# ARKANSAS REGISTER

## Proposed Rule Cover Sheet

Secretary of State
John Thurston
500 Woodlane Street, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

Name of Department Arkansas Department of Commerce

Agency or Division Name Arkansas Insurance Department

Other Subdivision or Department, If Applicable Compliance Division

Previous Agency Name, If Applicable

Contact Person Dan Honey

Contact E-mail dan.honey@arkansas.gov

Contact Phone 501-371-2807

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Name of Rule Proposed Amended Rule 106: "Network Adequacy Requirements for Health Benefit Plans"

Newspaper Name Arkansas Democrat Gazette

Date of Publishing July 25, July 26 July 27

Final Date for Public Comment August 27

Location and Time of Public Meeting August 26, 2021 10:00 AM,Second Floor Diamond Mine Room, Arkansas Department of Commerce Building, One Commerce Way, Little Rock, Arkansas

Michael Preston
SECRETARY OF COMMERCE

Alan McClain
COMMISSIONER,
ARKANSAS INSURANCE
DEPARTMENT

July 26, 2021

Arkansas Secretary of State
State Capitol Building
Little Rock, AR 72201
Attn. Arkansas Register

Re: Proposed Amended Rule 106: "Network Adequacy Requirements for Health Benefit Plans"

Dear Secretary:

Arkansas Act 1478 of 2003 adds to requirements for adoption and re-adoption of public agency rules and regulations. In that regard, the new Act:

(a) Requires notice of Proposed Amended Rule 106: "Network Adequacy Requirements for Health Benefit Plans", as well as the Public Rule Hearing at the Arkansas Insurance Department, to be published by the Arkansas Secretary Of State on the Internet for thirty (30) days pursuant to Ark. Code Ann. § 25-15-218 of the Arkansas Administrative Procedure Act, as amended; and

(b) Requires DOI filing of its adopted and proposed rules and notices with the Arkansas Secretary Of State in an electronic format acceptable to the Secretary.

In that regard, the Department has scheduled a public hearing as to Proposed Amended Rule 106: "Network Adequacy Requirements for Health Benefit Plans." Enclosed are the DOI Notices of Public Hearing and a copy of the proposed amended rule.

Please arrange to publish the information in a format acceptable to the Secretary for at least 30 days in advance. Can you send us confirmation that we can use in the transcript as a public hearing exhibit?

An electronic filing will be made within the statutorily required 7 days. Thanks for your help.

Sincerely,

Clara Mezza

Clara Mezza
Legal Administrative Coordinator/Legal Division
clara.mezza@arkansas.gov
501-683-3497

Enclosures

# PROPOSED AMENDED RULE 106
# NETWORK ADEQUACY REQUIREMENTS
# FOR HEALTH BENEFIT PLANS

**Table of Contents**



## Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a).

## Section 2. Purpose

The purpose of this Rule is to establish minimum standards for the creation and maintenance of networks by Health Carriers and to assure the adequacy, accessibility and quality of Health Care Services offered under Health Benefit Plans.

## Section 3. Definitions

For purposes of this Rule:

A. "Accredited Health Carrier" means a Health Carrier which has an adequate network as certified by an approved accrediting organization under the provisions of Section five (5)(K) of this Rule.

B. "Commissioner" means the Arkansas Insurance Commissioner.

C. "Covered Benefits" or "benefits" means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.

D. "Covered Person" means a policyholder, subscriber, enrollee or other individual participating in a Health Benefit Plan.

E. "Dental Benefits" means benefits for dental services embedded in, or offered by a rider attached to, (i) a QHP offered through the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

F. "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 or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

G. "Emergency Services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

H. "Essential Community Provider" means a provider that serves predominantly low income, medically underserved individuals as defined in 45 C.F.R. §156.235.

I. "Facility" means an institution providing Health Care Services or a health are setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

J. "Health Benefit Plan" means any individual, blanket, or group plan, policy or contract for Health Care Services issued or renewed by a Health Carrier on or after January 1, 2015 which requires a Covered Person to use Health Care Providers managed, owned, under contract with or employed by the Health Carrier. "Health Benefit Plan" does not include a plan providing Health Care Services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy. The provisions of this Rule also do not apply to Medicare Supplement or Medicare Advantage policies. This Rule applies to Dental Benefits as defined in Section (3)(E) and Vision Benefits as defined in Section three (3)(Y), as well as plans offered by Stand-alone Dental Carriers as defined in Section three (3)(V) of this rule.

K. "Health Care Professional" means a physician or other Health Care practitioner licensed, accredited or certified to perform physical, behavioral, mental health or substance use disorder and health services consistent with state law.

L. "Health Care Provider" or "provider" means a participating Health Care or dental professional or a facility.

M. "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

N. "Health Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of Health Care Services, including a health insurer, a health maintenance organization , a hospital and medical services corporation, or any other entity providing Health Benefit Plan A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self-insured employer Health Benefits Plan. A Health Carrier does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State providing medical or hospital benefits for accidental injury or accidental disability. A Health Carrier shall include an entity that provides Dental and/or Vision Benefits as defined in Section three (3)(E) and Section three (3)(Y) of this rule, respectively, or is ta Stand-alone Dental Carrier as defined by Section three (3)(V) of this Rule.

O. "Network" means the collection of all participating providers providing services to a Health Benefit Plan. The network associated with a health benefit plan should be identifiable using a suitable network ID, and one Health Benefit Plan can have only one such network ID.

P. "Provider" means a provider who, under a contract with a 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.

Q. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other Providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care.

R. "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.

S. "Primary Care Professional" means a participating Health Care Professional practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person.

T. "Qualified Health Plan" means an insurance policy that meets the requirements of 42 U.S.C. §18021(a)(1).

U. "Specialty Care Professional" means a participating Health Care Professional that is specialty qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive practice in the specialty.

V. "Stand-alone Dental Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which (i) offers plans through ACA approved Marketplace and/or (ii) offers plans outside the ACA Marketplace for the purpose of providing the essential health benefits category of pediatric level oral benefits.

W. "Service Area" means the collection of counties serviced by a Health Benefit Plan. Counties may be grouped into larger aggregations called Health Rating Areas and a Health Benefit Plan is required to cover at least one Health Rating Area. The aggregation of counties is published in the annual bulletin setting forth requirements for ACA submissions.

X. "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient, as well as store-and-forward technology and remote patient monitoring.

Y. "Vision Benefits" means benefits for vision services embedded in, or offered by a rider attached to, a QHP offered through (i) the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

**Section 4. Applicability and Scope**

This Rule applies to all Health Carriers that offer Health Benefit Plans in this State which are issued or renewed on or after January 1, 2015.

**Section 5. Network Adequacy Minimum Standards**

A. A Health Carrier providing a Health Benefit Plan shall maintain a network that is sufficient in numbers and types of providers to assure that all Health Care Services to Covered Persons will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the Health Carrier and approved by the Commissioner, including but not limited to: provider to Covered Person ratios by specialty; Primary Care Professional to Covered Person ratios; typical referral patterns; provider's hospital admitting privileges; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.

B. Every Health Carrier shall strive to meet the following guidelines related to geographic accessibility through geographical data or other information in format and with content specified by the Department set forth in Section Five (5)(F) below, for the plan year:

**(1)** In the case of Emergency Services, a Covered Person will have access to Emergency Services, twenty-four (24) hours per day, seven (7) days per week within a thirty (30) mile radius between the location of the Emergency Services and the residence of the Covered Person;

**(2)** In the case of a Primary Care Professional, a Covered Person will have access to covered Primary Care Professional within a thirty (30) mile radius between the location of the Primary Care Professional and the residence of the Covered Person;

**(3)** In the case of a Specialty Care Professional, a Covered Person will have access to at least one Specialty Care Services within a sixty (60) mile radius between the location of the Specialty Care Professional and the residence of the Covered Person; and

**(4)** For Qualified Health Plans participating in the ACA approved Marketplace, in the case of Essential Community Providers, a Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person.

**(5)** The Health Carrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.

C. In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the covered person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from participating providers.

D. In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of Health Care Providers in the service area under consideration.

E. A Health Carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to Covered Persons. A Health Carrier shall reasonably monitor:

**(1)** provider to Covered Person ratios by specialty;

**(2)** Primary Care Professional to Covered Person ratios;

**(3)** typical referral patterns;

**(4)** provider's hospital admitting privileges;

**(5)** geographic accessibility;

**(6)** waiting times for appointments with participating providers;

**(7)** general hours of operation, including part or full time status and weekend and after hour availability; and

**(8)** the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.

F. Geographical data must be submitted for each of the categories of care referenced in Section Five (5)(B)(1-4). Data specifications will be published by the Insurance Department and available online as (SERFF) Network Adequacy Data Submission Instructions updated for each plan year as necessary and appropriate. A Health Carrier shall strive to meet a compliance percentage of eighty percent (80%) for each of the categories of care referenced to Section Five (5)(B)(1-4). Provider data must indicate which providers are accepting new patients. The following are special requirements for each category of care:

**(1)** Health Carriers must provide geographical data for Primary Care professionals that include each general/family practitioner, internal medicine provider, and pediatrician.

**(2)** Health Carriers must provide geographical access maps for hospitals and Specialty Care Professionals according to the following categories:

- **(a)** hospitals by Arkansas hospital licensure type;
- **(b)** home health agencies;
- **(c)** skilled nursing Facilities
- **(d)** all specialty care categories and sub-specialty categories covered under the Health Benefit Plan;

**(3)** Health Carriers must provide geographical data for mental health, behavioral health, and substance use providers categorized between:

- **(a)** psychiatric and state licensed clinical psychologists;
- **(b)** substance use disorder providers; and
- **(c)** other mental health, behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category.

**(4)** Health Carriers seeking certification through the ACA approved Marketplace must provide geographical data for Essential Community Providers with the providers grouped as set forth in the ACA and pursuant to CMS guidelines

G. Performance Metrics: Non-accredited Health Carriers will be required to submit metrics demonstrating performance for each of the above standards for each county in the service area and overall service area. Accredited Health Carriers will be required to submit the following metrics for reporting purposes. These include:

**(1)** The number of members and percentage of total members meeting the geographical requirements under Section Five (5)(B) of this Rule.

**(2)** The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. Health Carriers who do not yet have enrollees in the State of Arkansas must attest to not currently having enrollees in Arkansas and provide geographical access data calculated using suitable sampling of U.S. Census data.

H. Essential Community Providers. Health Carriers issuing Qualified Health Plans are required to meet all federal requirements for inclusion of Essential Community Providers in the plan network. Qualifying Essential Community Providers include providers described in section 340B of the PHS Act and Section 1927(c)(1)(D)(i)(IV) of the Social Security Act. In addition, the following State guidelines must be met regarding Essential Community Providers:

**(1)** Each Health Carrier issuing Qualified Health Plans will be required to meet conditions of the Heath Care Independence Program 1115 Waiver and offer at least one Qualified health Plan that has at least one federally qualified health center or rural health center in each service area of the plan network.

**(2)** Each Health Carrier issuing Qualified Health Plans must submit a list of school-based providers included in the plan network.

**(3)** Each Health Carrier issuing Qualified Health Plans must offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

I. Access plans. A Health Carrier shall file with the Commissioner an access plan meeting the requirements of Section Five (5)(I)(1)-(12) of this Rule for Health Benefit Plans issued or renewed in this State on or after January 1, 2015. The Health Carrier shall make the access plans, absent proprietary information, available to its insured The Health Carrier shall prepare an access plan prior to offering a new Health Benefit Plan, and shall update an existing access plan whenever it makes any material change to an existing Health Benefit Plan such as the loss of a material provider such as a hospital or multi-specialty clinic. The access plan shall describe or contain at least the following:

**(1)** The Health Carrier's network;

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

**(3)** The Health Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

**(4)** The Health Carrier's efforts to address the needs of Covered Persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

**(5)** The Health Carrier's methods for assessing the health care needs of Covered Persons;

**(6)** The Health Carrier's method of informing Covered Persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

**(7)** The Health Carrier's method for assessing consumer satisfaction;

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

**(9)** The Health Carrier's system for ensuring the coordination and continuity of care for Covered Persons referred to specialty providers, for Covered Persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

**(10)** The Health Carrier's process for enabling Covered Persons to change primary care professionals;

**(11)** The Health Carrier's proposed plan for providing continuity of care in the event of contract termination between the Health Carrier and any of its participating providers, or in the event of the Health Carrier's insolvency or other inability to continue operations. The description shall explain how Covered Persons will be notified of the

contract termination, or the Health Carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

**(12)** Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

J. Provider Directories. A Health Carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Health Carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

**(1)** Health Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

**(2)** If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Health Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

**(3)** Online provider directories must be available in Spanish.

**(4)** The directory search must include the ability to filter by each category of ECP.

**(5)** The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

**(6)** Providers who participate in the Patient-Centered Medical Home program must be indicated in the provider directory.

K. If a Health Carrier has accreditation that includes an audit of the Health Carrier's network adequacy, the Commissioner will accept that accreditation in lieu of the Health Carrier demonstrating it has complied with the requirements under Section Five (5)(A) through (H) of this Rule, if the following conditions are met:

**(1)** A certificate of accreditation must be submitted by the certified accrediting entity that is recognized pursuant to 45

C.F.R. § 156.275, or any other certified entity as recognized by the Arkansas Insurance Department;

**(2)** The certified accrediting entity has submitted information showing that its audit includes a review of all reasonable and/or necessary requirements of state and federal law; and

**(3)** The Health Carrier agrees to provide to the Arkansas Insurance Department any and all material and information submitted to the certified accrediting entity upon the Commissioner's request.

**(4)** The accredited Health Carrier has submitted annual geographical data and performance metrics as required in Section Five (5) of this Rule for reporting purposes only.

**(5)** The Commissioner reserves the right to reverify compliance of network adequacy as a part of any quarterly audit or request for certification of a Qualified Health Plan.

L. The Commissioner will also accept an accreditation of a Health Carrier's access plan by a certified accrediting entity that a Health Carrier has an access plan meeting the requirements of Section Five (5) (I)(1)-(12) of this Rule although such plan must be filed with the Commissioner.

M. All Time and distance guidelines as set forth in this Rule are minimum standards only. The Commissioner, pursuant to his or her discretion, may publish more detailed and specific network adequacy time/distance standards, as well as guidelines regarding the use of telemedicine to meet network adequacy standards, via SERFF Network Adequacy Data Submission Instructions, and/or annual bulletin for setting forth certification requirements for ACA submissions.

## Section 6. Stand-alone Dental Plans

A. For Stand-alone dental plans offered through the ACA approved Marketplace or where a Stand-alone dental plan is offered outside of the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such Stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions. Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization. Networks shall strive to meet the following guidelines through geographical data or other information in format and with content specified by the Department, set forth in Section Five (5)(F), above, for the plan year:

**(1)** In the case of a non-specialist oral care provider, a Covered Person will have access to at least one (1) dentist within a thirty (30) mile radius between the location of the dentist and the residence of the Covered Person;

**(2)** In the case of a Specialist Oral Care provider, a Covered Person will have access to at least one specialist dentist within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the Covered Person; and

**(3)** If an Essential Community Provider that provides oral health services is located within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of a covered person, a Stand-alone Dental Carrier must make reasonably best efforts to provide the covered person access to that Essential Community Provider.

**(4)** For purposes of satisfying the requirements of Section Six (6)(A)(1)-(3) of this Rule, a Stand-alone Dental Carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section Five (5)(K) of this Rule.

**(5)** The Health Carrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.

B. Stand-alone Dental Carriers applying to the Commissioner to participate in the ACA approved Marketplace or offer a Stand-alone dental plan outside the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits are required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general dentist will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. These include:

**(1)** The number of members and percentage of total members meeting the geographical requirements under Section Six (6)(A) of this Rule.

(2) The average distance to first, second, and third closest provider for each provider type.

(3) Stand-alone Dental Carriers who do not yet have enrollees in the State of Arkansas must attest to not currently having enrollees in Arkansas and provide geographical access data calculated suitable sampling of U.S. Census data.

C. In the event that a Stand-alone Dental Carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health Carrier shall ensure that the Covered Person obtains the covered benefit at no greater cost to the Covered Person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

(1) provider to Covered Person ratios by dental specialty;

(2) general dentist to covered person ratios;

(3) typical referral patterns;

(4) geographic accessibility;

(5) waiting times for appointments with participating providers;

(6) general hours of operation, including part or full time status and weekend and after hour availability; and

D. In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

E. A Stand-alone Dental Carrier shall monitor, on an ongoing basis, the ability of its Participating providers to furnish all contracted benefits to Covered Persons.

F. Access plans. A Stand-alone Dental Carrier shall file with the Commissioner an access plan meeting the requirements of Section Six (6)(F)(1)-(12) of this Rule for Stand-alone dental plans issued or renewed in this State on or after January 1, 2015. The Stand-alone Dental Carrier shall make the access plans, absent proprietary information, available to its insureds. The Stand-alone Dental Carrier shall prepare an access plan prior to offering a new Stand-alone dental plan, and shall update an existing access plan whenever it makes any material change to an existing Stand-alone dental plan such as the loss of a material provider. The access plan shall describe or contain at least the following:

**(1)** The Stand-alone Dental Carrier's network;

**(2)** The Stand-alone Dental Carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

**(3)** The Stand-alone Dental Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its Health Benefit Plans;

**(4)** The Stand-alone Dental Carrier's efforts to address the needs of Covered Persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

**(5)** The Stand-alone Dental Carrier's methods for assessing the health care needs of Covered Persons;

**(6)** The Stand-alone Dental Carrier's method of informing Covered Persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

**(7)** The Stand-alone Dental Carrier's method for assessing consumer satisfaction;

**(8)** The Stand-alone Dental Carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

**(9)** The Stand-alone Dental Carrier's system for ensuring the coordination and continuity of care for Covered Persons referred to specialty providers, for Covered Persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

**(10)** The Stand-alone Dental Carrier's process for enabling covered persons to change non-specialist dental providers;

**(11)** The Stand-alone Dental Carrier's proposed plan for providing continuity of care in the event of contract

termination between the Health Carrier and any of its participating providers, or in the event of the Health Carrier's insolvency or other inability to continue operations. The description shall explain how Covered Persons will be notified of the contract termination, or the Health Carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

**(12)** Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

G. Provider Directories. A Stand-alone Dental Carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Stand-alone Dental Carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

**(1)** Stand-alone Dental Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

**(2)** If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Stand-alone Dental Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

**(3)** Online provider directories must be available in Spanish.

**(4)** The directory search must include the ability to filter by ECP.

**(5)** The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

**Section 7. Provider Type NPI Pool Data Maintenance**

A. A list of provider types developed by the Department and the Arkansas Department of Health will be monitored for network adequacy. The provider-types are defined in terms of National Uniform Claim Committee (NUCC) taxonomy codes. The provider-type list will be reviewed annually for:

**(1)** Sufficiency. This could be to add provider-types deemed necessary for coverage of health care services most appropriate for Arkansans or to remove provider-types that are no longer appropriate.

**(2)** Definitions. This is to ensure that the taxonomies associated with the provider-type conveys the intended scope of the provider-type. The taxonomy association with a provider-type definition communicates the actual practice of the provider rather than their academic qualification. For example, a provider qualified as an internal medicine physician cannot be considered a Primary Care Provider if the provider works only in emergency rooms or is only associated with a pain management clinic.

B. The Department will facilitate a system of on-going industry data maintenance of NPI association(s) with various provider types defined in Section 7(A). This association will be based on the provider's actual practice. This will be done to facilitate a common and uniform understanding of each provider's provider type(s) classification. This NPI association data with provider-types will be referred to as Provider-Type-NPI-Pool (PTNP) data. The process and timelines in the PTNP data maintenance effort will be outlined by the Department on an annual basis through online documentation. This process will involve two stages of data submission by the carriers. The first stage will involve carriers suggesting changes to the PTNP data followed by the second stage when the carriers will vote on the suggestions consolidated from the first stage. The Department will facilitate oversight of the process and may classify a NPI lacking unanimous agreement among carriers.

C. Participation exemptions. A carrier with fewer than five thousand (5,000) covered individuals as of December 31 of the previous calendar year will not be required to participate in the PTNP data maintenance process. For purposes of determining whether a carrier is subject to the participation requirements of PTNP data maintenance the carrier must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners. Carriers that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the five thousand (5,000) covered individual threshold.

D. If a carrier does not believe it meets the definition of a submitting entity herein or does not believe it meets the 5,000 covered individuals' threshold, that entity may dispute the Commissioner's decision in accordance with the Arkansas Administrative Procedure Act.

**Section 8. Submission Timeline for Network Adequacy Review**

Health Carriers will submit data for network adequacy review according to the timeline contained in the annual certification requirements bulletin.

**Section 9. Enforcement**

The penalties, license actions or orders as authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule.

**Section 10. Effective Date**

The effective date of this Rule is January 1, 2022.

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ALAN MCCLAIN
INSURANCE COMMISSIONER

_____

DATE

MARK-UP

# PROPOSED AMENDED RULE 106
# NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS

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## Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a).

## Section 2. Purpose

The purpose of this Rule is to establish minimum standards for the creation and maintenance of networks by Health Carriers and to assure the adequacy, accessibility and quality of Health Care Services offered under Health Benefit Plans.

## Section 3. Definitions

For purposes of this Rule:

A. "Accredited Health Carrier" means a Health Carrier which has an adequate network as certified by an approved accrediting organization under the provisions of Section five (5)-(K) of this Rule.

B. "Commissioner" means the Arkansas Insurance Commissioner.

C. "Covered Benefits" or "benefits" means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.

D. "Covered Person" means a policyholder, subscriber, enrollee or other individual participating in a Health Benefit Plan.

E. "Dental Benefits" means benefits for dental services embedded in, or offered by a rider attached to, (i) a QHP offered through the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

F. "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 or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

G

~~F~~. "Emergency Services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

H~~G~~. "Essential Community Provider" means a provider that serves predominantly low income, medically underserved individuals as defined in 45 C.F.R. §156.235.

~~H~~I. "Facility" means an institution providing Health Care Services or a health are setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

J~~I~~. "Health Benefit Plan" means any individual, blanket, or group plan, policy or contract for Health Care Services issued or renewed by a

Health Carrier on or after January 1, 2015 which requires a Covered Person to use Health Care Providers managed, owned, under contract with or employed by the Health Carrier. "Health Benefit Plan" does not include a plan providing Health Care Services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy. The provisions of this Rule also do not apply to Medicare Supplement or Medicare Advantage policies. This Rule applies to Dental Benefits as defined in Section (3)(E) and Vision Benefits as defined in Section three (3)(Y), as well as plans offered by Stand-alone Dental Carriers as defined in Section three (3)(V) of this rule. ~~This Rule does not apply to vision or dental only plans unless such plans are offered by Stand-alone Dental Carriers as defined in Section three (3) (U) of this Rule.~~

~~J~~K. "Health Care Professional" means a physician or other Health Care practitioner licensed, accredited or certified to perform physical, behavioral, mental health or substance use disorder and health services consistent with state law.

~~K~~L. "Health Care Provider" or "provider" means a participating Health Care or dental professional or a facility.

~~L~~M. "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

~~M~~N. "Health Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of Health Care Services, including a health insurer, a health maintenance organization , a hospital and medical services corporation, or any other entity providing Health Benefit Plan A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self-insured employer Health Benefits Plan. A Health Carrier does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State providing medical or hospital benefits for accidental injury or accidental disability. A Health Carrier shall include an entity that provides Dental and/or Vision Benefits as defined in Section three (3)(E) and Section three (3)(Y) of this rule, respectively, or is ~~not include a vision or dental insurer unless it is~~ a

Stand-alone Dental Carrier as defined by Section three (3)-(VU) of this Rule.

O.N. "Network" means the collectiongroup of all participating providers providing services to a Health Benefit Plan. The network associated with a health benefit plan should be identifiable using a suitable network ID, and one Health Benefit Plan can have only one such network ID.

OP. "Provider" means a provider who, under a contract with a 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.

PQ. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other Providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care.

RQ. "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.

RS. "Primary Care Professional" means a participating Health Care Professional practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing care to a covered person.

T.

S. "Qualified Health Plan" means an insurance policy that meets the requirements of 42 U.S.C. §18021(a)(1).

TU. "Specialty Care Professional" means a participating Health Care Professional that is specialty qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive practice in the specialty.

V.~~U.~~ "Stand-alone Dental Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which (i) offers plans through ACA approved Marketplace and/or (ii) offers plans outside the ACA Marketplace for the purpose of providing the essential health benefits category of pediatric level oral benefits.

W. "Service Area" means the collection of counties serviced by a Health Benefit Plan. Counties may be grouped into larger aggregations called Health Rating Areas and a Health Benefit Plan is required to cover at least one Health Rating Area. The aggregation of counties is published in the annual bulletin setting forth requirements for ACA submissions.

X. "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient, as well as store-and-forward technology and remote patient monitoring.

Y. "Vision Benefits" means benefits for vision services embedded in, or offered by a rider attached to, a QHP offered through (i) the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

**Section 4. Applicability and Scope**

This Rule applies to all Health Carriers that offer Health Benefit Plans in this State which are issued or renewed on or after January 1, 2015.

**Section 5. Network Adequacy Minimum Standards**

~~A~~A. A Health Carrier providing a Health Benefit Plan shall maintain a network that is sufficient in numbers and types of providers to assure that all Health Care Services to Covered Persons will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the Health Carrier and approved by the Commissioner, including but not limited to: provider to Covered Person ratios by specialty; Primary Care Professional to Covered Person ratios; typical referral patterns; provider's hospital admitting privileges; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.

B. Every Health Carrier shall strive to meet the following guidelines related to geographic accessibility through geographical data ~~access maps~~ or other

information in format and with content specified by the Department set forth in Section Five (5)(F) below, for the plan year:

**(1)** In the case of Emergency Services, a Covered Person will have access to Emergency Services, twenty-four (24) hours per day, seven (7) days per week within a thirty (30) mile radius between the location of the Emergency Services and the residence of the Covered Person;

**(2)** In the case of a Primary Care Professional, a Covered Person will have access to covered Primary Care Professional within a thirty (30) mile radius between the location of the Primary Care Professional and the residence of the Covered Person;

**(3)** In the case of a Specialty Care Professional, a Covered Person will have access to at least one Specialty Care Services within a sixty (60) mile radius between the location of the Specialty Care Professional and the residence of the Covered Person; and

**(4)** For Qualified Health Plans participating in the ACA approved Marketplace, in the case of Essential Community Providers, a Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person.

**(5)** The Health C~~c~~arrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.

C. In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the covered person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from participating providers.

D. In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of Health Care Providers in the service area under consideration.

E. A Health Carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to Covered Persons. A Health Carrier shall reasonably monitor:

(1) ~~(1)~~ provider to Covered Person ratios by specialty;

(2) ~~(2)~~ Primary Care Professional to Covered Person ratios;

(3) ~~(3)~~ typical referral patterns;

(4) ~~(4)~~ provider's hospital admitting privileges;

(5) ~~(5)~~ geographic accessibility;

(6) ~~(6)~~ waiting times for appointments with participating providers;

(7) ~~(7)~~ general hours of operation, including part or full time status and weekend and after hour availability; and

**(8)** the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.

F. Geographical ~~access maps~~data ~~and compliance percentages~~ must be submitted for each of the categories of care referenced in Section Five (5)(B)(1-4). Data specifications will be published by the Insurance Department and available online as (SERFF) Network Adequacy Data Submission Instructions updated for each plan year as necessary and appropriate. A Health Carrier shall strive to meet a compliance percentage of eighty percent (80%) for each of the categories of care referenced to Section Five (5)(B)(1-4). Provider data ~~Requested maps may be submitted separately or combined and distinguished by color or other method. The maps~~ must indicate which providers are accepting new patients. The following are special requirements for each category of care:

(1) ~~(1)~~ Health Carriers must provide geographical ~~access maps~~data for Primary Care professionals that include each general/family practitioner, internal medicine provider, and ~~family practitioner/~~pediatrician.

(2) ~~(2)~~ Health Carriers must provide geographical access maps for hospitals and Specialty Care ~~Proffesionals~~Professionals according to the following categories:

**(a)** hospitals by Arkansas hospital licensure type;

**(b)** home health agencies;

**(c)** skilled nursing Facilities

**(d)** all specialty care categories and sub-~~speciality~~specialty categories covered under the Health Benefit P~~B~~lan;

**(3)** Health Carriers must provide geographical ~~access maps~~data for mental health, behavioral health, and substance use providers categorized between:

**(a)** psychiatric and state licensed clinical psychologists;

**(b)** substance use disorder providers; and

**(c)** other mental health, behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category.

**(4)** Health Carriers seeking certification through the ACA approved Marketplace must provide geographical ~~access maps~~data for Essential Community Providers with the providers grouped ~~within the following categories~~as set forth in the ACA and pursuant to CMS guidelines~~:~~

~~(a) federally qualified health centers;~~

~~(b) Ryan White provider;~~

~~(c) family planning provider;~~

~~(d) Indian provider;~~

~~(e) hospital; and~~

~~(f) other Essential community providers including but not limited to school based providers.~~

G. Performance Metrics: Non-accredited Health Carriers will be required to submit metrics demonstrating performance for each of the above

standards for each county in the service area and overall service area. Accredited Health Carriers will be required to submit the following metrics for reporting purposes. These include:

**(1)** The number of members and percentage of total members meeting the geographical requirements under Section Five (5)(B) of this Rule.

**(2)** The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as ~~well~~ as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. Health Carriers who do not yet have enrollees in the State of Arkansas ~~will be exempt from this requirement and~~ must attest to not currently having enrollees in Arkansas and provide geographical access data calculated using suitable sampling of U.S. Census data.~~.~~

H. ~~-~~Essential Community Providers. Health Carriers issuing Qualified Health Plans are required to meet all federal requirements for inclusion of Essential Community Providers in the plan network. Qualifying Essential Community Providers include providers described in section 340B of the PHS Act and Ssection 1927(c)(1)(D)(i)(IV) of the Social Security Act. In addition, the following State guidelines must be met regarding Essential Community Providers:

(1) ~~(1)~~ Each Health Carrier issuing Qualified Health Plans will be required to meet conditions of the Heath Care Independence Program 1115 Waiver and offer at least one Qualified health Plan that has at least one federally qualified health center or rural health center in each service area of the plan network.

**(2)** Each Health Carrier issuing Qualified Health Plans must submit a list of school-based providers included in the plan network.

**(3)** Each Health Carrier issuing Qualified Health Plans must offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

I. ~~I.~~ Access plans. A Health Carrier shall file with the Commissioner an access plan meeting the requirements of Section Five (5)(I)(1)-

(12) of this Rule for Health Benefit Plans issued or renewed in this State on or after January 1, 2015. The Health Carrier shall make the access plans, absent proprietary information, available to its insured The Health Carrier shall prepare an access plan prior to offering a new Health Benefit Plan, and shall update an existing access plan whenever it makes any material change to an existing Health Benefit Plan such as the loss of a material provider such as a hospital or multi-specialty clinic. The access plan shall describe or contain at least the following:

**(1)** The Health Carrier's network;

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

(3) ~~(3)~~ The Health Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

**(4)** The Health Carrier's efforts to address the needs of Covered Persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

**(5)** The Health Carrier's methods for assessing the health care needs of Covered Persons;

**(6)** The Health Carrier's method of informing Covered Persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

**(7)** The Health Carrier's method for assessing consumer satisfaction;

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

**(9)** The Health Carrier's system for ensuring the coordination and continuity of care for Covered Persons referred to specialty providers, for

Covered Persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

**(10)** The Health Carrier's process for enabling Covered Persons to change primary care professionals;

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

**(12)** Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

J. Provider Directories. A Health Carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Health Carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

(1) ~~(1)~~ Health Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(2) ~~(2)~~ If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Health Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

**(3)** Online provider directories must be available in Spanish.

**(4)** The directory search must include the ability to filter by each category of ECP.

(5) ~~(5)~~ The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

**(6)** Providers who participate in the Patient-Centered Medical Home program must be indicated in the provider directory.

K. If a Health Carrier has accreditation that includes an audit of the Health Carrier's network adequacy, the Commissioner will accept that accreditation in lieu of the Health Carrier demonstrating it has complied with the requirements under Section Five (5)(A) through (H) of this Rule, if the following conditions are met:

**(1)** A certificate of accreditation must be submitted by the certified accrediting entity that is recognized pursuant to 45 C.F.R. § 156.275, or any other certified entity as recognized by the Arkansas Insurance Department;

(2) ~~(2)~~ The certified accrediting entity has submitted information showing that its audit includes a review of all reasonable and/or necessary requirements of state and federal law; and

(3) ~~(3)~~ The Health Carrier agrees to provide to the Arkansas Insurance Department any and all material and information submitted to the certified accrediting entity upon the Commissioner's request.

(4) ~~(4)~~ The accredited Health Carrier has submitted annual geographical ~~access maps~~data and performance metrics as required in Section Five (5) of this Rule for reporting purposes only.

(5) ~~(5)~~ The Commissioner reserves the right to reverify compliance of network adequacy as a part of any quarterly audit or request for certification of a Qualified Health Plan.

L. The Commissioner will also accept an accreditation of a Health Carrier's access plan by a certified accrediting entity that a Health Carrier has an access plan meeting the requirements of Section Five (5) (I)(1)-(12) of this Rule although such plan must be filed with the Commissioner.

M. All Time and distance guidelines as set forth in this Rule are minimum standards only. The Commissioner, pursuant to his or her discretion, may publish more detailed and specific network adequacy time/distance standards, as well as guidelines regarding the use of telemedicine to meet network adequacy standards, via SERFF Network Adequacy Data Submission Instructions, and/or annual bulletin for setting forth certification requirements for ACA submissions.

**Section 6. Stand-alone Dental Plans**

~~(~~A.~~)~~ For Stand-alone dental plans offered through the ACA approved Marketplace or where a Stand-alone dental plan is offered outside of the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such Stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions. Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization. Networks shall strive to meet the following guidelines through geographical ~~access maps~~data or other information in format and with content specified by the Department, set forth in Section Five (5)(F), above, for the plan year:

(1) ~~(1)~~ In the case of a non-specialist oral care provider, a Covered Person will have access to at least one (1) dentist within a thirty (30) mile radius between the location of the dentist and the residence of the Covered Person;

(2) ~~(2)~~ In the case of a Specialist Oral Care provider, a Covered Person will have access to at least one specialist dentist within a sixty (60) mile radius between the location of the Specialty care professional and the residence of the Covered Person; and

(3) If an Essential Community Provider that provides oral health services is located within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of a covered person, a Stand-alone Dental Carrier must make reasonably best efforts to provide the covered person access to that Essential Community Provider.

(4) For purposes of satisfying the requirements of Section Six (6)(A)(1)-(3) of this Rule, a Stand-alone Dental Carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section Five (5)(K) of this Rule.

(5) The Health Carrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.

~~(3) A Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person.~~

~~For purposes of satisfying the requirements of Section Six (6)(A)(1)-(3) of this Rule, a Stand-alone dental carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section five (5)(K)(1)-(5) of this Rule.~~

~~(~~B.~~)~~ Stand-alone Dental Carriers applying to the Commissioner to participate in the ACA approved Marketplace or offer a Stand-alone dental plan outside the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits are required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general dentist will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. These include:

~~(1)~~ The number of members and percentage of total members meeting the geographical requirements under Section Six (6)(A) of this Rule.

~~(2)~~ The average distance to first, second, and third closest provider for each provider type.

(3) Stand-alone Dental Carriers who do not yet have enrollees in the State of Arkansas ~~will be exempt from this requirement and~~ must attest to not currently having enrollees in Arkansas and provide geographical access data calculated suitable sampling of U.S. Census data.~~-~~

~~(~~C.~~)~~ In the event that a Stand-alone Dental Carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health Carrier shall ensure that the Covered Person obtains the covered benefit at no greater cost to

the Covered Person than if the benefit were obtained from Participating providers, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

(1) ~~(1)~~ provider to Covered Person ratios by dental specialty;

(2) ~~(2)~~ general dentist to covered person ratios;

(3) ~~(3)~~ typical referral patterns;

(4) ~~(4)~~ geographic accessibility;

(5) ~~(5)~~ waiting times for appointments with participating providers;

(6) ~~(6)~~ general hours of operation, including part or full time status and weekend and after hour availability; and

~~(~~D.~~)~~ In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

~~(~~E.~~)~~ A Stand-alone Dental Carrier shall monitor, on an ongoing basis, the ability of its Participating providers to furnish all contracted benefits to Covered Persons.

F.~~(F)~~ Access plans. A Stand-alone Dental Carrier shall file with the Commissioner an access plan meeting the requirements of Section Six (6)(F)(1)-(12) of this Rule for Stand-alone dental plans issued or renewed in this State on or after January 1, 2015. The Stand-alone Dental Carrier shall make the access plans, absent proprietary information, ~~available to~~available to its insureds. The Stand-alone Dental Carrier shall prepare an access plan prior to offering a new Stand-alone dental plan, and shall update an existing access plan whenever it makes any material change to an existing Stand-alone dental plan such as the loss of a material provider. The access plan shall describe or contain at least the following:

(1) ~~(1)~~ The Stand-alone Dental Carrier's network;

(2) ~~(2)~~ The Stand-alone Dental Carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential

enrollees regarding availability of network and out-of-network providers;

(3) ~~(3)~~ The Stand-alone Dental Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its Health Benefit Plans;

(4) ~~(4)~~ The Stand-alone Dental Carrier's efforts to address the needs of Covered Persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) ~~(5)~~ The Stand-alone Dental Carrier's methods for assessing the health care needs of Covered Persons;

~~(6)~~ **(6)** The Stand-alone Dental Carrier's method of informing Covered Persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) ~~(7)~~ The Stand-alone Dental Carrier's method for assessing consumer satisfaction;

(8) ~~(8)~~ The Stand-alone Dental Carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) ~~(9)~~ The Stand-alone Dental Carrier's system for ensuring the coordination and continuity of care for Covered Persons referred to specialty providers, for Covered Persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) ~~(10)~~ The Stand-alone Dental Carrier's process for enabling covered persons to change non-specialist dental providers;

(11) ~~(11)~~ The Stand-alone Dental Carrier's proposed plan for providing continuity of care in the event of contract termination between the Health Carrier and any of its participating providers, or in the event of the Health Carrier's insolvency or other inability to continue operations. The description shall explain how Covered Persons will be notified of the contract termination, or the Health Carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(12) ~~(12)~~ Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

G.~~(G)~~ Provider Directories. A Stand-alone Dental Carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Stand-alone Dental Carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

**(1)** Stand-alone Dental Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

**(2)** If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Stand-alone Dental Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

**(3)** Online provider directories must be available in Spanish.

**(4)** The directory search must include the ability to filter by ECP.

**(5)** The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

## Section 7. Provider Type NPI Pool Data Maintenance

A. A list of provider types developed by the Department and the Arkansas Department of Health will be monitored for network adequacy. The provider-types are defined in terms of National Uniform Claim Committee (NUCC) taxonomy codes. The provider-type list will be reviewed annually for:

(1) Sufficiency. This could be to add provider-types deemed necessary for coverage of health care services most appropriate for Arkansans or to remove provider-types that are no longer appropriate.

(2) Definitions. This is to ensure that the taxonomies associated with the provider-type conveys the intended scope of the provider-type. The taxonomy association with a provider-type definition communicates the actual practice of the provider rather than their academic qualification. For example, a provider qualified as an internal medicine physician cannot be considered a Primary Care Provider if the provider works only in emergency rooms or is only associated with a pain management clinic.

B. The Department will facilitate a system of on-going industry data maintenance of NPI association(s) with various provider types defined in Section 7(A). This association will be based on the provider's actual practice. This will be done to facilitate a common and uniform understanding of each provider's provider type(s) classification. This NPI association data with provider-types will be referred to as Provider-Type-NPI-Pool (PTNP) data. The process and timelines in the PTNP data maintenance effort will be outlined by the Department on an annual basis through online documentation. This ~~The~~ process will involve two stages of data submission by the carriers.~~:~~ The first stage will involve carriers suggesting changes ~~suggestions of changes to~~in the PTNP data followed by the second stage when the carriers will vote on the suggestions consolidated from the first stage. The Department will facilitate oversight of the process and may classify a NPI lacking unanimous agreement among carriers.

C. Participation exemptions. A carrier with fewer than five thousand (5,000) covered individuals as of December 31 of the previous calendar year will not be required to participate in the PTNP data maintenance process. For purposes of determining whether a carrier is subject to the participation requirements of PTNP data maintenance the carrier must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners. Carriers that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the five thousand (5,000) covered individual threshold.

D. If a carrier does not believe it meets the definition of a submitting entity herein or does not believe it meets the 5,000 covered individuals' threshold, that entity may dispute the Commissioner's decision in accordance with the Arkansas Administrative Procedure Act.

**Section 8. Submission Timeline for Network Adequacy Review**

Health Carriers will submit data for network adequacy review according to the timeline contained in the annual certification requirements bulletin.

**Section 9~~7~~. Enforcement**

The penalties, license actions or orders as authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule.

**Section 10.~~8.~~ Effective Date**

The effective date of this Rule is January 1, 20~~15~~22.

ALAN MCCLAIN ~~JAY BRADFORD~~
INSURANCE COMMISSIONER

DATE

**SUMMARY**

ARKANSAS INSURANCE DEPARTMENT PROPOSED AMENDED RULE 106

Network Adequacy Requirements for Health Benefit Plan

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To: Arkansas Legislative Council & Arkansas Bureau of Legislative Research

From: Dan Honey, Counsel Product Compliance, Arkansas Insurance Department

CC: Alan McClain, Arkansas Insurance Commissioner; Steve Porch, General Counsel, Arkansas Department of Commerce; Russ Galbraith, Deputy Insurance Commissioner; Jim Brader, General Counsel; Jennifer Bruce, Public and Legislative Affairs Director

Date: June 24, 2021

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**LEGISLATIVE AUTHORITY FOR RULE**

The proposed Rule revises and updates existing AID Rule 106 setting forth network adequacy requirements for health plan. Authority for the rule is pursuant to Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers.

**BACKGROUND AND PURPOSE OF RULE**

The purpose of revisions to existing Rule 106 is to update the Rule to accurately reflect AID processes and procedures regarding review and enforcement.

**EXPLANATION OF THE PROPOSED RULE**

The proposed Rule amends existing AID Rule 106 by (1) reflect processes and procedures to accurately reflect AID enforcement;(2) clarifies definitions to include all dental plans;(3) clarifies time and distance standards regarding network adequacy requirements.

AID Rule 106 was effective January 1, 2015. Since then, AID has updated it's processes and procedures regarding the implementation and enforcement of the Rule. Namely, AID has tightened up and more closely monitored network adequacy based on provider type taxonomy codes as defined by the National Uniform Claim Committee (NCCU) taxonomy codes. This is to ensure that the taxonomies associated with a particular provider type adequately conveys the scope of said provider type. As opposed to the submission by plans of access maps and compliance percentages, the updated Rule requires submission of more detailed data in order to facilitate a common and uniform understanding of each provider's provider type(s) classification.

The proposed amendments also clarify definitions to apply the rule to all dental plans, whether embedded or stand-alone, and both on and off the Marketplace Exchange.

Finally, time and distance standards as they relate to network adequacy requirements are clarified by the amended rule, and telemedicine is defined, and language added, providing the Commissioner authority and discretion to establish guidelines regarding the use of telemedicine to meet network adequacy standards.

# NOTICE OF PUBLIC HEARING

The Arkansas Insurance Department will host a Public Hearing on August 26, 2021, at 10:00 AM., in the Second Floor Diamond Mine Hearing Room, in the Arkansas Department of Commerce Building, One Commerce Way, Little Rock, Arkansas 72202. The Arkansas Insurance Commissioner is considering adopting the proposed Rule that amends the existing AID Rule 106 to reflect processes and procedures to accurately reflect AID enforcement off network adequacy; clarifies definitions to include all dental plans; and clarifies time and distance standards regarding network adequacy requirements. This Notice is required by the Arkansas Administrative Procedures Act in Ark. Code Ann. § 25-15-206. Copies of the proposed Rule may be obtained by writing or calling the Arkansas Insurance Department, or by visiting its Internet site at https://www.insurance.arkansas.gov/pages/industry-regulation/legal/proposed-rules/. Comments from the public will be accepted until August 26, 2021, and may be submitted to the Department in writing at the address above or electronically to the following email address: Insurance.compliance@arkansas.gov. For more information, please contact Mr. Dan Honey, Compliance Division, Arkansas Insurance Department at 501-371-2800.

Michael Preston
SECRETARY OF COMMERCE

Alan McClain
COMMISSIONER,
ARKANSAS INSURANCE
DEPARTMENT

DATE: JULY 23, 2021

TO: ALL INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: RULE 106: "NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS"

## NOTICE OF PUBLIC HEARING

Please find attached or available by electronic publication by the Arkansas Insurance Department ("AID") Proposed Rule 106, "Network Adequacy Requirements for Health Benefit Plans".

Pursuant to Arkansas Administrative Procedures Act, and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on August 26, 2021 at 10:00 A.M., in the Second Floor Hearing Room ("Diamond Mine"), at the Arkansas Department of Commerce, 1 Commerce Way, Little Rock, AR 72202.

The Arkansas Insurance Commissioner is considering adopting the proposed Rule that amends the existing AID Rule 106 to reflect processes and procedures to accurately reflect AID enforcement off network adequacy; clarifies definitions to include all dental plans; and clarifies time and distance standards regarding network adequacy requirements. Comments from the public will be accepted until August 26, 2021 and may be submitted to the Department in writing at the address above or electronically to the following email address: Insurance.compliance@arkansas.gov. For more information, please contact Mr. Dan Honey, Compliance Division, Arkansas Insurance Department at 501-371-2800.

This Notice is required by the Arkansas Administrative Procedures Act in Ark. Code Ann. § 25-15-206. Copies of the proposed Rule may be obtained by writing or calling the Arkansas Insurance Department, or by visiting its Internet site at https://www.insurance.arkansas.gov/pages/industry-regulation/legal/proposed-rules/. Comments from the public will be accepted until August 26, 2021, and may be submitted to the Department in writing at the address above or electronically to the following email address: Insurance.compliance@arkansas.gov. For more information, please contact Mr. Dan Honey, Compliance Division, Arkansas Insurance Department at 501-371-2800.

Sincerely,

Dan Honey

Dan Honey,
Counsel Product Compliance
Arkansas Insurance Department

# NOTICE OF PUBLIC HEARING

The Arkansas Insurance Department will host a Public Hearing on August 26, 2021, at 10:00 AM., in the Second Floor Diamond Mine Hearing Room, in the Arkansas Department of Commerce Building, One Commerce Way, Little Rock, Arkansas 72202. The Arkansas Insurance Commissioner is considering adopting the proposed Rule that amends the existing AID Rule 106 to reflect processes and procedures to accurately reflect AID enforcement off network adequacy; clarifies definitions to include all dental plans; and clarifies time and distance standards regarding network adequacy requirements. This Notice is required by the Arkansas Administrative Procedures Act in Ark. Code Ann. § 25-15-206. Copies of the proposed Rule may be obtained by writing or calling the Arkansas Insurance Department, or by visiting its Internet site at https://www.insurance.arkansas.gov/pages/industry-regulation/legal/proposed-rules/. Comments from the public will be accepted until August 26, 2021, and may be submitted to the Department in writing at the address above or electronically to the following email address: Insurance.compliance@arkansas.gov. For more information, please contact Mr. Dan Honey, Compliance Division, Arkansas Insurance Department at 501-371-2800.

# ECONOMIC IMPACT STATEMENT
# OF PROPOSED RULES OR REGULATIONS
# EO 05-04: Regulatory Flexibility

**Department:** Arkansas Insurance Department **Division:** Legal
**Contact Person:** Crystal Phelps **Date:** July 22, 2021
**Contact Phone: (**501) 371-2841 **Contact Email:** crystal.phelps@arkansas.gov

## Title or Subject:

Proposed Rule 120: Coverage for Early Refills of Prescription Eye Drops

## Benefits of the Proposed Rule or Regulation

1. Explain the need for the proposed change(s). Did any complaints motivate you to pursue regulatory action? If so, please explain the nature of such complaints.

   Proposed Rule 120 implements Act 357 of 2021 requiring early refills of prescription eye drops under described circumstances. The Arkansas Insurance Department is unaware of complaints.

2. What are the top three benefits of the proposed rule or regulation?

   (1) The Proposed Rule requires an insurer that provides coverage for prescription eye drops under a health plan to provide consumers with early refills under certain circumstances; (2) the Proposed Rule prevents individuals with chronic eye conditions from suffering harm to or loss of vision as a result of accidentally spilling, spoiling, or wasting prescribed eye drops; and (3) the Proposed Rule satisfies the requirement of Act 357 of 2021 requiring the Arkansas Insurance Commissioner to promulgate rules necessary to implement Act 357 of 2021.

   See attached Summary.

3. What, in your estimation, would be the consequence of taking no action, thereby maintaining the status quo?

   Patients with chronic vision problems and without access to prescription eye drops risk further harming or even losing their vision if they are unable to obtain prescription eye drops when needed.

4. Describe market-based alternatives or voluntary standards that were considered in place of the proposed regulation and state the reason(s) for not selecting those alternatives.

   None.

**Impact of Proposed Rule or Regulation**

5. Estimate the cost to state government of collecting information, completing paperwork, filing, recordkeeping, auditing and inspecting associated with this new rule or regulation.

   None.

6. What types of small businesses will be required to comply with the proposed rule or regulation? Please estimate the number of small businesses affected.

   None.

7. Does the proposed regulation create barriers to entry? If so, please describe those barriers and why those barriers are necessary.

   None.

8. Explain the additional requirements with which small business owners will have to comply and estimate the costs associated with compliance.

   None.

9. State whether the proposed regulation contains different requirements for different sized entities, and explain why this is, or is not, necessary.

   None.

10. Describe your understanding of the ability of small business owners to implement changes required by the proposed regulation.

    The Proposed Rule does not require “small business owners” to implement provisions in the Proposed Rule.

11. How does this rule or regulation compare to similar rules and regulations in other states or the federal government?

According to the American Academy of Ophthalmology, more than 50% of the United States offers early refills of prescription eye drops. Oklahoma and Tennessee also allow early refills. The Centers for Medicare and Medicaid Services have adopted similar guidelines for the Medicare Part D program.

12. Provide a summary of the input your agency has received from small business or small business advocates about the proposed rule or regulation.

    We have received no comments from small businesses at this time.

**FINANCIAL IMPACT STATEMENT**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

**DEPARTMENT** Arkansas Insurance Department

**DIVISION** Legal Division

**PERSON COMPLETING THIS STATEMENT** Crystal Phelps

**TELEPHONE** (501) 371-2841 **FAX** (501) 371-2618 **EMAIL:** crystal.phelps@arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

**SHORT TITLE OF THIS RULE** Rule 120 Coverage for Early Refills of Prescription Eye Drops

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

NONE or NOT APPLICABLE.

| **Current Fiscal Year** | | **Next Fiscal Year** | |
|---|---|---|---|
| General Revenue | | General Revenue | |
| Federal Funds | | Federal Funds | |
| Cash Funds | | Cash Funds | |
| Special Revenue | | Special Revenue | |
| Other (Identify) | | Other (Identify) | |
| Total | | Total | |

(b) What is the additional cost of the state rule?

NONE

| **Current Fiscal Year** | | **Next Fiscal Year** | |
|---|---|---|---|
| General Revenue | | General Revenue | |
| Federal Funds | | Federal Funds | |
| Cash Funds | | Cash Funds | |
| Special Revenue | | Special Revenue | |
| Other (Identify) | | Other (Identify) | |
| Total | | Total | |

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

   Healthcare insurers required to early refill eye drop prescriptions may end up providing more medication to an insured than would have been provided without the availability of early refills.

| **Current Fiscal Year** | **Next Fiscal Year** |
|---|---|
| $ | $ |

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

NONE

| **Current Fiscal Year** | **Next Fiscal Year** |
|---|---|
| $ | $ |

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☐

NOT APPLICABLE

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously
with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
   (a) justifies the agency's need for the proposed rule; and
   (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
   (a) the rule is achieving the statutory objectives;
   (b) the benefits of the rule continue to justify its costs; and
   (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

**QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL**

**DEPARTMENT/AGENCY** Arkansas Insurance Department

**DIVISION** Legal Division

**DIVISION DIRECTOR** Jim Brader

**CONTACT PERSON** Crystal Phelps

**ADDRESS** 1200 West Third Street

**PHONE NO.** (501) 371-2841 **FAX NO.** (501) 371-2618 **E-MAIL** crystal.phelps@arkansas.gov

**NAME OF PRESENTER AT COMMITTEE MEETING** Crystal Phelps, Associate Counsel

**PRESENTER E-MAIL** crystal.phelps@arkansas.gov

**INSTRUCTIONS**

**A. Please make copies of this form for future use.**
**B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
**C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
**D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

**Jessica Sutton, ESQ.**
**Administrative Rules Review Section**
**Arkansas Legislative Council**
**Bureau of Legislative Research**
**One Capitol Mall, 5th Floor**
**Little Rock, AR 72201**

**********

1. What is the short title of this rule? Rule 120 Coverage for Early Refills of Prescription Eye Drops

2. What is the subject of the proposed rule? Proposed Rule 120 implements Act 357 of 2021 which addresses insurance coverage requirements for early refills of prescription eye drops.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? N/A

When does the emergency rule N/A

expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☒

5. Is this a new rule? Yes ☒ No ☐
   If yes, please provide a brief summary explaining the regulation. See Attached Summary

   Does this repeal an existing rule? Yes ☐ No ☒
   If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

   Is this an amendment to an existing rule? Yes ☐ No ☒
   If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation.

   Act 357 of 2021, Section 2 (a)(1) requires the Arkansas Insurance Department ("AID") to issue rules for the implementation and administration of coverage for early refills of prescription eye drops.

7. What is the purpose of this proposed rule? Why is it necessary?

   Persons suffering from chronic eye diseases need prescription eye drops to prevent their vision from worsening. However, such persons, particularly older persons, often inadvertently spill or waste eye drops causing them to run out of a medication before a health plan will cover the plan. This Rule describes circumstances under which patients are able to obtain early refills of prescription eye drops.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). https://www.insurance.arkansas.gov/pages/industry-regulation/

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
   If yes, please complete the following:

   Date: August 26, 2021
   Time: 9:30 AM
   Place: Arkansas Department of Commerce, Second Floor Hearing Room, 1 Commerce Way , Little Rock, AR 72202

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
    August 27 at 4:30 PM

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

November 1, 2021

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. We will update this after we send out our NOPH ("Notice of Public Hearing") and receive newspaper documentation from the Arkansas Democrat-Gazette.

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e).

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

The Department does not know at this time but will update BLR and ALC in the public comments summary following the close of the comment period and public hearing.

Michael Preston
SECRETARY OF COMMERCE

Alan McClain
COMMISSIONER,
ARKANSAS INSURANCE
DEPARTMENT

July 26, 2021

Ms. Jessica Whittaker, ESQ.
Arkansas Legislative Council
Arkansas Bureau of Legislative Research
State Capitol, Suite 315
Little Rock, Arkansas 72201

RE: Proposed Amended Rule 106: "Network Adequacy Requirements for Health Benefit Plans"

Dear Ms. Whittaker:

Enclosed for your review and for filing with the Arkansas Legislative Council "Network Adequacy Requirements for Health Benefit Plans."

Pursuant to Arkansas Administrative Procedure Act, and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on August 26, 2021, at 10:00 A.M., in the Second Floor Hearing Room, at the Arkansas Department of Commerce, 1 Commerce Way, Little Rock, AR 72202.

The purpose of the Public Hearing will be to determine whether the Department should adopt the "Network Adequacy Requirements for Health Benefit Plans." The Arkansas Insurance Commissioner is considering adopting the proposed Rule that amends existing AID Rule 106 to reflect processes and procedures that accurately represent AID enforcement of network adequacy; clarifies definitions to include all dental plans; and clarifies time and distance standards regarding network adequacy requirements.

I have enclosed the proposed Amended Rule, Mark-up of the Rule, our Notice of Public Hearing, the standard Questionnaire, Financial Impact Statement, and a summary of the Proposed Amended Rule.

Sincerely,

Dan Honey
Counsel, Product Compliance
dan.honey@arkansas.gov

cc: Brandy Wedsted, Administrative Analyst
Clara Mezza, Insurance Administrative Coordinator

Document: A.C.A. § 23-61-108

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# A.C.A. § 23-61-108

**Copy Citation**

Unofficially updated through Act 58 of the 2021 Regular Session, which includes but is not limited to all laws effective through February 2, 2021. Unofficial updates are provisional only and do not include corrections and edits by the Arkansas Code Revision Commission

AR - Arkansas Code Annotated Title 23 Public Utilities and Regulated Industries Subtitle 3. Insurance Chapter 61 State Insurance Department Subchapter 1 — General Provisions

## 23-61-108. Rules.

**(a)**

**(1)** The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, may make reasonable rules necessary for or as an aid to the effectuation of any provision of the Arkansas Insurance Code.

**(2)** No rule shall extend, modify, or conflict with any law of this state or the reasonable implications thereof.

**(3)** Any rule affecting persons or matters other than the personnel or the internal affairs of the commissioner's office shall be made or amended only after a hearing thereon of which notice was given as required by § 23-61-304.

**(4)** If reasonably possible, the commissioner shall set forth the proposed rule or amendment in or with the notice of hearing.

**(5)** No rule as to which a hearing is required under this subsection shall be effective until after it has been on file as a public record in the commissioner's office, and otherwise as provided by law, for at least ten (10) days.

**(b)**

**(1)** The commissioner, in consultation with the Secretary of the Department of Commerce, shall have the authority to promulgate rules necessary for the effective regulation of the business of insurance or as required for this state to be in compliance with federal laws.

**(2)** The commissioner shall have the authority to coordinate regulatory activities and administration with other states and their appropriate regulatory officials and with the federal government with respect to the regulation of insurance.

**(c)** In addition to any other penalty provided, willful violation of any rule shall subject the violator to such denial, suspension, or revocation of certificate of authority or license as may be applicable under the Arkansas Insurance Code for violation of the provision to which the

be applicable under the Arkansas Insurance Code for violation of the provision to which the rule relates.

**(d)**

**(1)** The commissioner is authorized to employ the standards and requirements set forth in publications recited in the Arkansas Insurance Code, as those publications existed on January 1, 2001, and adopted and published by the National Association of Insurance Commissioners or by other authors in the regulation of insurance, including, but not limited to, the Valuation of Securities Manual, the examiners handbook, the Accounting Practices and Procedures Manual, and the Annual Statement Instructions as published by the National Association of Insurance Commissioners.

**(2)** The publications identified in subdivision (d)(1) of this section and others recited in and throughout § 23-60-101 et seq. are hereby adopted as they existed on January 1, 2001.

**(3)** The commissioner is authorized and empowered to promulgate rules for the purposes of adopting all or part of other publications of the National Association of Insurance Commissioners or publications by other authors if the commissioner determines that such an action is in the best interest of the public.

**(4)** Upon the mailing of written notice by the commissioner to all domestic reporting entities of promulgation and publication by the National Association of Insurance Commissioners or other authors of amendments, revisions, or modifications to any publication previously adopted by the commissioner in the Arkansas Insurance Code, such published amendments, revisions, or modifications shall become effective on the date designated by the commissioner in the written notice, which date shall not be earlier than eight (8) months after the date of mailing of the notice.

**(e)** The commissioner is authorized and empowered to adopt rules for the purpose of modifying, amending, or revising any publication promulgated by the National Association of Insurance Commissioners or other authors, or any published amendments, modifications, or revisions to any such publications if the commissioner determines that such an action is in the best interest of the public. In such an event the effective date of any modification, amendment, or revision shall be the effective date of the rule.

## History

Acts 1959, No. 148, § 26; A.S.A. 1947, § 66-2111; Acts 2001, No. 1239, § 1; 2001, No. 1604, § 7; 2019, No. 315, § 2612; 2019, No. 910, §§ 596, 597.

Arkansas Code of 1987 Annotated Official Edition
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42 USC 300gg-1: Guaranteed availability of coverage Text contains those laws in effect on May 31, 2021
From Title 42-THE PUBLIC HEALTH AND WELFARECHAPTER 6A-PUBLIC HEALTH SERVICESUBCHAPTER XXV-REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGEPart A-Individual and Group Market ReformsSubpart I-General Reform
Jump To: Source CreditCodificationPrior ProvisionsAmendmentsEffective Date

## §300gg–1. Guaranteed availability of coverage

### (a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e),[1] each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

### (b) Enrollment

#### (1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

#### (2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of title 29).

#### (3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

### (c) Special rules for network plans

#### (1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may-

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that-

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals [1] employees and dependents.

#### (2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

**(d) Application of financial capacity limits**

**(1) In general**

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that-

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

**(2) 180-day suspension upon denial of coverage**

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(July 1, 1944, ch. 373, title XXVII, §2702, as added and amended Pub. L. 111–148, title I, §§1201(4), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156 , 266, 911.)

## Codification

The text of section 300gg–11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2731, formerly §2711, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962 ; renumbered §2731, Pub. L. 111–148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130 .

## Prior Provisions

A prior section 300gg–1, act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961 ; Pub. L. 110–233, title I, §102(a)(1)–(3), May 21, 2008, 122 Stat. 888 , 890, which related to prohibition on discrimination against individual participants and beneficiaries based on health status, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154 , effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title.

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

## Amendments

**2010**-Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), transferred section 300gg–11 of this title to the end of this section after amending it by striking out the section catchline "Guaranteed availability of coverage for employers in group market", by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting "group and individual" for "small group" in introductory provisions of par. (1), inserting "and individuals" after "employers" in introductory provisions of par. (1)(B), inserting "or any additional individuals" after "additional groups" in par. (1)(B)(i), substituting "and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals" for "without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such" in par. (1)(B)(ii), and substituting "group or individual" for "small group" in par. (2), and by amending subsec. (d) by substituting "group or individual" for "small group" wherever appearing and substituting "all employers and individuals" for "all employers", "those individuals, employers" for "those employers", and "such individuals, employees" for "such employees" in par. (1)(B).

## Effective Date

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

[1] So in original.

# 45 CFR § 156.230 - Network adequacy standards.

CFR

## § 156.230 Network adequacy standards.

**(a)** ***General requirement.*** Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards -

**(1)** Includes essential community providers in accordance with § 156.235;

**(2)** Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

**(3)** Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

**(b)** ***Access to provider directory.***

**(1)** A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider

directory, a QHP issuer must identify providers that are not accepting new patients.

**(2)** For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when -

**(i)** The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

**(ii)** If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

**(c)** ***Increasing consumer transparency.*** A QHP issuer in a Federally-facilitated Exchange must make available the information described in paragraph (b) of this section on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS.

**(d)** ***Provider transitions.*** A QHP issuer in a Federally-facilitated Exchange must -

**(1)** Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

**(2)** In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

**(i)** For the purposes of paragraph (d)(2) of this section, active course of treatment means:

**(A)** An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

**(B)** An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

**(C)** The second or third trimester of pregnancy, through the postpartum period; or

**(D)** An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

**(ii)** Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

**(e)** ***Out-of-network cost sharing.*** Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP that uses a provider network must:

**(1)** Notwithstanding § 156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

**(2)** Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided by an out-of- network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

**(f)** ***Exception.*** Paragraphs (a) through (e) of this section do not apply to a plan for which an issuer seeks QHP certification or to any certified QHP that does not use a provider network, meaning that the plan or QHP does not

condition or differentiate benefits based on whether the issuer has a network participation agreement with the provider that furnishes covered services.

[77 FR 18469, Mar. 27, 2012, as amended at 80 FR 10873, Feb. 27, 2015; 81 FR 12349, Mar. 8, 2016; 86 FR 6178, Jan. 19, 2021]

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