

# Arkansas Insurance Department

Mike Beebe  
Governor



Jay Bradford  
Commissioner

**BULLETIN NO. 11A-2013**

**TO: ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS (HMOs), FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES**

**FROM: ARKANSAS INSURANCE DEPARTMENT**

**SUBJECT: NETWORK ADEQUACY REQUIREMENTS FOR HEALTH PLAN CERTIFICATION IN ARKANSAS FEDERALLY-FACILITATED MARKETPLACE**

**DATE: May 14, 2013**

The Department previously issued Bulletin 3A-2013, "Requirements for Qualified Health Plan Certification in the Arkansas Federally Facilitated Exchange," announcing requirements including time deadlines for submission of rate and form filings on or before June 30, 2013.

One component of qualified health plan approval for policies issued in the Health Insurance Marketplace is network adequacy. Pursuant to federal law, under the ACA, specifically 45 C.F.R. 156.230, "Network Adequacy Standards," and Section 2702(c) of the PHS Act, a health benefit plan in the Marketplace is required to have an adequate network, which is described in part to be "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." The federal requirements however do not provide any further detail or standards elaborating on adequacy or sufficiency of a medical network for filings required to be made on or before June 30, 2013. The purpose of this Bulletin is to provide more detail as to the federal network adequacy standards of qualified health plans to be recommended for approval by the Arkansas Federally Facilitated Partnership Marketplace (FFPM).

The Department intends to apply the core network adequacy standards as have previously been approved by the National Association of Insurance Commissioners in the Managed Care Plan Network Adequacy Model Act. These standards will be included in the access plans that will be submitted as a part of the qualified health plan application on or before June 30, 2013. Qualified Health Plan Issuers who currently have accreditation from an accrediting organization

recognized by CCIIO for their policies and procedures related to network adequacy may submit proof of the accreditation in lieu of submitting the access plans.

Qualified Health Plan Issuers applying for FFPM certification who currently are not certified on their policies and procedures related to network adequacy must submit on or prior to June 30, 2013, an access plan showing at least the following:

(1) The Qualified Health Plan Issuer's network 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;

(2) The Qualified Health Plan Issuer's procedures for making referrals within and outside its network and notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Qualified Health Plan Issuer'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 its health benefit plans;

(4) The Qualified Health Plan Issuer'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;

(5) The Qualified Health Plan Issuer's methods for assessing the health care needs of covered persons;

(6) The Qualified Health Plan Issuer's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, process for choosing and changing providers, and procedures for providing and approving emergency and specialty care;

(7) The Qualified Health Plan Issuer's method for assessing consumer satisfaction;

(8) The Qualified Health Plan Issuer's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Qualified Health Plan Issuer's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Qualified Health Plan Issuer's process for enabling covered persons to change primary care professionals;

(11) The Qualified Health Plan Issuer's proposed plan for providing continuity of care in the event of contract termination of the Qualified Health Plan Issuer and any of its participating providers, or in the event of the Qualified Health Plan Issuer's insolvency or other

inability to continue operations. This plan shall explain how covered persons will be notified of the contract termination, or the Qualified Health Plan Issuer's insolvency or other cessation of operations, and transferred to other providers in a timely manner;

(12) The Qualified Health Plan Issuer shall provide access or coverage for health care providers as required by federal law;

(13) The Qualified Health Plan Issuer's procedures to ensure reasonable proximity of participating providers to the business or personal residence of covered persons;

(14) The Qualified Health Plan Issuer's plan that shows how it will continually monitor the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons;

(15) The Qualified Health Plan Issuer's procedures that ensure that if the Issuer has an insufficient number or type of participating providers to provide a covered benefit, the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers; and

(16) Qualified Health Plan Issuer should file with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries

Sufficiency, as discussed above, may be established by reference to any reasonable criteria used by the Qualified Health Plan Issuer, including but not limited to: provider covered person ratios by specialty; primary care provider covered person ratios; typical referral patterns; provider's hospital admitting privileges; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

A Qualified Health Plan Issuer shall make its provider directory available for online publication by the Commissioner and make its provider directory accessible by a link to the Qualified Health Plan Issuer's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are not currently accepting new patients. This directory must be updated, and the Commissioner notified, within fourteen (14) days of that change becoming effective. If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Qualified Health Plan Issuers shall state the reason for online unavailability, what steps are being taken to get the information back online, and the expected online re-launch date.

In the event that a Qualified Health Plan Issuer makes any material changes to contract that would affect any provision of this Bulletin, the Qualified Health Plan Issuer must submit those changes to the Commissioner for approval sixty (60) days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes.

The Qualified Health Plan Issuer may request the Commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public if revealing the information would cause the Qualified Health Plan Issuer's competitors to obtain valuable business information. The Qualified Health Plan Issuer shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request.

The Department intends to issue a Rule related to network adequacy to apply to all health plans in and out of the Health Insurance Marketplace as soon as possible. However for purposes of satisfying the network adequacy requirements for plans to be issued through the FFPM on or after January 1, 2014, please abide by the requirements in this Bulletin.

If you have any questions or comments, please call the Health Benefits Exchange Partnership Division at 501-683-3483, or e-mail at [insurance.exchange@arkansas.gov](mailto:insurance.exchange@arkansas.gov).

  
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Jay Bradford  
Insurance Department Commissioner

5-14-13  
Date