

## NETWORK ADEQUACY STANDARDS AND GUIDANCE

Section 3241 of the Insurance Law requires insurers, including municipal cooperative health benefit plans and student health plans, that issue a health insurance policy or contract or a dental policy or contract with a network of providers to ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. This requirement applies beginning March 31, 2015 upon Department of Financial Services (DFS) approval of all new policies and contracts and upon application for the expansion of any service area associated with the policy or contract. The following provides information about the network adequacy requirements and standards.

### 1. Applicability

- DFS will review provider networks that will be used with a health insurance policy or contract, or a dental policy or contract, that have not been approved by the Department of Health (DOH).
- **Same Network as NYSOH.** If an insurer uses the same network for an insurance product offered outside the New York State of Health (NYSOH) that has been approved by DOH for an insurance product offered inside NYSOH, the insurer will need to certify to DFS that the network is the same. DFS will deem the network adequate if it has been approved by DOH.
- **Same Network as HMO.** If an insurer uses the same network for an insurance product that has been approved by DOH for a HMO product, the insurer will need to certify to DFS that the network is the same. DFS will deem the network adequate if it has been approved by DOH.
- **Same Network as NYSOH or HMO in Some Counties.** If an insurer uses the same network for an insurance product offered outside NYSOH that has been approved by DOH for an insurance product offered inside NYSOH or for an HMO, but would like to add additional counties that have not been approved by DOH, the insurer will need to (1) identify the counties that have been approved by DOH and the counties that have not been approved by DOH; (2) certify to DFS that the network, in the counties approved by DOH, is the same; and (3) provide the requisite information to DFS for review of the additional counties that were not approved by DOH.
- **Network with More Providers Than Approved for HMO or NYSOH.** If an insurer uses a network for an insurance product offered outside NYSOH that has the same or more providers in each provider type and county than a network approved by DOH for an insurance product offered inside NYSOH or for an HMO, the insurer will need to certify to DFS that the network has more providers than the network that was approved by

DOH. DFS will deem the network adequate if it has more providers than the network that was approved by DOH. If there are any provider types in any counties that have fewer providers than approved by DOH, the insurer will need to (1) identify the counties that have more providers than the network that was approved by DOH and certify that the network is the same as DOH approved for those counties, except for the additional providers; (2) identify the counties that have fewer providers than approved by DOH and the provider types; and (3) provide the requisite information to DFS for review of the counties that have fewer providers than approved by DOH.

- **Network with Fewer Providers Than Approved for HMO or NYSOH in Some Counties.** If an insurer uses a network for an insurance product offered outside NYSOH that has fewer providers in some counties than approved by DOH for an insurance product offered inside NYSOH or for an HMO, the insurer will need to (1) identify the counties that have the same network as approved by DOH and certify that the network is the same as approved by DOH; (2) identify the counties that have fewer providers than the network that was approved by DOH and the provider types; and (3) provide the requisite information to DFS for review of the counties that have fewer providers than approved by DOH.

## **2. Review Of Networks**

Insurers will need to submit their networks through the System for Electronic Rate and Form Filing (SERFF), the online portal insurers currently use for form and rate submissions. DFS will supply a template and instructions for insurers to use when submitting their provider networks through SERFF.

Insurers will need to make their network submissions when filing a policy form or contract for approval. DFS network approval will be valid for one year. Insurers will need to advise DFS of any changes to the network after one year.

## **3. Standards For Review Of Provider Networks**

- When establishing a network, an insurer will need to consider: anticipated enrollment; expected utilization of services by the population to be enrolled; the number and types of providers necessary to furnish the services covered in each product; the number of providers who are not accepting new patients; and the geographic location of the providers and enrollees.
- To be considered accessible, the network will need to contain a sufficient number and array of providers to meet the diverse needs of the insured population and to ensure that all services will be accessible without undue delay. This includes being

geographically accessible (i.e., meeting time/distance standards) and being accessible for people with disabilities.

- DFS will be using the same standards as DOH uses to determine network adequacy. In general, these standards include the following:
  - At least one hospital in each county; however, for Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York and Queens the network will need to include at least 3 hospitals;
  - A choice of 3 primary care physicians (PCPs) in each county, and potentially more based on enrollment and geographic accessibility; and
  - At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility.

#### **4. Service Area**

For network adequacy purposes, a service area is defined as a county. For most counties, however, the service area will be “extended” to include portions of adjacent counties because of health care resources and the utilization patterns of consumers. This extension could expand the county border approximately 10 miles into a contiguous county.

#### **5. Network Composition**

The insurer’s network will need to contain all of the provider types necessary to provide services under the insurance product, including but not limited to: hospitals; physicians (primary care and specialists); mental health and substance use disorder treatment providers; allied health professionals; ancillary providers; durable medical equipment (DME) providers; home health providers; and pharmacies. DFS may ask for further explanations and/or details in the event the system is not able to capture or accurately identify particular service providers.

#### **6. Time and Distance Standards For Primary Care Providers**

- Metropolitan Areas: 30 minutes by public transportation.
- Non-Metropolitan Areas: 30 minutes or 30 miles by public transportation or by car.
- In rural areas, transportation may exceed these standards if justified.

#### **7. Time and Distance Standards For Providers That Are Not Primary Care Providers**

- It is preferred that an insurer meet the 30 minute or 30 mile standard for other providers that are not primary care providers.

#### **8. Behavioral Health Providers**

- The insurer will need to include individual providers, outpatient facilities and inpatient facilities in its behavioral health network. The network will need to include facilities that provide inpatient and outpatient mental health and inpatient and outpatient substance

use disorder treatment services. Facilities providing inpatient substance use disorder treatment services will need to be capable of providing detoxification and rehabilitation services.

## **9. Dental Coverage**

- The insurer's dental network will need to include geographically accessible general dentists sufficient to offer insureds a choice of 2 primary dentists in their service area and to achieve a ratio of at least 1 primary care dentist for each 2,000 insureds.
- Networks will need to include at least the following providers: 2 orthodontists, 1 pedodontist and 1 oral surgeon.
- Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics will need to be provided through any qualified dentist, either in-network or by referral.
- Periodontists and endodontists will need to be available by referral.
- The network will need to include dentists with expertise serving special needs populations (e.g. HIV+ and developmentally disabled patients).

## **10. Providers That Should Not Be Included In An Insurer's Network**

An insurer should not include in its network any provider who:

- Has been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
- Is deceased; or
- Had his/her license suspended or revoked by the New York State Education Department or the NYSDOH Office of Professional Medical Conduct.