combination of the foregoing.

(21) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(22) "Telemedicine" or "telehealth" means the delivery of clinical health care services by means of real time two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(23) "Tiered provider network" or "tiered network" means a network that identifies and groups participating providers into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered person or provider behavior.

(24) "To stabilize" means with respect to an emergency medical condition, as defined in subsection (5) of this section, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in subsection (5)(iv) of this section, to deliver, including the placenta.

(25) "Transfer" means, for purposes of subsection (5) of this section, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(i) Has been declared dead; or

(ii) Leaves the facility without the permission of any such person.

27-81-4. Applicability and scope. -- This chapter applies to all health carriers that offer network plans.

27-81-5. Network adequacy. -- (a) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services

to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. A health carrier providing a tiered network plan shall ensure that all covered services be accessible through a provider in the lowest cost-sharing tier.

(b)(1) Sufficiency shall be determined in accordance with the requirements adopted by the commissioner through rulemaking. Such requirement must include quantitative criteria and other requirements that the commissioner deems appropriate. When developing its criteria, the commissioner must incorporate the following:

(i) Maximum travel time and distance standards in miles by city or town to access a full-time equivalent primary care physician, specialist, facility, and other health care provider.

(ii) Minimum ratio of providers to covered persons for primary care physicians, specialists, and other health care providers.

(iii) Minimum number and range of full-time equivalent physicians and health care providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

(iv) Maximum time and distance standards in miles by city to access full-time equivalent diagnostic and ancillary services.

(v) Maximum time and distance standards in miles by city or town to access general hospital services with emergency care.

(2) The commissioner shall consider the following factors in the access standards identified in § 27-81-5(b)(1):

(i) Geographic variations that without regulator consideration might otherwise prevent in-network access to specialty care.

(ii) Maximum allowable wait times for an appointment with a primary care physician, specialist, and other health care provider.

(iii) Regular assessment of provider capacity, including the availability of providers to accept new patients.

(iv) The breadth of hours of operation for network providers.

(v) The quality measures used to evaluate providers for network inclusion.

(vi) The degree to which in-network physicians are authorized to admit patients to, or in the case of hospital-based physicians, practice at in-network hospitals.

(vii) New health care service delivery system options, such as telemedicine or telehealth.

(viii) The volume of technological and specialty services available to serve the needs of covered persons required technologically advanced or specialty care.

(3) All requirements of the regulations to be issued hereunder shall be applied to the lowest cost-sharing tier of any tiered network.

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

(c)(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit or shall make other arrangements acceptable to the commissioner when:

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

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

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

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

(ii) The health carrier:

(A) Does not have a network provider of the required specialty or subspecialty with the professional training, expertise and experience to treat or provide health care services for the condition or disease; or

(B) Cannot provide reasonable access to a network provider with the professional training, expertise and experience to treat or provide health care services for the condition or disease without unreasonable delay.

(3) The health carrier shall ensure that the covered person's financial responsibilities are not greater than if the service had been provided by an in-network provider, and shall include the covered person's cost-sharing toward the maximum out-of-pocket limit.

(4) For the processes required under subsections (c)(1) and (c)(2) of this section, a covered person and the requesting provider shall be notified of a decision to approve or decline the request within seven (7) calendar days of receipt of the request. However, if the covered person's life, health or ability to regain or maintain optimal function is in jeopardy, as indicated by the requesting provider, the health carrier must notify the covered person and requesting provider of approval or denial within twenty-four (24) hours of receipt of the request. Denials will be subject to expedited carrier review and external review, if necessary.

(5) The carrier shall have a system in place that documents all requests to obtain a

covered benefit from a non-participating provider. This document must include a log subject to review at the discretion of the commissioner to be updated on no less than a monthly basis. The frequency with which the processes described in subsections (c)(1) and (c)(2) of this section are used may be used as a potential indicator of failure to comply with the requirements of this chapter.

(6) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims, grievance and appeals processes.

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

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

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

(f)(1) Beginning January 1, 2016, a health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this chapter for each of the network plans the carrier offers in this state.

(2)(i) The health carrier may request the commissioner to deem sections of the access plan as proprietary or confidential, and such sections shall not be made public. The health carrier shall make the access plans, absent any proprietary or confidential information, available on its business premises and shall provide them to any person upon request.

(ii) For the purposes of this subsection, information is proprietary or confidential if revealing the information would cause the health carrier's competitors to obtain valuable business information.

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

(4) The access plan shall describe or contain at least the following:

(i) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards;

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

(iii) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(iv) The health carrier's process for making available in consumer-friendly language the criteria it has used to build its provider network, including information about the breadth of the network and how it selects or tiers providers, which must be made available through the health carrier's online and in-print provider directories;

(v) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(vi) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(vii) The health carrier's method of informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, its process for updating its provider directories for each of its network plans, a statement of services offered, including those services offered through the preventative care benefit, if applicable, and its procedures for providing and approving emergency and specialty care;

(viii) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(ix) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(x) The health carrier's methods for ensuring provision of health benefits in accordance with legal requirements;

(xi) The health carrier's methods for selecting providers for networks that are offered as "high-performance," "high-value," or any other label indicating that providers in such networks are selectively chosen;

(xii) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(xiii) Any other information required by the commissioner to determine compliance with the provisions of this chapter.

27-81-6. Requirements for health carriers and participating providers. -- (a) A health carrier offering a network plan shall satisfy all the requirements contained in this section:

(1) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

(2) Every contract between a health carrier and a participating provider shall set forth a "hold harmless" provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

(i) "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

(b)(1) Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered benefits to covered persons will continue through the period for which a premium has

been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater.

(2) After the period for which premium has been paid, covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the earlier of:

(i) The effective date of new health benefit plan coverage; or

(ii) Their discharge from the inpatient facility because their continued confinement in the inpatient facility is no longer medically necessary.

(c) The contract provisions that satisfy the requirements of subsections (a) and (b) of this section shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by subsections (a) and (b) of this section.

(d) In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(e)(1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for providers and each health care professional specialty.

(2) The standards shall be used in determining the selection or tiering of providers by the health carrier, and its intermediaries with which it contracts.

(3) Selection criteria shall not be established in a manner:

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

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or

(iii) That fails to regard provider performance on quality metrics as a major and essential component of provider selection criteria.

(4) Section 27-81-6(e)(3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this chapter.

(5) The provisions of this chapter do not require a health carrier, its intermediaries or the

provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain sufficient provider network, as required under § 27-81-5.

(f) A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review and approval by the commissioner, and the health carrier shall make the standards available to the public on its website. Any material changes made to the standards for selecting and tiering participating providers throughout the plan year shall be submitted to the commissioner for review and approval prior to implementation.

(g) A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

(h) A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to furnish to provide less than medically necessary services to a covered person.

(i) A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review, grievance or appeals processes established by the carrier or a person contracting with the carrier.

(j) A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

(k)(1) A health carrier and participating provider shall provide at least ninety (90) days written notice to each other before terminating the contract without cause.

(2) The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a participating provider is reassigned to a higher cost-sharing tier during the patient's plan year, the patient may

continue seeing the provider at the original cost-sharing level until the end of the covered person's contract year.

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

(4) Whenever a provider's contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less. For purposes of this paragraph, "active treatment" means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(5) Each contract between a health carrier and a participating provider shall provide that termination of the contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person, and:

(i) The physician or provider requests that the covered person be permitted to continue treatment under the physician's or provider's care;

(ii) The physician or provider agrees to accept the same reimbursement from the health carrier for that covered person as provided under the contract between the physician or the provider; and

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

(l) The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the health carrier without prior written notice to the provider.

(m) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not

render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

(n) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

(o) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(p) A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not an individual is covered by the carrier. Any positive eligibility determinations made by the health carrier using the established mechanism are binding on the health carrier.

(q) A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

(r) A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this chapter.

(s) A health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions at the time the contract is executed and of any material changes in the contract.

27-81-7. Disclosure and notice requirements. -- (a) A health carrier, for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital.

(b) For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for inpatient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person's network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital.

27-81-8. Provider directories. -- (a)(1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions

described in subsection (c) of this section. In making a directory available online, the carrier shall do so in a manner that:

(i) Clearly indicates which provider directory applies to which network plan; and

(ii) Does not place any barriers to allowing any individual from accessing the directory.

(2) The health carrier shall update each network plan provider directory at least monthly and shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in subsection (b) of this section upon request of a covered person or a prospective covered person.

(b) The health carrier shall make available in print and online the following provider directory information for each network plan:

(1) For each network:

(i) The type of plan and the patient cost-sharing responsibilities (deductibles, co-pays, premiums, etc.);

(ii) Whether there is out-of-network coverage, and the methodology used to determine payment amounts for out-of-network services, if applicable;

(iii) The standards used to select or tier participating providers and the cost-sharing differentials that may result from using a non-participating provider or a provider in a higher cost-sharing tier; and

(iv) The email addresses and phone numbers individuals may use to report inaccuracies to the provider directories to the plans.

(2) For health care professionals:

(i) Name;

(ii) Gender;

(iii) Contact information;

(iv) Specialty and subspecialty if applicable and indication of whether the provider may be chosen as a primary care provider;

(v) Network tier to which the provider is assigned, if applicable, and

(vi) Whether accepting new patients.

(3) For hospitals:

(i) Hospital name and type (e.g. general acute care, children's cancer, rehab, etc.);

(ii) Hospital location and telephone number;

(iii) Network tier to which the hospital is assigned; and

(iv) Hospital accreditation status; and

(4) Except hospitals, other facilities by type:

(i) Facility name;

(ii) Facility type;

(iii) Procedures performed;

(iv) Network tier to which the facility is assigned, if applicable; and

(v) Facility location and telephone number.

(c) For the online provider directories, for each network plan, a health carrier shall include the information required under subsection (b) of this section and additionally:

(1) The health care professional information such as:

(i) Hospital affiliations;

(ii) Medical group affiliations;

(iii) Board certification(s);

(iv) Languages spoken by the health care professional or clinical staff; and

(v) Office location(s);

(2) For hospitals, the following information with search functions for specific data types and instructions for searching for the following information:

(i) Hospital name; and

(ii) Hospital location; and

(3) Except hospitals, for other facilities, the following information with search functions for specific data types and instructions for searching for the following information:

(i) Facility name;

(ii) Facility type;

(iii) Procedures performed; and

(iv) Facility location.

27-81-9. Intermediaries. -- (a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of § 27-81-6.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary

subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.

(g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this chapter.

(h) A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If the health carrier requires assignment, the health carrier shall remain obligated to pay the provider for providing covered services under the same terms and conditions as the intermediary prior to the insolvency.

(i) Notwithstanding any other provision of this section, the health carrier shall retain full responsibility for the intermediary's compliance with the requirements of this chapter, as well as full legal responsibility for any other entity's compliance with this chapter's requirements.

27-81-10. Filing requirement and state administration. -- (a) Beginning January 1, 2016, a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect a provision required under this chapter or implementing regulations to the commissioner for approval at least ninety (90) days prior to use.

(c) If the commissioner takes no action within ninety (90) days after submission of a material change to a contract by a health carrier, the change is deemed approved.

(d) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

27-81-11. Contracting. -- (a) The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable

regulations.

(b) All contracts shall be in writing and subject to review.

(c) All contracts shall comply with applicable requirements of the law and applicable regulations.

27-81-12. Enforcement. -- (a) If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to ensure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not ensure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this chapter, or that a health carrier has not complied with a provision of this chapter, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this chapter.

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

27-81-13. Regulations. -- The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this chapter. The regulations shall be subject to review in accordance with chapter 35 of title 42.

27-81-14. Severability. -- If any provision of this chapter, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the chapter, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

27-81-15. Effective date. -- This chapter shall be effective January 1, 2016.

(1) All provider and intermediary contracts in effect on January 1, 2016, shall comply with this chapter no later than eighteen (18) months after January 1, 2016. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

(2) A new provider or intermediary contract that is issued or put in force on or after July 1, 2016 shall comply with this chapter.

(3) A provider contract or intermediary contract not described in subsection (1) or (2) of this section shall comply with this chapter no later than eighteen (18) months after January 1, 2016.

SECTION 2. This act shall take effect on January 1, 2016.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT

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This act would establish criteria by which the office of the health insurance commissioner shall review and regulate the adequacy of health plan networks.

This act would take effect on January 1, 2016.

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