

PART Ins 2701 NETWORK ADEQUACY

Statutory Authority: RSA 400-A:15; RSA 420-J:7 and RSA 420-J:12

Ins 2701.01 Purpose. The purpose of these rules is to define a network for carriers providing managed care coverage that is sufficient in numbers, types and geographic location of providers to ensure that covered persons will have access to health care services without unreasonable delay.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10

Ins 2701.02 Scope. These rules shall apply to all insurers offering or issuing policies of health insurance in the state of New Hampshire that provide managed care services to persons covered under those policies of insurance.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10

Ins 2701.03 Definitions. For the purposes of this rule:

- (a) “Commissioner” means the insurance commissioner.
- (b) “Covered benefits” means those health care services and other medical services to which a covered person is entitled under the terms of a health benefit plan.
- (c) “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- (d) “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
- (e) “Emergency mental health condition” means the sudden, and at the time, unexpected onset of a mental health condition of a covered person, which if not treated immediately would likely result in serious bodily injury, or would likely present an imminent danger of harm to the covered person or to others.
- (f) “Emergency mental health services” means health care services provided to an enrollee, insured or subscriber after the onset of an emergency mental health condition, that requires immediate mental health attention in a licensed hospital emergency facility or at the offices of a community mental health program approved by the commissioner of the New Hampshire department of health and human services in accordance with RSA 135-C:10, where failure to provide treatment would likely result in serious bodily injury, or would likely present an imminent danger of harm to the covered person or to others.
- (g) “Emergency services” means health care services that are provided to an enrollee, insured, or subscriber in a licensed hospital emergency facility by a provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could be expected to result in one or more of the following:
 - (1) Serious jeopardy to the patient's health;
 - (2) Serious impairment to bodily functions; and
 - (3) Serious dysfunction of any bodily organ or part.

(h) “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 covered benefits.

(i) “Health 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 to provide, deliver, arrange for, pay for or reimburse any of the covered costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

~~(j) “Hospital service area” means a regional geographic grouping of cities and towns that have been identified by the health services planning and review board in accordance with He-Hea 1000.02 as a means of breaking the state into units of analysis.~~

(k) “Managed care 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.

(l) “National Committee for Quality Assurance (NCQA)” means the independent, nonprofit organization based in Washington, D.C. whose primary purpose is to assess and report on the quality of managed care plans, including health maintenance organizations;

(m) “Network” means the group of participating providers contracted to provide services to a managed care plan.

(n) “Open panel provider” means a participating provider who is accepting new patients.

(o) “Participating provider” means a person or entity 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, co-payments or deductibles, directly or indirectly from the health carrier.

(p) “Point of service plan” means a multi-tiered managed care plan in which covered persons may access care according to the plan’s network referral rules or may access care by self-referral to network or non-network providers.

(q) “Select plan” means a managed care plan in which covered persons can select at the point of service from among different network-based delivery systems, one of which is designed as the select network and the benefits associated with receiving care from a select network provider result in lower out-of-pocket costs to the covered person than when care is received from a network provider that is not in the select network.

(r) “Urgent services” means health care services that are provided to treat a medical or mental health condition or symptomatic illness of a covered person that if not treated within 48 hours presents a risk of serious harm.

(s) “Utilization Review Accreditation Commission (URAC)” means the voluntary, nonprofit organization based in Washington, D.C. whose primary purposes are to provide a centralized review and accreditation process for medical utilization.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10 (from Ins 2701.01)

Ins 2701.04 Basic Access Requirement.

(a) Each health carrier offering a managed care plan shall maintain a network of primary care providers, specialists, institutional providers, and other ancillary health care personnel that is sufficient in numbers, types and geographic location of providers to ensure that all covered health care services are accessible to covered persons without unreasonable delay.

(b) A health carrier's network of participating providers shall be considered sufficient to meet the basic access requirement in Ins 2701.04(a) if it meets all of the standards contained in Ins 2701.02 through 2701.09.

(c) The basic access requirement in Ins 2701.04(a) shall be met in each county ~~or hospital service area~~ in which the health carrier ~~has 1000 or more covered persons~~ is actively soliciting marketing a health benefit plan. For the purpose of this paragraph "active solicitation marketing" means advertising in publications published within the county or hospital service area or initiating contact with a potential policyholder in person, by phone or by mail. In the event the carrier has fewer than 1,000 covered members in a particular county, the evaluation of network adequacy shall be based on the most recent census data for populations under 65 years of age.

(d) In a multi-tiered health benefit plan, such as a point of service plan or a select plan, the networks of participating providers that are associated with all benefit levels shall be considered in determining compliance with the geographic accessibility standards in Ins 2701.06(d)(1)b. and c.

(e) In any county ~~or hospital service area~~ in which compliance with Ins 2701.04(a) is required and in which a health carrier's network is insufficient to meet one of the access standards in Ins 2701.06 and in which the carrier has not been granted an exception pursuant to Ins 2701.06(e), the health carrier shall cover services provided by a non-participating provider located within the applicable geographic area at no greater cost to the covered person than if the services were obtained from a participating provider. Coverage under this paragraph shall be subject to all other terms and conditions of the covered person's health benefit plan, including, but not limited to, referral and authorization requirements. Nothing in this paragraph shall be construed to require a health carrier to provide coverage for services provided by a non-participating provider who has been excluded from the health carrier's network for failing to meet any applicable credentialing standards. This provision shall not prohibit reimbursement for services rendered by a community mental health program that is approved by the commissioner of the New Hampshire department of health and human services in accordance with RSA 135-C:10, provided that community mental health program meets the carrier's credentialing standards as a facility.

(f) A health carrier shall not actively solicit new policyholders in any county ~~or hospital service area~~ in which compliance with Ins 2701.04(a) is required and in which it does not meet the access standards in Ins 2701.06, unless the health carrier has been granted an exception under Ins 2701.06(e). ~~For the purpose of this paragraph "active solicitation" means advertising in publications published within the county or hospital service area or initiating contact with a potential policyholder in person, by phone or by mail.~~

(g) Nothing in (f) above shall be construed to prohibit a health carrier from:

- (1) Advertising in publications distributed within the county ~~or hospital service area~~ which are published outside of the county ~~or hospital service area~~;
- (2) Responding to inquiries initiated by a potential policyholder; or
- (3) Issuing or renewing coverage as required by federal or state law, including RSA 420-G.

(h) Each health carrier and its health benefit plans, provider contracts, networks and operations shall conform to the provisions of Ins 2701.01 through Ins 2701.09.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10 (from Ins 2701.02)

Ins 2701.05 Primary Care Providers Reasonable Access to Health Care Services.

(a) For purposes of demonstrating compliance with the requirements in Ins 2701.06(b) regarding access to primary care providers, only the categories of physicians and health care professionals set forth in this section may be considered by the health carrier to be primary care providers.

(b) Physicians qualified to be considered primary care providers shall include:

(1) Licensed physicians who have successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, or pediatrics; health care services, the network shall include

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(2) Licensed physicians providers for which the service in question is within their scope of practice; providers may include. This includes nurse practitioners, osteopaths, naturopaths, midwives, physician assistants, clinical nurse specialists, dentists, dental hygienists, or any provider trained and appropriately licensed, and when required, working under a supervising physician in compliance with New Hampshire laws. the qualifications in Ins 2701.05(a)(1) above, but who can demonstrate, through training, education and experience, sufficient expertise in primary care to meet the health carrier's credentialing standards for primary care provider status; and

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(e) Health care professionals qualified to be considered primary care providers shall include advanced registered nurse practitioners licensed by the New Hampshire board of nursing in the advance practice categories of family practice, internal medicine or pediatrics.

(b) Satisfying network adequacy requirements for access to health care services includes network coverage for any provider who is integral to providing the identified service, even if the related service is not performed in every circumstance. A carrier shall not meet network adequacy standards unless it can ensure access to all services that are considered incidental and related to the service identified in these rules, within a timeframe that complies with an acceptable standard of care.

(c) Access to medically necessary health care services through the use of telemedicine or telehealth may be used to satisfy the network adequacy geographic access requirements when an acceptable standard of care can be met by the provider offering the service.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10 (from Ins 2701.03)

Ins 2701.06 Standards for Geographic Accessibility.

(a) Geographic access standards shall be measured in terms of distance or travel times for covered persons under normal conditions from their place of residence. Services must be available to ninety percent of the enrolled population within the time and distance standards.

(b) Geographic access standards for primary care providers are based on the Centers for Medicare and Medicaid Services (CMS) county types: Rural, Micro, and Metro; and maximum travel times are based on the service type and county. Services are classified as Core, Common, Specialized, and Highly

~~Specialized. Services must be available to ninety percent of the enrolled population within the time and distance standards.~~ Time and distance standards are as follows:

1. Rural (Coos County):
 - a. Core = 30 miles or one hour driving time
 - b. Common = 80 miles or two hours driving time
 - c. Specialized = 200 miles or three and a half hours driving time
 - d. Highly Specialized = 400 miles or six hours driving time.
2. Micro (Grafton, Carroll, and Sullivan counties):
 - a. Core = 20 miles or 40 minutes driving time
 - b. Common = 40 miles or 80 minutes driving time
 - c. Specialized = 70 miles or two hours driving time
 - d. Highly Specialized = 180 miles or three and a half hours driving time.
3. Metro (Belknap, Merrimack, Strafford, Cheshire, Hillsborough, and Rockingham counties):
 - a. Core = 10 miles or 15 minutes driving time
 - b. Common = 20 miles or 30 minutes driving time
 - c. Specialized = 40 miles or one hours driving time
 - d. Highly Specialized = 160 miles or two and a half hours driving time.

(c) Services are classified as Core, Common, Specialized, and Highly Specialized.

1. Core services include:

- Ambulance, non-emergency transport
 - Chiropractic
 - Contraceptive services
 - Screening and assessment services for mental health
 - Individual and group counseling for mental health
 - Screening and assessment services for substance abuse disorders
 - Individual and group counseling for substance use disorders
 - Diagnostic physical therapy evaluation
 - Home health care
 - Patient education and self-management support
 - Pediatric oral health services, including routine care
 - Preventive and routine acute care, adult
 - Preventive and routine acute care, pediatric
 - Physical therapy procedures not requiring specialized equipment
 - Clinical and non-clinical recovery support services for substance abuse disorder
 - Outpatient and intensive outpatient services for substance use disorder
 - Routine EKG
 - Routine immunizations and injections, adult
 - Routine immunizations and injections, pediatric
 - Routine pre-natal care
 - Routine lab tests and venipuncture
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- Suture of non-life threatening wound
 - Urgent care services
 - Dental diagnostic services
 - Dental preventive services

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[Dental restorative services](#)

[2. Common Services include:](#)

[Amputation of toe](#)

[Apply splint](#)

[Asthma and bronchial care](#)

[Biopsy \(procedure to obtain tissue\)](#)

[Biopsy of skin lesions](#)

[Bone biopsy \(procedure to obtain tissue\)](#)

[Bone marrow aspiration](#)

[Cardiac monitoring and stress testing](#)

[Cardioversion](#)

[Central venous access device insertion and removal](#)

[Chemotherapy](#)

[Cystoscopy](#)

[Delivery of newborn](#)

[Destruction of benign or premalignant lesion](#)

[Developmental, hearing and vision testing, pediatric](#)

[Diagnosis and therapy for rheumatic disease](#)

[Drainage of skin abscess](#)

[Ear, nose, and throat procedures](#)

[Electroencephalogram \(EEG\) testing](#)

[Eye procedures](#)

[General surgery](#)

[Gastrointestinal endoscopy with biopsy](#)

[Hernia repair](#)

[Immunotherapy](#)

[Incision and drainage, deep abscess](#)

[Injection, aspiration, arthrocentesis of a joint](#)

[Insertion of chest tube](#)

[Laparoscopic surgery](#)

[Medical eye exam](#)

[Muscle tests](#)

[Non-routine venipuncture](#)

[Occupational therapy](#)

[Osteopathic manipulation](#)

[Paring or cutting benign lesion](#)

[Psychiatric diagnostic evaluation with medical services](#)

[Physical therapy or other rehabilitation or habilitation treatment, requiring specialized equipment](#)

[Radiation therapy](#)

[Renal dialysis](#)

[Routine endoscopy](#)

[Routine overnight care for medical conditions](#)

[Routine overnight care for mental health conditions](#)

[Inpatient residential treatment for substance abuse disorder](#)

[Short term inpatient stabilization and detoxification for substance use disorder](#)

[Routine overnight care for surgical conditions](#)

[Skin replacement surgery \(grafts\)](#)

[Speech therapy](#)

[Spinal injection and nerve block](#)

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[Standard imaging](#)
[Thoracentesis](#)
[Treatment for endocrinological disorders](#)
[Treatment of bone and joint disorders](#)
[Trim or debride nails](#)
[Vision care](#)
[Wound closure](#)
[Wound debridement](#)
[Dental endodontics](#)
[Dental periodontics](#)
[Dental prosthodontics \(removable\)](#)
[Dental maxillofacial prosthetics](#)
[Dental implant services](#)
[Dental oral and maxillofacial surgery](#)
[Dental orthodontics](#)
[Dental adjunctive general services](#)

3. Specialized Services include:

[Advanced imaging: computed tomography \(CT\) and computed axial tomography \(CAT\)](#)
[Magnetic resonance imaging tomography](#)
[Allergy testing](#)
[Complex endoscopy](#)
[Complex overnight care for medical conditions](#)
[Complex overnight care for mental health conditions](#)
[Complex overnight care for substance use disorder treatment](#)
[Complex overnight care for surgical conditions](#)
[High risk delivery of newborn](#)
[Neurological testing](#)
[Non-routine conditions of pregnancy](#)
[Uncomplicated major procedures](#)

4. Highly specialized services include:

[Complicated major procedures](#)
[Conditions and treatments not specifically mentioned in other proximities](#)
[Rare conditions](#)
[Treatment for complex, severe, or co-occurring mental and behavioral disorders](#)
[Treatments requiring extraordinary equipment or facilities](#)

shall be as follows:

~~(1) There shall be 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; and~~

~~(2) In order to demonstrate primary care provider availability, a health carrier shall verify, by submission of a consumer survey broken down by county or hospital service area, that the primary care provider network is offering a level of service that meets the members' needs.~~

~~(c) Geographic access standards for key specialty care practitioners shall be as follows:~~

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~~(1) There shall be a sufficient number of licensed medical specialists in the following key specialty areas who are available to covered persons to provide medically necessary specialty care:~~

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- ~~a. Allergists;~~
- ~~b. Cardiologists;~~
- ~~c. General surgeons;~~
- ~~d. Neurologists;~~
- ~~e. Obstetrician/gynecologists;~~
- ~~f. Oncologists;~~
- ~~g. Ophthalmologists;~~
- ~~h. Orthopedists;~~
- ~~i. Otolaryngologists;~~
- ~~j. Psychiatrists; and~~
- ~~k. Urologists;~~

~~(2) Access to each of the licensed medical specialists listed in Ins 2701.06(e)(1) shall be within 45 miles or 60 minutes travel time for at least 90 percent of the enrolled population within each county or hospital service area;~~

~~(3) Access to the specialists listed below shall be within travel times that are not more than 50 percent greater than the travel time or distance set in Ins 2701.06(e)(1).~~

- ~~a. Plastic surgeons; and~~
- ~~b. Thoracic surgeons.~~

~~(d) Geographic access standards for institutional providers and providers of certain other specialty services that are covered under the terms of the health benefit plan shall be as follows:~~

~~(1) Access to the following providers or categories of service shall be within the following distances or travel time intervals for at least 90 percent of the enrolled population within each county or hospital service area:~~

- ~~a. The travel time interval to a pharmacy shall be 15 miles or 45 minutes travel time;~~
- ~~b. The travel time interval to a provider of outpatient mental health services shall be 25 miles or 45 minutes travel time;~~
- ~~c. The travel time interval for the following list of services shall be 45 miles or 60 minutes~~
 - ~~1. Licensed medical surgical, pediatric, obstetrical and critical care services associated with acute care hospital services;~~
 - ~~2. Surgical facilities associated with acute care hospital services;~~

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~~3. Laboratory, magnetic resonance imaging center, diagnostic radiology provider, x-ray, ultrasound, CAT scan, therapeutic radiation provider associated with acute care hospital services; and~~

~~4. Licensed renal dialysis provider associated with acute care hospital services;~~

~~d. The travel time interval for the following list of services shall be 45 miles or 60 minutes travel time for:~~

~~1. General inpatient psychiatric;~~

~~2. Emergency mental health provider;~~

~~3. Short term care facility for involuntary psychiatric admissions;~~

~~4. Short term care facility for substance abuse treatment; and~~

~~5. Short term care facility for inpatient medical rehabilitation services; and~~

~~e. The travel time interval for the following tertiary or specialized services shall be 80 miles or 120 minutes travel time:~~

~~1. Diagnostic cardiac catheterization;~~

~~2. Major trauma treatment;~~

~~3. Neonatal intensive care; and~~

~~4. Open heart surgery services.~~

~~(2) The health carrier shall have a policy assuring accessibility within the New England region, if available, for other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers, services for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and home health agencies, hospice programs, and licensed long term care facilities with Medicare certified skilled nursing beds. To the extent that the above specialty services are available within New Hampshire, the plan shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable; and~~

~~(3e) The policy may offer such tertiary or specialized services at so-called “centers of excellence”. The tertiary or specialized services shall be offered within the New England region, if available. The plan shall not exclude New Hampshire providers of tertiary or specialized services from its network provided that the negotiated rates are commercially reasonable.~~

~~(ef) Exceptions to the standards for geographic accessibility in Ins 2701.06(b), (c) and (d) shall be permitted where:~~

~~(1) A health carrier can establish that an insufficient number of qualified providers or facilities are available in the county or hospital service area to meet the geographic accessibility standards contained in Ins 2701.06, and that all of the following apply:~~

~~a. Customary practice and travel arrangements in the local area exceed the standards in Ins 2701.06; and~~

~~b. The health carrier's provider network is sufficient to ensure that the level of geographic accessibility to covered services that covered persons enjoy is at least equal to the customary practice and travel arrangements;~~

~~c. With respect to outpatient mental health services, access to the nearest community mental health program approved by the commissioner of the New Hampshire department of health and human services in accordance with RSA 135-C:10 have been deemed to provide a level of geographic accessibility that is at least equal to the customary practice and travel arrangements; and~~

~~d.—~~The health carrier has taken all reasonable steps to effectively mitigate any detrimental impact to covered persons; or

(2) A health carrier can establish that the carrier's failure to develop a provider network in a given county ~~or hospital service area~~ that is sufficient in number, type and geographic location of providers to meet all of the standards in Ins 2701.06(b), (c) and (d) is due to the refusal of a local provider to accept a commercially reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons; or

(3) A health carrier can establish that an exception from the geographic accessibility standards will permit the provision of better quality services, and the quality improvements to services significantly outweigh any detrimental impact to covered persons or that the health carrier has taken steps to effectively mitigate any detrimental impact to covered persons.

Source. #7701, eff 8-1-02; ss by #9722, eff 8-1-10 (from Ins 2701.04)

Ins 2701.07 Standards for Waiting Times for Appointments and Access to After-Hours Care.

(a) Standard waiting times for appointments shall be measured from the initial request for an appointment and shall meet NCQA requirements.

(b) Health carriers shall ensure that all covered persons have access to a utilization reviewer to make prior approval or pre-authorization decisions in accordance with URAC or NCQA standards.

Source. #7701, eff 8-1-02; ss by #9399, eff 3-1-09; ss by #9722, eff 8-1-10 (from Ins 2701.05)

Ins 2701.08 Choice of and Access to Providers of Specialty Care.

(a) Each health carrier shall establish policies and procedures through which a member with a condition that requires ongoing care from a specialist may obtain a standing referral to a network specialist, subject to the utilization review procedures used by the health carrier. For purposes of this provision, "standing referral" means a referral for ongoing care to be provided by a network specialist that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan developed by the covered person's primary care provider, the specialist, the covered person and the plan.

(b) Each health carrier shall ensure that covered persons may obtain a referral to a health care provider outside of the health carrier's network when the health carrier does not have a health care provider with appropriate training and experience within its network who can meet the particular health care needs of the covered person. Services provided by out-of-network providers shall be subject to the utilization review procedures used by the health carrier. The covered person shall not be responsible for

any additional costs incurred by the health carrier under this paragraph other than any applicable co-payment, coinsurance or deductible.

Source. #7701, eff 8-1-02; ss by #9399, eff 3-1-09 ss by #9722, eff 8-1-10 (from Ins 2701.06)

Ins 2701.09 Reporting Requirement.

(a) Each health carrier shall prepare an annual health care certification of compliance report for each of the health benefit plans that the carrier offers in this state. The health care certification of compliance report shall certify compliance with the requirements of this rule and shall be signed by an authorized representative of the company. The health care certification of compliance report shall specifically state that the carrier has prepared a network adequacy report meeting the requirements of these rules. If the network adequacy report prepared by the carrier identifies any noncompliance in the network, the health carrier shall identify the noncompliance in its annual health care certification of compliance report and shall not certify compliance until the noncompliance is corrected.

(b) If the identical provider network is associated with more than one health benefit plan, a single network adequacy report shall be prepared, and a single health care certification of compliance report shall be filed. The health care certification of compliance report shall identify all health benefit plans using the identical provider network.

(c) The health carrier shall make the network adequacy reports available on its business premises and accessible on their carrier's website. The carrier shall provide them to any interested party upon request.

(d) The carrier shall prepare a network adequacy report and shall submit a health care certification of compliance report prior to offering a new health benefit plan.

(e) In addition to the annual health care certification of compliance report reporting requirement, a carrier shall notify the commissioner in writing within 10 days of the net loss of 10% or more of its ~~primary-Corere~~ providers in any county ~~or hospital service area~~ within any 30-day period. The carrier shall be required to demonstrate compliance with the network adequacy requirements by submitting a certification of continued compliance no later than 10 days after it becomes aware of the loss of its ~~primary care~~Core providers.

(f) The annual health care certification of compliance report shall be filed with the commissioner annually on March 1st.

(g) The network adequacy report prepared by the health carrier shall describe and contain the following:

(1) For each type of health benefit plan offered by the carrier, the current enrollment in this state in the form of a table setting forth the number of enrollees by county of residence and the total number of enrollees statewide;

(2) A description of the network associated with each health benefit plan offered by the carrier, including a list of the network providers who are primary careCore, Common, Specialized, and Highly Specialized providers, ~~specialty care practitioners, and institutional providers by license, certification or specialty type and~~ by county ~~and hospital service area~~;

(3) For each distinct network offered by the carrier, using a network accessibility analysis system such as GeoNetworks or any other system having similar capabilities, the following:

a. Maps showing the residential location of covered persons in New Hampshire, Core, Common, Specialized, and Highly Specialized providers~~primary care providers, specialty care practitioners, and institutional providers~~; and

b. An access table illustrating the relationship between providers and covered persons by county ~~or hospital service area~~, and also on a statewide basis, including at a minimum:

1. The total number of covered persons;
2. The total number of primary care~~Core service~~ providers who are accepting new patients;
3. The total number of primary care~~Core service~~ providers who are not accepting new patients; and
4. Separate by category, the percentage of covered persons for whom meeting the primary care~~Core, Common, Specialized, and Highly Specialized service~~ provider access standards in Ins 2701.06 (b) are met; ~~;~~
- ~~5. The percentage of covered persons meeting the specialty care practitioner access standard in Ins 2701.06 (c) for each type of specialty care practitioner listed in Ins 2701.06 (c) (1);~~
- ~~6. The total number of institutional providers and providers of certain other specialty services specified in Ins 2701.06 (d) by type; and~~
- ~~7. The percentage of covered persons meeting the access standard for institutional providers and certain other specialty services in Ins 2701.06 (d).~~

- (4) The health carrier's procedures for making referrals within and outside its network;
- (5) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the health care needs of persons who enroll in managed care plans;
- (6) The health carrier's plan for providing services in rural and underserved areas and for developing relationships with essential community providers;
- (7) The health carrier's method of informing covered persons of the requirements and procedures for gaining access to network providers, including but not limited to the following:
 - a. The process for choosing and changing network providers;
 - b. The process for providing and approving emergency, urgent, and specialty care;
 - c. The identity of all of the plan's participating providers and facilities, including a specification of those participating providers, if any, that are accessible only at a reduced benefit level; and
 - d. Whether and when referral options are restricted to less than all providers in the network who are qualified to provide covered specialty services.

(8) The health carrier's system for ensuring the coordination of care for covered persons referred to specialty [physicians/providers](#), for covered persons using ancillary services, including social services, behavioral health services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care providers; and

(10) The health carrier's proposed plan for providing 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.

(11) The description in (g)(10) shall explain how impacted 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.

[Source.](#) #9722, eff 8-1-10 (from Ins 2701.07)

Ins 2701.10 Enforcement. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area or that a health carrier's health care certification of compliance report does not assure reasonable access to covered benefits, the commissioner shall issue an order requiring the health carrier to institute a corrective action, or shall use other enforcement powers under RSA 420-J to ensure that covered persons have access to covered benefits.

[Source.](#) #9722, eff 8-1-10 (from Ins 2701.08)