

## PART Ins 2701 HEALTH AND DENTAL BENEFIT PLAN 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 establish standards for determining whether a carrier's provider network 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 and dental insurance in the state of New Hampshire when the plan design includes a provider network with differential payment or coverage associated with use of an in-network provider.

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, including dental benefits, 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 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 physical, behavioral or mental health 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 the absence of immediate medical attention to result in one or more of the following:
  - (1) Serious jeopardy to the patient's physical, mental or behavioral health, including, with respect to a pregnant woman, the health of her unborn child;
  - (2) Serious impairment to a bodily function; or
  - (3) Serious dysfunction of any bodily organ or part.
- (e) "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 with respect to any "health coverage" as defined in RSA 420-G:2, IX and any network-based coverage for dental services.
- (f) "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.
- (g) "Network" means the group of participating providers contracted under a network plan.

- (h) "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.
- (i) "Open panel provider" means a participating provider who is accepting new patients.
- (j) "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.
- (k) "Point of service plan" means a multi-tiered network 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.
- (l) "Primary care provider" means a licensed physician who has 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, or an advanced registered nurse practitioner licensed by the New Hampshire board of nursing in the advanced practice categories of family practice, internal medicine or pediatrics, or a doctor of naturopathic medicine authorized and licensed to practice naturopathic medicine under RSA chapter 328-E.
- (m) "Select plan" means a network 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.
- (n) "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.

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 network plan shall maintain a network of primary care providers, dental providers, specialists, institutional providers, and other ancillary health care personnel that is sufficient in numbers and types 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 2701.13.
- (c) The basic access requirement in Ins 2701.04(a) shall be met in each county in which the health carrier is actively marketing a health benefit plan. For the purpose of this paragraph "active marketing" means advertising in publications published within the county or initiating contact

with a potential policyholder in person, by phone or by mail. The evaluation of network adequacy shall be based on the most recent United States 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 network tier of participating providers that is associated with the lowest level of cost sharing for the consumer shall be the network that is considered in determining compliance with the geographic accessibility standards in Ins 2701.06.
- (e) In any county 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 2701.08, 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.
- (f) A health carrier shall not actively solicit new policyholders in any county 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 2701.08.
- (g) Nothing in (f) above shall be construed to prohibit a health carrier from:
  - (1) Advertising in publications distributed within the county which are published outside of the county;
  - (2) Responding to inquiries initiated by a potential policyholder; or
  - (3) Issuing or renewing coverage as required by federal or state law, including RSA chapter 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 2701.13.

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

#### Ins 2701.05 Reasonable Access to Health Care Services.

- (a) To constitute reasonable access to health care services, a provider network must supply access to the services listed in Ins 2701.07, which are typical of covered health care services in a health benefit plan and are categorized as Core, Common, Specialized or Highly Specialized services, in a manner consistent with the geographic accessibility standards for services in each category set forth in Ins 2701.06.
- (b) To be deemed adequate for each of the listed services, the network shall include, within the applicable geographic area, a sufficient number of licensed providers for which the service in question is within their scope of practice. In addition to physicians, providers may include 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.

- (c) To be deemed adequate, the network shall also include all providers whose services are integral to providing a Core, Common, Specialized, or Highly Specialized service, even if the integral service is not performed in every circumstance. A carrier shall not be required to demonstrate that a provider of integral services is permanently located within the specified time and distance standards, but the carrier will be required to verify and provide an attestation that in-network providers of the integrated service will provide the service without requiring additional travel by the member, and within a timeframe that complies with an acceptable standard of care.
- (d) For Common services only, a carrier may choose to meet the access requirements either by demonstrating access to the services listed as Common in Ins 2701.07, or by maintaining a network that includes a sufficient number of licensed medical specialists in all of the following key specialty areas:
  - (1) Allergists;
  - (2) Cardiologists;
  - (3) General surgeons;
  - (4) Neurologists;
  - (5) Obstetrician/gynecologists;
  - (6) Oncologists;
  - (7) Ophthalmologists;
  - (8) Orthopedists;
  - (9) Otolaryngologists;
  - (10) Primary care providers;
  - (11) Psychiatrists;
  - (12) Urologists;
  - (13) Plastic surgeons; and
  - (14) Thoracic surgeons.
- (e) To the extent that Specialized and Highly Specialized Services are available within New Hampshire, a carrier shall not exclude New Hampshire providers from its network if the negotiated rates are commercially reasonable.
- (f) 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.
- (g) Carriers must satisfy any Affordable Care Act federal requirements for access to essential community providers, as directed under 45 CFR 156.235, for all for all policies subject to this Part.

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 population under the age of 65 within the time and distance standards.
- (b) Geographic access standards 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. Time and distance standards are as follows:
  - (1) 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 hour driving time
    - d. Highly Specialized = 160 miles or two and a half hours driving time.
  - (2) Micro (Grafton, Carroll, and Sullivan counties):
    - e. Core = 20 miles or 40 minutes driving time
    - f. Common = 40 miles or 80 minutes driving time
    - g. Specialized = 70 miles or two hours driving time
    - h. Highly Specialized = 180 miles or three and a half hours driving time.
  - (3) Rural (Coos County):
    - i. Core = 30 miles or one hour driving time
    - j. Common = 80 miles or two hours driving time
    - k. Specialized = 200 miles or three and a half hours driving time
    - l. Highly Specialized = 400 miles or six hours driving time.

Ins 2701.07 Classification of Services as Core, Common, Specialized, and Highly Specialized.

- (a) The following services shall be classified as Core services for purposes of network adequacy review:
  - (1) Ambulance, non-emergency transport
  - (2) Chiropractic
  - (3) Clinical and non-clinical recovery support services for substance abuse disorder
  - (4) Contraceptive services
  - (5) Dental diagnostic services
  - (6) Dental preventive services
  - (7) Dental restorative services
  - (8) Diagnostic physical therapy evaluation
  - (9) Home health care
  - (10) Individual and group counseling for mental health
  - (11) Individual and group counseling for substance use disorders
  - (12) Outpatient and intensive outpatient services for substance use disorder
  - (13) Patient education and self-management support
  - (14) Pediatric oral health services, including routine care
  - (15) Physical therapy procedures not requiring specialized equipment
  - (16) Preventive and routine acute care, adult
  - (17) Preventive and routine acute care, pediatric
  - (18) Routine EKG
  - (19) Routine immunizations and injections, adult
  - (20) Routine immunizations and injections, pediatric
  - (21) Routine pre-natal care
  - (22) Routine lab tests and venipuncture

- (23) Screening and assessment services for mental health
  - (24) Screening and assessment services for substance abuse disorders
  - (25) Suture of non-life threatening wound
  - (26) Urgent care services
- (b) The following services shall be classified as Common Services for purposes of network adequacy review:
- (1) Amputation of toe
  - (2) Apply splint
  - (3) Asthma and bronchial care
  - (4) Biopsy (procedure to obtain tissue)
  - (5) Biopsy of skin lesions
  - (6) Bone biopsy (procedure to obtain tissue)
  - (7) Bone marrow aspiration
  - (8) Cardiac monitoring and stress testing
  - (9) Cardioversion
  - (10) Central venous access device insertion and removal
  - (11) Chemotherapy
  - (12) Cystoscopy
  - (13) Delivery of newborn
  - (14) Dental endodontics
  - (15) Dental periodontics
  - (16) Dental prosthodontics (removable)
  - (17) Dental maxillofacial prosthetics
  - (18) Dental implant services
  - (19) Dental oral and maxillofacial surgery
  - (20) Dental orthodontics
  - (21) Dental adjunctive general services
  - (22) Destruction of benign or premalignant lesion
  - (23) Developmental, hearing and vision testing, pediatric
  - (24) Diagnosis and therapy for rheumatic disease
  - (25) Drainage of skin abscess
  - (26) Durable Medical Equipment (DME)
  - (27) Ear, nose, and throat procedures
  - (28) Electroencephalogram (EEG) testing
  - (29) Eye procedures
  - (30) Gastrointestinal endoscopy with biopsy
  - (31) General surgery
  - (32) Hernia repair
  - (33) Immunotherapy
  - (34) Incision and drainage, deep abscess
  - (35) Injection, aspiration, arthrocentesis of a joint
  - (36) Inpatient residential treatment for substance abuse disorder
  - (37) Insertion of chest tube
  - (38) Laparoscopic surgery
  - (39) Medical eye exam
  - (40) Muscle tests
  - (41) Non-routine venipuncture
  - (42) Occupational therapy

- (43) Osteopathic manipulation
- (44) Paring or cutting benign lesion
- (45) Physical therapy or other rehabilitation or habilitation treatment, requiring specialized equipment
- (46) Psychiatric diagnostic evaluation with medical services
- (47) Radiation therapy
- (48) Renal dialysis
- (49) Routine endoscopy
- (50) Routine overnight care for medical conditions
- (51) Routine overnight care for mental health conditions
- (52) Routine overnight care for surgical conditions
- (53) Short term inpatient stabilization and detoxification for substance use disorder
- (54) Skin replacement surgery (grafts)
- (55) Speech therapy
- (56) Spinal injection and nerve block
- (57) Standard imaging
- (58) Thoracentesis
- (59) Treatment for endocrinological disorders
- (60) Treatment of bone and joint disorders
- (61) Trim or debride nails
- (62) Vision care
- (63) Wound closure
- (64) Wound debridement

(c) The following services shall be classified as Specialized Services for purposes of network adequacy review:

- (1) Advanced imaging: computed tomography (CT) and computed axial tomography (CAT)
- (2) Allergy testing
- (3) Complex endoscopy
- (4) Complex overnight care for medical conditions
- (5) Complex overnight care for mental health conditions
- (6) Complex overnight care for substance use disorder treatment
- (7) Complex overnight care for surgical conditions
- (8) High risk delivery of newborn
- (9) Magnetic resonance imaging tomography
- (10) Neurological testing
- (11) Non-routine conditions of pregnancy
- (12) Uncomplicated major procedures

(d) The following services shall be classified as Highly Specialized Services for purposes of network adequacy review:

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

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

#### Ins 2701.08 Exceptions

- (a) The Department may grant a carrier an exception to the standards for geographic accessibility in Ins 2701.06 where:
- (1) A health carrier can establish that an insufficient number of qualified providers or facilities are available in the county 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 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 that is sufficient in number and type of providers to meet all of the standards in Ins 2701.06, 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.
- (b) The Department may grant a carrier an exception excluding one of more of the services listed in Ins 2701.07 from the network adequacy analysis, where a health carrier can establish that the service in question is not a covered service for the health benefit plan to which the network applies, and that exclusion of the service is appropriate for that coverage.

#### Ins 2701.09 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.
- (b) For behavioral health services, the carrier shall ensure that covered persons may obtain an initial appointment with an in-network provider within:
- (1) Six hours for a non-life-threatening emergency;
  - (2) Forty-eight hours for urgent care; and
  - (3) Ten calendar days for an initial (evaluation) visit.
- (c) For other services, the carrier shall ensure that covered persons may obtain an initial appointment with an in-network provider within:
- (1) One day for urgent care; and
  - (2) Thirty days for other routine care, including an initial (evaluation) visit.
- (d) For substance use disorder services for which prior authorization requirements are governed by RSA 420-J:17, health carriers shall comply with the requirements of that section.
- (e) For services not governed by RSA 420-J:17, health carriers shall ensure that all covered persons have access to a utilization reviewer to make prior approval or pre-authorization decisions.]

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 2701.10 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 2701.11 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, and submit a listing of participating providers using a template provided by the commissioner. 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 performed a network adequacy analysis and meets the requirements of these rules. If the network adequacy analysis performed 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) The network adequacy report prepared by the health carrier shall use a template provided by the commissioner which shall describe and contain the following:
  - (1) A description of the network associated with each health benefit plan offered by the carrier, including a list of the network providers by county, as follows:
    - a. For each plan, required information shall include:
      - 1. Plan ID
      - 2. Network name
    - b. For each provider, required information shall include:
      - 1. Provider name
      - 2. Carrier specific provider identifier number
      - 3. NPI number

4. Specialty
  5. Counties (s) where they provide services, and
  6. Any services or locations in which the provider contract excludes services that are typically a covered benefit;
  7. Indication of what services are provided through telemedicine/telehealth.
- c. For each network, required information shall include:
1. Network name
  2. Network ID, and
  3. Network URL.
- (2) The health carrier's procedures for making referrals within and outside its network;
- (3) 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;
- (4) 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.
- (5) The health carrier's system for ensuring the coordination of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services, behavioral health services and other community resources, and for ensuring appropriate discharge planning;
- (6) The health carrier's process for enabling covered persons to change primary care providers; and
- (7) 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.
- (8) 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.
- (c) If the identical provider network is associated with more than one health benefit plan, a single network adequacy report shall be prepared for that network, 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.
- (d) In addition to the annual health care certification of compliance report reporting requirement, a carrier shall notify the commissioner in writing, including a certification of continued

compliance with these rule or a plan for coming into compliance, within 10 days of any of the following events:

1. The net loss of 10% or more of its Core providers in any county within any 30-day period;
  2. Loss of one or more network hospitals; or
  3. The carrier no longer meeting any network adequacy standards with respect to any county.
- (e) For coverage in the individual and small group markets, the annual health care certification of compliance report shall be filed with the commissioner annually on April 15, and shall reflect contracts in place as of April 1. For as long as members are receiving coverage under an approved product, carriers shall submit quarterly an updated list of network providers as described under (b)(1) above.
- (f) For coverage in the large group market, the annual health care certification of compliance report shall be filed with the commissioner annually on July 1, and shall reflect contracts in place as of June 15. For as long as members are receiving coverage under an approved product, carriers shall submit quarterly an updated list of network providers as described under (b)(1) above.
- (g) Carriers introducing new products with new networks shall submit the certificate of compliance report in conjunction with the rate and form filing, reflecting the expected network as of the product's effective date.

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

Ins 2701.12          Provider Directories

- (a) 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 Subsection C.
- (1) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.
  - (2) The health carrier shall update each network plan provider directory at least monthly.
  - (3) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.
  - (4) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.
  - (5) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:
    - a. In plain language, a description of the criteria the carrier has used to build its provider network;
    - b. If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

- c. If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and
  - d. If applicable, note that authorization or referral may be required to access some providers.
- (6) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.
- (7) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.
- (8) For the pieces of information required pursuant to Part Ins 2701.12 (b), (c), and (d) in a provider directory 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, if applicable.
- (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.
- (b) The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:
- (1) For health care professionals:
    - a. Name;
    - b. Gender;
    - c. Participating office location(s);
    - d. Specialty, if applicable;
    - e. Medical group affiliations, if applicable;
    - f. Facility affiliations, if applicable;
    - g. Participating facility affiliations, if applicable;
    - h. Languages spoken other than English, if applicable; and
    - i. Whether accepting new patients.

- (2) For hospitals:
    - a. Hospital name;
    - b. Hospital type (i.e. acute, rehabilitation, children's, cancer);
    - c. Participating hospital location; and
    - d. Hospital accreditation status; and
  - (3) For facilities, other than hospitals, by type:
    - a. Facility name;
    - b. Facility type;
    - c. Types of services performed; and
    - d. Participating facility location(s).
- (c) For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Part Ins 2701.12 (b):
- (1) For health care professionals:
    - a. Contact information;
    - b. Board certification(s); and
    - c. Languages spoken other than English by clinical staff, if applicable.
  - (2) For hospitals: Telephone number; and
  - (3) For facilities other than hospitals: Telephone number.
- (d) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:
- (1) For health care professionals:
    - a. Name;
    - b. Contact information;
    - c. Participating office location(s);
    - d. Specialty, if applicable;

- e. Languages spoken other than English, if applicable; and
- (2) For hospitals:
- a. Hospital name;
  - b. Hospital type (i.e. acute, rehabilitation, children's, cancer); and
  - c. Participating hospital location and telephone number; and
- (3) For facilities, other than hospitals, by type:
- a. Facility name;
  - b. Facility type;
  - c. Types of services performed; and
  - d. Participating facility location(s) and telephone number.
- (e) The health carrier shall include a disclosure in the directory that the information in Paragraph (1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain current provider directory information.

#### Ins 2701.13 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)