TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 100
HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY

Section

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HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY

§114-100-1. General.

1.1. Scope. -- This rule provides insurance carriers offering health benefit plans with standards and guidance regarding network access plan filings and provider directories. These standards shall serve as the measurable criteria used by the Commissioner to evaluate the adequacy of carrier network access plan filings and provider directories. This rule applies to all health carriers that offer network plans in West Virginia.

1.2. Authority. -- W. Va. Code §§33-2-10 and 33-55-9.

1.3. Filing Date. -- April 1, 2021.

1.4. Effective Date. – April 1, 2021.

1.5. Sunset Provision. -- This rule shall terminate and have no further force or effect upon August 1, 2026.

§114-100-2. Definitions.

2.1. "Commissioner" means the Insurance Commissioner of this state.

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

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

2.4. "Essential community provider" or "ECP" means a provider that:

2.4.1. Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

2.4.2. Is described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub. L. 111-8.

2.5. "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 or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

2.6. "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.

2.7. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified (physical, mental or behavioral) health care services consistent with their scope of practice under state law.

2.8. "Health care provider" or "provider" means a health care professional, a pharmacy or a facility.

2.9. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance use disorders.

2.10. "Health carrier" or "carrier" means an entity subject to the insurance laws and rules 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 an insurer issuing an accident and sickness insurance policy pursuant to W.Va. Code §33-15-1 *et seq.* of this code, an insurer issuing an accident and sickness group policy pursuant to W.Va. Code §33-16-1 *et seq.* of this code, a hospital medical and dental corporation licensed pursuant to W.Va. Code §33-24-1 *et seq.* of this code, a health care corporation licensed pursuant to W.Va. Code §33-25-1 *et seq.* of this code, or a health maintenance organization licensed pursuant to W.Va. Code §33-25A-1 *et seq.* of this code. For purposes of this rule, the term "health carrier" or "carrier" does not include insurers or managed care organizations with respect to their Medicaid or CHIP plans or contracts which are reviewed and approved by the Department of Health and Human Resources Bureau for Medical Services.

2.11. "Limited scope dental plan" means a plan that provides coverage, substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

2.12. "Limited scope vision plan" means a plan that provides coverage, substantially all of which is for treatment of the eye, that is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

2.13. "Material change" means changes in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons that may render the carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material include:

2.13.1. A significant reduction in the number of primary or specialty care physicians available in a network;

2.13.2. A reduction in a specific type of provider such that a specific covered service is no longer available;

2.13.3. A change to the tiered, multi-tiered, layered or multi-level network plan structure; and

2.13.4. A change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

2.14. "Network" means the group or groups of participating providers providing services under a network plan.

2.15. "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.

2.16. "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.

2.17. "Pediatric" means the specialty of medical science concerned with the physical, mental, and social health of children from birth up to the age of nineteen.

2.18. "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.

2.19. "Primary care" means health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or nonphysician primary care professional.

2.20. "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.

2.21. "SERFF" means the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing.

2.22. "Specialist" means a physician or non-physician health care professional, including a subspecialist who has additional training and recognition above and beyond his or her specialty training, who:

2.22.1. Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

2.22.2. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

2.23. "Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional

or other health care professional.

2.24. "Telemedicine" or "telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

2.25. "Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

2.26. "Transfer" means 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:

2.26.1. Has been declared dead; or

2.26.2. Leaves the facility without the permission of any such person.

§114-100-3. Network Adequacy Standards.

3.1. The following provider-to-covered person ratios shall be met by a health carrier in order to comply with network adequacy requirements, except that limited scope dental plans and limited scope vision plans are not subject to this subsection:

Provider Type	Ratio
Primary Care Physician	1 for every 500 covered person
Pediatrician	1 for every 250 covered person
Obstetrics/Gynecology	1 for every 1000 covered person
Specialist	1 for every 2,000 covered person

3.1.1. At least seventy percent of the health carrier's providers named in this subsection must be accepting new patients.

3.2. The following geographic accessibility standards shall be met by a health carrier in order to comply with network adequacy requirements, except that limited scope dental plans and limited scope vision plans are not subject to this subsection:

Specialty	Travel Time/Distance
At least two of the following: Allergists Audiologists Cardiologists Dentist for Pediatric only	30 minutes travel time from member residence and/or 25 miles

Continued

Specialty	Travel Time/Distance
At least two of the following: Dermatologists General Surgery Gastroenterologists Neurologists Occupational Therapy Oncologists OB/GYNs and/or Nurse Midwives Ophthalmologists Orthopedic Orthopedic Surgeons Otolaryngologist/Otorhinolaryngologic Pediatric or Age appropriate Primary Care Physicians (PCPs) Physical Therapy Primary Care Physicians (PCPs) Pulmonologists	30 minutes travel time from member residence and/or 25 miles

Specialty	Travel Time/Distance
At least one of the following: Anesthesiology Chiropractic Dialysis Durable Medical Equipment (DME) Endocrinology Hematology Home Health Services Laboratory, Nephrology Neurosurgery Orthotics/Prosthetics Pathology Plastic surgery Podiatry Radiology Services Thoracic Surgery Urology	30 minutes travel time from member residence and/or 25 miles

Specialty	Travel Time/Distance
At least one of the following for Pediatric:	
Oral Surgeon Orthodontist	60 minutes travel time from member residence and/or 45 miles

Specialty	Travel Time/Distance
At least two of the following behavioral health providers:	
Psychologists Psychiatrists Licensed Independent Clinical Social Worker	60 minutes travel time from member residence and/or 45 miles

Specialty	Travel Time/Distance
At least one of the following:	
Hospital Access Hospital with the following Tertiary Services Access: Acute care services to pediatric patients in medical and surgical units; Obstetric services; and Neo-natal intensive care unit	45 minutes travel time from member residence and/or 30 miles

Specialty	Travel Time/Distance
Behavioral Health (Substance Use Disorder):	
Outpatient SUD Provider	60 minutes travel time from member residence and/or 45 miles

3.2.1. At least seventy percent of the health carrier's providers named in this subsection must be accepting new patients.

3.2.2. The standards set forth in this subsection are satisfied if ninety percent of the health carrier's members are within the travel time and/or distance standards.

3.2.3. If a carrier cannot meet the standards set forth in this subsection, the carrier must have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits from a nonparticipating provider or make other arrangements acceptable to the Commissioner, which may include contracting with the nearest like provider.

§114-100-4. Network Access Plan Standards.

4.1. For health benefit plan years beginning January 1, 2022, a health carrier shall file with the Commissioner an access plan meeting the requirements of this rule and W. Va. Code §33-55-3. An access

plan for a newly offered network must be filed for review and approval on or before April 1 of the year preceding the plan year. For the purposes of this rule, a "newly offered network" includes an existing network at the time this rule becomes effective irrespective of whether the Commissioner has approved the network.

4.2. A health carrier shall file, maintain and make available on their website an access plan, absent proprietary information, for each network plan that the carrier offers in West Virginia. The health carrier may request the Commissioner to deem sections of the access plan as proprietary information that not be made public.

4.3. A health carrier shall prepare and file 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 business days after the change occurs, including a reasonable timeframe within which it will file an update to an existing access plan.

4.4. A health carrier shall make an access plan, absent proprietary information pursuant to W. Va. Code §33-55-3(e)(2), available to any person upon request.

4.5. All health benefit plans and marketing materials of a health carrier shall clearly disclose the existence and availability of the access plan.

4.6. All rights and responsibilities of the covered person under a health benefit plan shall be included in the contract provisions of the health benefit plan, regardless of whether or not such provisions are also specified in the access plan.

4.7. A health carrier shall submit access plans to the Commissioner through SERFF.

4.8. An access plan shall describe, contain or address the following:

4.8.1. The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

4.8.2. The factors used by the health carrier to build its network, including a description of the criteria used to select providers;

4.8.3. Establishing that the health carrier's network has an adequate number of providers and facilities within a reasonable distance of covered persons;

4.8.4. The specific provider and facility types within the network per West Virginia county;

4.8.5. The health carrier's documented, quantifiable and measurable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of covered persons on an ongoing basis;

4.8.6. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network benefit level, from a non-participating provider should the carrier's network prove to not be sufficient;

4.8.7. The health carrier's procedures for making and authorizing referrals within and outside its network. The procedures should address the health carrier's processes regarding:

4.8.7.a. The provision of a comprehensive listing of the health carrier's network of participating providers and facilities to covered persons and primary care providers;

4.8.7.b. Timely referrals for access to specialty care;

4.8.7.c. Expedition of the referral process when indicated by the covered person's medical condition; and

4.8.7.d. Member access to services outside the network when necessary;

4.8.8. The health carrier's process for enabling covered persons to change primary care providers (PCP), if applicable;

4.8.9. The health carrier's quality assurance standards, which must be adequate to identify, evaluate and remedy problems relating to access, continuity and quality of care;

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

4.8.11. The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

4.8.12. The health carrier's method of informing covered persons of the plan's covered services and features, including, but not limited to:

4.8.12.a. The plan's grievance and appeal procedures;

4.8.12.b. Its process for choosing and changing providers;

4.8.12.c. Its process for updating its provider directories for each of its network plans;

4.8.12.d. A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

4.8.12.e. Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

4.8.13. 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 transitioned to other providers in a timely manner; and

4.8.14. The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals. This subdivision does not apply to limited scope vision plans or limited scope dental plans as defined in W.Va. Code §33-55-1.

4.9. The Commissioner may develop forms to be completed by the health carrier regarding the information required by subsection 4.8 of this rule.

§114-100-5. Coordination and Continuity of Care.

5.1. A health carrier shall address its process for ensuring the coordination and continuity of care for its covered persons in the access plan for each network offered by the carrier.

5.2. The process for ensuring the coordination and continuity of care shall include, but is not limited to, the following:

5.2.1. The heath carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

5.2.2. The health carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources;

5.2.3. The health carrier's documented process for ensuring appropriate discharge planning;

5.2.4. The health carrier's process for enabling covered persons to change primary care providers; and

5.2.5. The health carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process shall include an explanation of how covered persons will be notified in the case of a provider contract termination, the health carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.

§114-100-6. Network Access Plan Disclosures; Attestations.

6.1. In the access plan for each network plan offered, a health carrier shall explain its method for informing covered persons of the plan's services and features through disclosures to covered persons.

6.1.1. Required disclosures include:

6.1.1.a. The health carrier's grievance and appeal procedures;

6.1.1.b. The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy and rehabilitation services, are available;

6.1.1.c. The health carrier's procedures for providing and approving emergency and non-emergency medical care;

6.1.1.d. The health carrier's process for choosing and changing network providers;

6.1.1.e. The health carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities; and

6.1.1.f. The health carrier's documented process to identify the potential needs of special populations.

6.2. The following attestations shall be submitted with the access plan:

6.2.1. Health carrier attests that each of its health benefit plans having a network plan will maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health, behavioral health and substance abuse care services, to assure that the services will be accessible without unreasonable delay. The attestation should include language stating that the health carrier's network is in compliance with the network adequacy standards set forth in section 3 of this rule.

6.2.2. Health carrier attests that each of its health benefit plans having a provider network include in its provider network(s) a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in their service areas.

6.2.3. If the health carrier does not immediately meet access plan standards, the carrier will include an attestation adequately addressing how it plans to meet the standards specified in sections 3 and 4 of this rule. Such changes shall be implemented and filed by the health carrier in accordance with the reasonable schedule established by the carrier and reviewed by the Commissioner.

§114-100-7. Provider Directories.

7.1. Provider directories shall be maintained by a health carrier for each of its health benefit plans having a network plan. Sample screen shots of the carrier's electronic provider directory and a PDF sample of the carriers printed provider directory must both be filed in SERFF with the access plan filing.

7.2. Provider directories maintained by a health carrier shall meet all of the following requirements:

7.2.1. A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions as described in W.Va. Code §33-55-4;

7.2.2. When making the directory available electronically, the health carrier shall ensure that the general public is able to view all of the current providers for a network through a clearly identifiable link or tab without requiring an individual to create or access an account or requiring the entry of a policy or contract number;

7.2.3. The health carrier shall include a disclosure in the directory of the date of the most recent update for electronic directories, or the date of printing for printed directories. This disclosure shall state that the information included in the directory is accurate, to the best of the carrier's knowledge, as of the date of updating/printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website, or call the carrier's customer service telephone number, to obtain current provider directory information;

7.2.4. A health carrier shall provide a print copy of the requested pertinent portion of the current provider directory to a covered person or a prospective covered person within five business days of the request;

7.2.5. A health carrier shall include, in both the electronic and print directory, the following general information for each of its provider networks:

7.2.5.a. A description of the criteria the health carrier has used to build its provider network;

7.2.5.b. A note that an authorization or referral may be required to access some providers;

7.2.5.c. A description of the criteria the health carrier has used to tier providers; and

7.2.5.d. A description of how the health carrier designates the different provider tiers or levels in the network and identifies (*e.g.*, by name, symbols or grouping) which tier or level the following are placed in:

7.2.5.d.1. Each specific provider;

7.2.5.d.2. Each specific hospital; and

7.2.5.d.3. Each specific other type of facility in the network;

7.2.6. A health carrier shall make it clear, in both its electronic and print directories, which provider directory applies to a particular health benefit plan, such as including the specific name of the health benefit plan as marketed and issued in West Virginia;

7.2.7. The health carrier shall include, in both its electronic and print directories, customer service contact information by electronic means such as email, text or social media and, telephone number and an electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information;

7.2.8. For the items of information required in a provider directory pursuant to W.Va. Code §33-55-4 pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available, through the directory, the source of the information and any limitations; and

7.2.9. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

7.3. A health carrier shall update each electronic provider directory at least monthly. Current provider directories shall be made available to the Commissioner, upon request.

7.4. No less frequently than three times during each plan year, a health carrier shall audit at least fifty percent of the providers contained in its provider directories for accuracy and update that directory based upon its findings. Every provider in the directory must be audited at least once during each plan year.

7.5. Audits shall be conducted such that all entries in a provider directory will be audited at least once every eighteen months. Documentation of the process and findings of all audits and the information required by this rule shall be retained for no less than thirty-six months and shall be made available to the Commissioner upon request.