DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING

NOTICE OF FINAL RULEMAKING

The Commissioner of the Department of Insurance, Securities and Banking, pursuant to the authority set forth in Section 101(c) of the Federal Health Reform Implementation and Omnibus Amendment Act of 2014, effective May 2, 2015 (D.C. Law 20-265; D.C. Official Code § 31-3461(c)), and Section 207 of the Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998, effective April 13, 1999 (D.C. Law 12-209; D.C. Official Code § 31-3302.07), hereby gives notice of the adoption of a new Chapter 47 (Health Benefit Plan Network Access and Adequacy), of Title 26 (Insurance, Securities, and Banking), Subtitle A (Insurance), of the District of Columbia Municipal Regulations (DCMR).

These rules establish standards for health carrier provider networks to ensure the adequacy and accessibility of medical and behavioral health care services. Specifically, the rules address requirements for health carriers in recruiting and maintaining participating provider networks to sufficiently meet the needs of their enrollees.

An initial Notice of Proposed Rulemaking ("NOPR") was published in the *District of Columbia Register* on November 23, 2018, at 65 DCR 013035. Based on the public comments received in response to the NOPR from the Children's Law Center, Children's National Hospital, DC Behavioral Health Association, Early Childhood Innovation Network, Families USA, AHIP, CareFirst, Kaiser Permanente, and United Healthcare, the Commissioner agreed with most of the comments and amended the proposed rules accordingly and published a Second Notice of Proposed Rulemaking ("Second NOPR") in the *District of Columbia Register* on July 29, 2022, at 69 DCR 009585. This Notice of Final Rulemaking ("NOFR") adopts the amendments in the Second NOPR with several technical and clarifying revisions.

The technical and clarifying revisions are summarized as follows: (1) § 4701.1, which previously applied to Medicaid plans by implication, was revised to explicitly include Medicaid plans; (2) § 4702.2 was revised to expressly, rather than by implication, allow carriers to deem proprietary information in their Network Adequacy Report/Request for Waiver Form confidential; (3) § 4702.4 was revised to clarify that health plans that do not use Qualified Health Plan templates to submit plan information must submit the same information in substantially the same form; (4) § 4702.5(c) and 4702.6(c) were revised to add March 1 as the date when the Commissioner shall make the list of qualified physicians available to carriers; (5) § 4702.5(e) and 4702.6(e) were renamed "Essential Community Providers" and § 4702.5(e)(1) and 4702.6(e)(1), which required carriers to have a sufficient network for special needs populations, were struck as duplicative of subparagraphs (3) in both subsections and renumbered; (6) § 4703 was revised and renumbered to clarify how requests for confidential treatment of Access Plans shall be made; (7) § 4704.12 addressing marketing and branding standards of networks was struck as redundant of the qualitative standards in the rules; (8) § 4704.16 and 4704.17 were struck because they addressed provider contracts, which was beyond the immediate scope of establishing standards for network adequacy; (9) § 4704 and 4707 were renumbered; and (10) due to the delay in adopting the rulemaking, the applicability date was changed from January 1, 2023, to January 1, 2024.

The Commissioner adopted this final rulemaking on December 7, 2022, and the final rules shall become effective upon the date of publication of this notice in the *District of Columbia Register*.

A new Chapter 47, HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY, of Title 26-A DCMR, INSURANCE, is added to read as follows:

CHAPTER 47 HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY

4700 PURPOSE

4700.1 The purpose and intent of these rules are to:

(a) Establish standards for the creation and maintenance of networks by health carriers; and

(b) Ensure the adequacy, accessibility, transparency, and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide covered services to covered persons; and

(2) Requiring health carriers to maintain and follow Access Plans that consist of policies and procedures for ensuring the ongoing sufficiency of provider networks, including any requirements related to their availability to the public.

4701 APPLICABILITY AND SCOPE

4701.1 Except as provided in § 4701.2, this chapter applies to all health carriers that offer network plans, including Medicaid.

4701.2 These rules shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans.

4702 NETWORK ADEQUACY

4702.1 A health carrier providing a network plan shall maintain a network that is sufficient in numbers and facilitates access to appropriate types of providers, including those that are (1) racially, ethnically, and gender diverse; (2) culturally aware of and sensitive to the needs of the diverse communities and gender identities in the District; and (3) serve predominantly low-income, medically underserved individuals, to ensure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

4702.2 Carriers shall submit to the Commissioner a Network Adequacy Report demonstrating compliance with this section, no later than September 1 of each year, for health plans being sold, issued, or renewed on or after January 1 of the subsequent year. If a carrier is unable to demonstrate compliance with any of the provisions set forth under this chapter, the carrier may submit a Request for Waiver Form for approval by the Commissioner. A health carrier may request that the Commissioner deem portions of its filed Network Adequacy Report or Request for Waiver Form confidential. The Commissioner may request additional information to evaluate efforts to achieve a sufficient network when reviewing a waiver request, including but not limited to:

(a) A list of providers or physicians that the carrier attempted to contract with, identified by name, practice location, and specialty or facility type;

(b) A description of when and how many times the carrier last contacted each provider or physician;

(c) A description of any reason(s) each provider or physician gave for refusing to contract with the carrier;

(d) A description of any modifications to the contract or contracting process offered to providers or facilities described in paragraph (c);

(e) Steps the carrier will take to attempt to improve its network to meet the requirements of this section;

(f) Carriers that provide a majority of their covered professional services through physicians employed by the carrier, or through a single medical

group in contract with the carrier, shall include, in a waiver request, a description of how the carrier otherwise meets the access needs of its enrollees, and a description of expansion plans, if applicable;

(g) If this additional information is required because an issuer is not in compliance with any provision of this chapter or requested a waiver, the Commissioner may publish a report for consumers to understand efforts the issuer is taking to come into compliance or why any provision of this chapter does not apply.

4702.3 The Commissioner shall determine the sufficiency of a network in accordance with the requirements of this section.

4702.4 For any provider-to-covered person ratio referenced in this section, the ratio shall be formulated by dividing the number of providers in each network, as listed in the carrier's submitted Centers for Medicare and Medicaid Services (CMS) Qualified Health Plan (QHP) network template, by the number of covered persons with access to that same network. If a carrier submits more than one Network ID, then separate ratios shall be formulated for each Network ID. For plans that do not use QHP templates, separate ratios shall be formulated for each established network and identified in a manner substantially similar to the Network ID.

4702.5 For plans sold, issued, or renewed on or after January 1, 2024, carriers that provide a majority of covered professional services through physicians employed by the carrier, or through a single medical group in contract with the carrier, shall provide services consistent with the following requirements:

(a) Provider-to-covered person ratios by specialty using the following standards:

Neurology	**1:7,500**
Cardiology	**1:7,500**
Hematology/Oncology	**1:7,500**
Dermatology	**1:7,500**
Rheumatology	**1:7,500**
Orthopedics	**1:7,500**
Nephrology	**1:7,500**
Plastic Surgery	**1:7,500**

(b) Provider--to-covered person ratios using the following standards:

Primary Care	**1:3,000**
(Medical Doctor, Nurse Provider)	
Pediatrics	**1:3,000**
(Board Certified Pediatrician or Family Medicine)	
OB/GYN	**1:3,000**

(Board Certified OB/GYN, Nurse Provider, or Midwife)
Behavioral Health & Substance Use **1:3,000**
(Board Certified Neurology or Psychiatry; PsyD, PhD, Masters level clinician in the areas of Social Work, Family Therapy, Licensed Professional Counselors)
Habilitative Services **1:3,000**
(Speech, Language and Occupational and Physical Therapists, Applied Behavior Analysis providers)

(c) Physician Accessibility:

(1) On or before March 1 of each year, the Commissioner shall make available to the carriers a list of physicians with a fully privileged, active license to practice medicine in the District of Columbia, and other qualified providers if applicable, their primary practice address in the District of Columbia, and identify the physicians with an office located within half (1/2) of a mile of a Metrorail stop. The Commissioner, in consultation with carriers, shall include additional data elements in the listing as necessary to allow for comparison with carrier data. In the event no update is made available, the carriers shall use the prior year's list.

(2) The Commissioner shall provide a mechanism for a carrier to report providers who are improperly excluded from the list; included on the list; or improperly identified as having or not having an office within half (1/2) of a mile of a Metrorail stop.

(3) Carriers shall have in their network at least fifteen percent (15%) of providers with a primary practice address within the District of Columbia identified as having an office within half (1/2) of a mile of a Metrorail stop on the list of providers.

(d) Appointment Wait Times:

(1) Carriers shall establish the standards listed below for appointment wait times for services within the network. The standard shall not be defined in terms of an appointment with a specific provider, but rather any qualified provider employed by the carrier or single contracted medical group who is available within a reasonable time frame to see a covered person.

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care physician	within 7 business days

First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days
First appointment with a new or replacement provider for Prenatal Care treatment	within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days

(2) Carriers shall communicate the appointment wait time standards to all covered persons in their welcome packet, and post or link the standards in online provider directory pages. The language used shall be substantially similar to the following:

Requirements for Timely Medical Appointments

Some customers of [Company Name] have a right to an appointment with an in-network health care provider within a certain number of days. You have this right if:

(1) You buy your health insurance directly or receive it through your employer in the District of Columbia, **and**
(2) The appointment is for your **first visit** with a provider. A first visit includes when you:
    a. Schedule your first primary care visit with a provider;
    b. Have changed primary care providers and need to schedule your first visit with a new primary care provider; or
    c. Schedule your first visit with a provider other than your primary care provider, your behavioral health / substance use provider, or your prenatal care provider for specialty treatment.

How quickly can you expect to be seen? The District of Columbia has set the standards below for appointments with an in-network provider.

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care physician	within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days

First appointment with a new or replacement provider for Prenatal Care treatment	within 15 business days	If you have trouble scheduling an appointment within the timeframes listed, please call [Phone Number] to speak to a [Company Name] representative. That person will help you schedule an appointment within the timeframes listed.
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days	

(3) Carriers shall maintain and publicize a toll-free number to a call center through which covered persons can promptly speak to an individual who shall assist them with identifying providers who have appointments available within the timeframes required based on the date of the initial call to the call center.

(4) Carriers shall include information in its Network Adequacy Report summarizing the activities of the call center, including statistics on the number of calls received, the issues addressed, and resolution of the calls.

(e) Essential Community Providers:

(1) Carriers are required to have a sufficient number and geographic distribution of providers employed by the carrier, or single medical group in contract with the carrier, to ensure reasonable and timely access, consistent with the provisions set forth in this subsection, to a broad range of services for low-income or medically underserved individuals in their service areas.

(2) Carriers shall demonstrate that at least twenty percent (20%) of the providers employed by the carrier, or the single medical group in contract with the carrier, are located within Health Professional Shortage Areas (HPSAs), or five-digit ZIP codes designated as Medically Underserved Areas/Populations (MUA/P), as determined by DC Health.

4702.6 For plans sold, issued, or renewed on or after January 1, 2024, carriers that do not provide a majority of covered professional services through physicians employed by the carrier, or through a single medical group in contract with the carrier, shall provide services consistent with the following requirements:

(a) Provider-to-covered person ratios by specialty using the following standards:

Neurology	**1:5,000**
Cardiology	**1:5,000**
Hematology/Oncology	**1:5,000**
Dermatology	**1:5,000**
Rheumatology	**1:5,000**
Orthopedics	**1:5,000**
Nephrology	**1:5,000**
Plastic Surgery	**1:5,000**

(b) Provider-to-covered person ratios using the following standards:

Primary Care (Medical Doctor, Nurse Provider)	**1:2,000**
Pediatrics (Board Certified Pediatrician or Family Medicine)	**1:2,000**
OB/GYN (Board Certified OB/GYN, Nurse Provider, or Midwife)	**1:2,000**
Behavioral Health & Substance Use (Board Certified Neurology or Psychiatry; PsyD, PhD, Masters level clinician in the areas of Social Work, Family Therapy, Licensed Professional Counselors)	**1:2,000**
Habilitative Services (Speech, Language and Occupational and Physical Therapists, Applied Behavior Analysis providers)	**1:2,000**

(c) Physician Accessibility:

(1) On or before March 1 of each year, the Commissioner shall make available to the carriers a list of physicians with a fully privileged, active license to practice medicine in the District of Columbia, and other qualified providers if applicable, among the specialties listed in (3), with their primary practice address in the District of Columbia. The list will identify among those on the list the physicians with an office located within half (1/2) of a mile of a Metrorail stop. The Commissioner, in consultation with carriers, shall include additional data elements in the listing as necessary to allow for comparison with carrier data. In the event no update is made available, the carriers shall use the prior year's list.

(2) The Commissioner shall provide a mechanism for a carrier to report providers who are improperly excluded from the list; improperly included on the list; or improperly identified as having or not having an office within half (1/2) of a mile of a Metrorail stop.

(3) Carriers shall contract with a minimum of thirty percent (30%) of the providers on the list provided by the Commissioner for each of the specialties listed below:

Primary Care
Pediatrics
OB/GYN
Behavioral Health & Substance Use
Neurology
Cardiology
Hematology / Oncology
Dermatology
Rheumatology
Orthopedics
Nephrology

(4) Carriers shall have in their network at least thirty percent (30%) of all providers (not just those on the specialty list) with a primary practice address within the District of Columbia identified as having an office within half (1/2) of a mile of a Metrorail stop on the list of providers.

(d) Appointment Wait Times:

(1) Carriers shall establish the standards listed below for appointment wait times for services within the network. The standard shall not be defined in terms of an appointment with a specific provider, but rather any qualified in-network provider.

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care physician	within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days
First appointment with a new or replacement provider for Prenatal Care treatment	within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days

(2) Carriers shall communicate the appointment wait time standards to

all covered persons in their welcome packet, and post or link the standards in online provider directory pages. The language used shall be substantially similar to the following:

Requirements for Timely Medical Appointments

Some customers of [Company Name] have a right to an appointment with an in-network health care provider within a certain number of days. You have this right if:

(1) You buy your health insurance directly or receive it through your employer in the District of Columbia. **and**
(2) The appointment is for your **first visit** with a provider. A first visit includes when you:
    a. Schedule your first primary care visit with a provider;
    b. Have changed primary care providers and need to schedule your first visit with a new primary care provider; or
    c. Schedule your first visit with a provider other than your primary care provider, your behavioral health / substance use provider, or your prenatal care provider for specialty treatment.

How quickly can you expect to be seen? The District of Columbia has set the standards below for appointments with in-network providers.

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care physician	within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days
First appointment with a new or replacement provider for Prenatal Care treatment	within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days

If you have trouble scheduling an appointment within the timeframes listed, please call [Phone Number] to speak to a [Company Name] representative. That person will help you schedule an appointment within the timeframes listed.

Please note:

1. The [Company Name] representative will likely give you the provider's contact information and you may need to schedule the appointment yourself.
2. The [Company Name] representative can't force the specific provider *you want to see* to give you an appointment within the timeframe, as the provider may have already scheduled appointments with other patients or is otherwise unavailable. Instead, the representative will give you contact information for a qualified, in-network provider who *is available to see you* within the above timeframe.

3. The [Company Name] representative can't otherwise guarantee an appointment with a provider you've seen before.

(3) Carriers shall maintain and publicize a toll-free number to a call center through which covered persons can speak to an individual who shall assist them with identifying providers who have appointments available within the timeframes required based on the date of the initial call to the call center.

(4) Carrier shall include information in its Network Adequacy Report summarizing the activities of the call center including statistics on the calls received and resolution of the calls.

(e) Essential Community Providers:

(1) Carriers are required to have a sufficient number and geographic distribution of essential community providers ("ECPs"), where available. An essential community provider is a provider that serves predominantly low-income, medically underserved individuals, including: a health care provider as defined in Section 340(B)(a)(4) of the Public Health Service Act (PHSA) (42 USC § 256b), or as described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act (42 USC § 1396r-8); or a State-owned family planning service site, or governmental family planning service site that does not receive Federal funding under special programs, including under Title X of the PHSA (42 USC §§ 300 to 300a-6), unless any of the above providers has lost its status under either of these sections, Section 340(B) of the PHSA, or Section 1902 of the Social Security Act (42 USC § 1396a) as a result of violating Federal law.

(2) Carriers shall demonstrate in their Network Adequacy Report that at least twenty percent (20%) of available ECPs in each plan's service area participate in the plan's network.

4702.7 A health carrier shall have procedures to ensure that a covered person may obtain covered benefits from non-participating providers at in-network benefit levels, including for cost-sharing, or shall make other arrangements acceptable to the Commissioner when the health carrier has met the requirements of this chapter, but does not have participating providers available to provide medically necessary covered benefits which meet any one of the three standards below:

(a) The service or benefit will, or is reasonably expected to, prevent the onset of an illness condition, or disability;

(b) The service or benefit will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, or disability;

(c) The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities that take into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

4702.8 (a) A health carrier shall provide instructions to covered persons explaining how to make a written request for access to covered benefits from non-participating providers under circumstances provided in § 4702.7.

(b) The carrier shall treat the health care services received by a covered person from a non-participating provider pursuant to §§ 4702.7 and 4702.8(a)-(b) as if the services were provided by a participating provider, including crediting the cost-sharing for such services toward the applicable maximum out-of-pocket limit for services obtained from participating providers under the health benefit plan.

(c) The procedures described in § 4702.8(d) shall ensure that requests to obtain covered benefits from non-participating providers are addressed in a timely fashion relative to the covered person's condition.

(d) The carrier shall document and retain copies of all requests for covered benefits from non-participating providers, for as long as the enrollee maintains coverage plus a minimum of one (1) year after an enrollee terminates coverage and shall make the information available to the Commissioner upon request.

(1) The procedures established in this subsection are not intended to be used as a substitute for establishing and maintaining a sufficient provider network or to circumvent the use of covered benefits available through a health carrier's network.

(2) Nothing in this section prevents a covered person from exercising any right and remedy available under applicable District or federal law relating to internal and external claims grievance and appeals procedures.

4703 ACCESS PLAN

4703.1 A health carrier shall file an Access Plan prior to or at the time it files a new or amended network plan, in a manner and form set by the Commissioner, separate and apart from the Network Adequacy Report, meeting the requirements of this chapter with the Commissioner by September 1 of each year.

4703.2 A health carrier shall notify the Commissioner of any material change to any existing network plan, as noted in the filed Access Plan, including but not limited to:

(a) A ten percent (10%) or greater change in the carrier's total number of network of providers;

(b) A twenty percent (20%) or greater reduction in the number of primary care providers in the carrier's network;

(c) A twenty percent (20%) or greater reduction in the number of specialty providers available in the carrier's network;

(d) A reduction in a specific type of provider, such that the provider type or a specific covered service is no longer available;

(e) A twenty percent (20%) change to a tiered, multi-tiered, layered, or multi-level network plan structure, including a reduction or greater in the number of providers in any tier, layer, or level; or

(f) An increase or decrease of twenty percent (20%) or more covered persons since the previous filing.

4703.3 A health carrier's Access Plan shall describe or contain the following:

(a) The provider network, including the extent it supports the use of telemedicine or other technology to enhance network access;

(b) The procedures for making and authorizing referrals within and outside the network, if applicable;

(c) The process for monitoring and assuring the sufficiency of the network to meet the health care needs of populations that use the network;

(d) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select or tier providers;

(e) The efforts to address the needs of covered persons, including children and adults, persons with limited English proficiency or literacy, persons with diverse cultural and ethnic backgrounds, and persons with physical or mental disabilities or other serious, chronic, or complex medical conditions. This includes a health carrier's efforts, when appropriate, to include various types of essential community providers, as described in § 4702.6(e)(2), in its network;

(f) The methods for assessing the health care needs of covered persons and their satisfaction with the services provided;

(g) The method of informing covered persons of covered services and features, including but not limited to:

(1) The grievance and appeals procedures;

(2) The process for selecting and changing providers;

(3) The process for updating provider directories for each network plan;

(4) A statement of health care services offered, including services offered through the preventive care benefit, if applicable; and

(5) The procedures for covering and approving emergency, urgent, and specialty care, if applicable;

(h) The process for ensuring the coordination and continuity of care:

(1) For covered persons referred to specialty providers; and

(2) For covered persons using ancillary services, including social services and other community resources, and for appropriate discharge planning;

(i) The process for covered persons to change primary care professionals, if applicable;

(j) A 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 plan shall explain how covered persons will be notified and transitioned to other providers, in a timely manner, due to termination of a provider contract, the health carrier's insolvency, or other cessation of operations; and

(k) Any other information required by the Commissioner to determine compliance with this chapter.

4703.4 The Commissioner shall publish the filed Access Plan online, and a health carrier may file a written request that the Commissioner deem portions of its filed Access Plan confidential and redact the confidential portions from published version. A written request shall:

(a) Identify the particular information that the carrier requests be deemed confidential; and

(b) Cite the legal basis for the request.

4703.5 The Commissioner shall have the authority to deem the following as confidential:

(a) Proprietary methodology used to annually assess the carrier's performance in meeting the standards established under this rule;

(b) Proprietary methodology used to annually measure timely access to health care services;

(c) Factors used by the carrier to build its network; and

(d) Any other subject-matter recognized as confidential, proprietary, or otherwise prohibited from disclosure under District law.

4704 REQUIREMENTS FOR HEALTH CARRIERS AND PARTICIPATING PROVIDERS

4704.1 A health carrier offering a network plan shall satisfy all the requirements contained in this section.

4704.2 A health carrier shall notify the participating providers which of the covered health care services the provider will be responsible for, including any limitations or conditions on those services.

4704.3 Every contract between a health carrier and a participating provider shall include a hold harmless provision. The requirement may be satisfied by including the following language, or other language approved by the Commissioner:

"[Physician/Hospital] hereby agrees that in no event, including, but not limited to, non-payment by Corporation or entity with access to this Agreement by virtue of a contract with Corporation for any reason, including a determination that the services furnished were not Medically Necessary, Corporation's insolvency, [Physician/Hospital]'s failure to submit claims within the time period specified or breach of this Agreement, will [Physician/Hospital] bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than Corporation for Covered Services furnished pursuant to this Agreement. This provision will not prohibit collection of applicable copayments, coinsurance or deductibles billed in accordance with the terms of Corporation's agreements with Members.

[Physician/Hospital] further agrees that this provision will survive the termination of this Agreement regardless of the cause giving rise to such termination and will be construed to be for the benefit of Members. Finally, this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between [Physician/Hospital] and Members or persons acting on their behalf.

Any modifications, additions, or deletions to the provisions of this hold harmless clause will become effective on a date no earlier than thirty (30) days after the Commissioner has received written notice of such proposed changes."

4704.4 Carriers shall file with the Commissioner the language used for hold harmless provisions as described under § 4704.3 no later than thirty (30) days after the effective date of these rules.

4704.5 Every contract between a health carrier and a participating provider shall set forth that, in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(a) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms, or applicable District or federal law for covered persons who are in an active course of treatment or totally disabled; or

(b) The date the contract between the carrier and the provider would have terminated if the carrier or intermediary had remained in operation, including any required extension for covered persons in an active course of treatment.

4704.6 The contract provisions that satisfy the requirements of §§ 4704.2 and 4704.3 shall be construed in favor of the covered person, and shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by §§ 4704.2 and 4704.3 of this section.

4704.7 In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

4704.8 Health carrier selection standards for selecting and tiering (if applicable) participating providers shall be developed for providers and each health care professional specialty, if applicable. The standards shall be used in determining the selection and tiering of participating providers by the health carrier and its intermediaries.

4704.9 Health carrier selection standards shall meet the requirements of the District's health care credentialing rules at 26-A DCMR §§ 4200 *et seq*.

4704.10 The health carrier selection standards may not:

(a) Allow a health carrier to discriminate against high-risk populations by excluding and/or tiering providers negatively because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses, or health care services utilization;

(b) Exclude or negatively tier providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health care services utilization; or

(c) Discriminate against a provider with respect to participation under the health benefit plan for acting within the scope of the provider's license or certification under applicable District law or regulations.

4704.11 Section 4704.10 may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier and shall not be construed to prohibit a carrier from declining to select a provider who fails to meet legitimate criteria in the health carrier selection standards developed in compliance with this section.

4704.12 A health carrier shall notify participating providers of the provider's responsibilities with respect to the health carrier's administrative policies and programs regarding, among others: payment terms; provider directory updates; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable District or federal programs.

4704.13 A health carrier is prohibited from offering anything of value as an inducement to a provider to withhold medically necessary services, equipment, prescriptions and referrals.

4704.14 A health carrier shall not prohibit a participating provider from discussing any treatment options with covered persons, irrespective of the health carrier's position on the treatment options; or from advocating on behalf of covered persons for medically necessary treatments during the utilization review, or grievance or appeals processes, or on behalf of other persons who have contracted with the carrier while enforcing any right or remedy available under applicable District or federal law.

4704.15 A health carrier shall provide at least sixty (60) days written notice to a participating provider before the provider is removed from the network without cause.

4704.16 The health carrier shall make a good faith effort to provide written notice of a provider's removal or withdrawal from the network, within thirty (30) days of receipt or delivery of the notice, to all covered persons who have that provider as their assigned provider.

4704.17 The provisions of this chapter do not require a health carrier, its intermediaries, or the provider networks that it contracts with, to employ specific providers acting within the scope of their license or certification under District law that may meet their selection criteria; or to contract with or retain more providers acting within the scope of their license or certification under District law than are necessary to maintain a sufficient provider network under § 4702 of this chapter.

4704.18 A provider contract shall not contain provisions that conflict with the provisions contained in the network plan, or the requirements of this chapter.

4704.19 A health carrier shall inform a provider in a timely manner of the provider's network participation status on any health benefit plan in which the provider participates.

4704.20 Where a provider is terminated without cause, a carrier shall allow a covered person receiving an active course of treatment to continue treatment with that provider until the treatment is complete, or until ninety (90) days after the discontinuation's effective date, whichever is shorter, at in-network cost-sharing rates.

4704.21 If applicable, for non-emergency services, a provider contract with a facility shall include a provision regarding the written disclosure or notice to be provided to a covered person, and who shall provide such notice, at the time of authorization for services, or within ten (10) days of an appointment for in-patient or outpatient services at the facility, or at the time of a non-emergency admission at the facility, acknowledging that the facility is a participating provider of the covered person's network plan and disclosing that certain providers at the facility may not be participating providers, such as an anesthesiologist, pathologist or radiologist, but may be performing services for the covered person. The disclosure or notice shall state that the covered person may be subject to higher cost-sharing pursuant to the plan summary of benefits and coverage, including balance billing, if the covered services are performed by an out-of-network provider at a participating facility, and that information regarding how much the health plan will pay for covered services performed by out-of-network providers is available upon request. The disclosure or notice also shall inform a covered person, or their authorized representative, of the participating providers available to provide the covered services.

4705 PROVIDER DIRECTORIES

4705.1 A health carrier shall post electronically a current and accurate provider directory for each of its network plans. The directory should include at least the following information:

(a) The following identifiers for health care professionals:

(1) Name;

(2) Gender;

(3) Participating office location(s), ADA accessibility and contact information;

(4) Specialty;

(5) Facility affiliations;

(6) Languages spoken other than English; and

(7) Whether accepting new patients;

(b) The following identifiers for hospitals:

(1) Hospital name;

(2) Hospital type (*i.e.,* acute, rehabilitation, children's, cancer); and

(3) Participating hospital location, and contact information; and

(c) The following identifiers for facilities, other than hospitals, organized by type:

(1) Facility name;

(2) Facility type; and

(3) Participating facility location(s), ADA accessibility and contact information.

4705.2 The directory for individual and small group plans shall be made available to the District of Columbia Health Benefit Exchange Authority ("Exchange"), provided at regular intervals, and in a format approved by the Commissioner for use to populate the Exchange's single provider directory search tool.

4705.3 The directory available electronically for a plan on a carrier's own website shall allow the general public to view all of the current providers, except for those providers which a carrier may need to suppress, through a clearly identifiable link or tab without creating or accessing an account or entering a policy or contract number.

4705.4 Carriers shall make the directory available by mail, to covered persons or potential covered persons in hard copy upon request. The hard copy may be a print-out of all or part of the online directory sufficient to meet the needs of the requester and not a pre-printed book.

4705.5 To ensure online directory accuracy, the health carrier shall do the following:

(a) Include in its directories a customer service email address or electronic link, and telephone number, that covered persons and the general public may use to notify the carrier of inaccurate information;

(b) Maintain a log, looking back at least two years of provider directory inaccuracies reported to the carrier, and make the log available to the Commissioner upon request;

(c) Validate reports that online directories are inaccurate or incomplete, and correct flawed provider information within thirty (30) days;

(d) On a quarterly basis, for providers who have not filed a claim with a carrier in two years or more, verify, audit, and update (if necessary).

(e) Conduct, at a minimum, an annual audit of at least fifteen percent (15%) of providers in each specialty included in § 4702.5 and § 4702.6 in each of its networks, to determine whether their network status and contact information in the carrier's directory are accurate or require updates. Necessary updates shall be completed within one month of the completion of an audit; and

(f) Make it clear which products its provider directory applies to.

4705.6 A carrier who uses Council for Affordable Quality Healthcare's DirectAssure, or other similar resource approved by the Commissioner, will be deemed compliant with § 4705.5 upon submission of supporting documentation from the health carrier.

4705.7 Where a covered person receives covered services from a non-participating provider, where the online directory indicates that the provider is a participating provider at the time the services are rendered, the carrier shall reimburse the provider for the full amount of services billed, less the amount of cost-sharing as if the services were obtained from a participating provider, and the cost-sharing shall apply to the in-network deductible and out-of-pocket maximum.

4705.8 Covered persons who believe they are entitled to in-network benefits due to material error in an online directory may appeal a denial of such benefits through internal and external appeals processes.

4705.9 Both electronic and print provider directories shall include in plain language that authorization or referral may be required to access some providers and the process to obtain that authorization or referral.

4705.10 Both electronic and print provider directories shall accommodate the communication needs of individuals with disabilities and include a link to or information regarding assistance for persons with limited English proficiency.

4705.11 A printed directory shall include a disclosure that the information provided is only accurate as of the date printed, and that a more current provider directory after that date may be available and obtained at a specific electronic link, or a customer service telephone number.

4705.12 When a covered individual requests information regarding a provider directory:

(a) A carrier shall respond as soon as practicable and in no case later than 1 business day after the request for information is received; and

(b) A carrier shall retain such communication in such individual's file for at least two (2) years following such response.

4706 INTERMEDIARIES

4706.1 This section is only applicable to the extent that a health carrier, provider, or medical group uses an intermediary.

4706.2 A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

4706.3 Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of § 4705 of this chapter.

4706.4 A health carrier shall have the right to disapprove the participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits.

4706.5 A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the District of Columbia or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, and provide copies of those subcontracts to the Commissioner within twenty (20) days of receiving a request to furnish them.

4706.6 If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. A carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

4706.7 If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its

principal place of business in the District of Columbia and preserve them for seven (7) years.

4706.8 An intermediary shall allow the Commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons as necessary to determine compliance with this chapter.

4706.9 In the event of the intermediary's insolvency, a health carrier shall have the right to require that the provisions of the provider contract addressing the provider's obligation to furnish covered services be assigned to the health carrier, and the health carrier shall then be obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

4706.10 Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this chapter.

4707 FILING REQUIREMENTS FOR CARRIER – PROVIDER AND INTERMEDIARY CONTRACTS

4707.1 At the time a health carrier files its initial Access Plan or subsequently, the health carrier shall file as part of the Access Plan, with the Commissioner:

(a) Sample (template) contract forms proposed for use with its participating providers and intermediaries, excluding downstream vendor contracts.

(b) At least thirty (30) days prior to use, a health carrier shall submit any material changes to a contract that would affect a provision required under this chapter to the Commissioner through the System for Electronic Rate and Form Filing ("SERFF").

(c) A health carrier shall provide copies of provider and intermediary contracts to the Commissioner for regulatory review within twenty (20) days of receiving written notice and maintain the provider and intermediary contracts at its principal place of business, or otherwise having access to all of those contracts.

4707.2 The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services or of its responsibility for compliance with District of Columbia law or this chapter.

4707.3 All contracts between carriers and providers or facilities shall be in writing and subject to review by the Commissioner upon request.

4708 ENFORCEMENT

4708.1 The Commissioner may require a modification to the Access Plan, order an appropriate corrective action plan that shall be followed by the health carrier, or use any other enforcement powers permitted under District of Columbia law or regulation to obtain the health carrier's compliance with this chapter, if the Commissioner determines that one or more of the following has occurred:

(a) The health carrier has not contracted with a sufficient number of participating providers to ensure that covered persons will have reasonably accessible health care services in a geographic area;

(b) The health carrier's Access Plan does not ensure reasonable access to covered benefits;

(c) The health carrier's appeals process regarding coverage and billing is inaccessible or if its decisions are not in conformity with applicable law and regulations; or

(d) The health carrier has not complied with a provision of this chapter.

4708.2 The Commissioner will not arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or provider network, or regarding any other dispute between a health carrier, its intermediaries, or providers, arising under or by reason of a provider contract or the contract's termination.

4709 APPLICABILITY

4709.1 All health carriers offering or renewing network plans in the individual and small group markets in the District of Columbia shall file an Access Plan, and a Network Adequacy Report (including a Request for Waiver form, if necessary) that complies with this chapter, beginning with the 2024 plan year.

4709.2 All health carriers shall comply with the provisions in this chapter concerning notices and disclosures to consumers, including but not limited to, the requirements for timely medical appointments under §§ 4702.5(d) and 4702.6(d), and the circumstances to request covered benefits from non-participating providers under § 4702.8, for all plans sold, issued, or renewed on or after January 1, 2024.

4709.3 All provider and intermediary contracts shall comply with this chapter for all plans sold, issued, or renewed on or after January 1, 2024.

4710-4798 [RESERVED]

4799 DEFINITIONS

4799.1 For purposes of this chapter, the following terms and phrases shall have the meanings ascribed:

"Access Plan" – a document consisting of policies and procedures for assuring the ongoing sufficiency of provider networks, developed in accordance with § 4702 of this chapter.

"Active course of treatment" –

(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.

"Authorized representative" –

(a) A person to whom a covered person has given express written consent to represent the interests of the covered person;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) The covered person's treating health care professional, but only when the covered person or a family member of the covered person is unable to provide consent.

"Balance billing" – the practice of a provider billing the covered person for the difference between the provider's charge and the health carrier's allowed reimbursement rate.

"Commissioner" – the Commissioner of the Department of Insurance, Securities and Banking.

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

"Covered person" – a policyholder or other person participating in a health benefit plan.

"Emergency medical condition" – a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, would result in:

(a) Serious jeopardy to the individual's physical, mental, or behavioral health or, with respect to a pregnant woman, her unborn child's health;

(b) Serious impairment to a bodily function;

(c) Serious impairment of any bodily organ or part; or

(d) With respect to a pregnant woman who is having contractions:

(1) That there is inadequate time to affect a safe transfer to another hospital before delivery; or

(2) That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

"Emergency services" – a medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and shall include any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

"Facility" – an institution licensed pursuant to D.C. Official Code §§ 44-501 *et seq*.

"Health benefit plan" -- the same meaning as provided in D.C. Official Code § 31-3301.01(20).

"Health care professional" – a physician or other health care provider who is licensed, accredited, or certified to perform specified physical, mental, or behavioral health care services consistent with their scope of practice pursuant to D.C. Official Code §§ 3-1201 *et seq*.

"Health care provider" or "provider" – a "provider" as defined by D.C. Official Code § 31-3131(7).

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

"Health carrier" or "carrier" – a "health insurer," as defined by D.C. Official Code § 31-3131(5).

"Intermediary" – a person not employed by a carrier or by a provider but who is otherwise authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

"Limited scope dental plan" – a plan that is provided under a separate policy, certificate, or contract of insurance, or is otherwise not an integral part of a health benefit plan, which provides coverage generally limited to treatment of the mouth, including any organ or structure within the mouth.

"Limited scope vision plan" – a plan that is provided under a separate policy, certificate, or contract of insurance, or is otherwise not an integral part of a health benefit plan, which provides coverage generally limited to treatment of the eye.

"Network" – the group or groups of participating providers and facilities rendering services under a network plan.

"Network plan" – a health benefit plan that requires, or creates incentives for, a covered person to use health care providers that are under contract with, or managed, owned, or employed by the health carrier.

"Participating provider" – a provider who has contractually 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.

"Person" – 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.

"Primary care" – health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or non-physician primary care professional.

"Primary care professional" – a participating health care professional designated by the health carrier to supervise, coordinate or provide initial or continuing care to a covered person, and who may also be required by the health carrier to initiate a referral for specialty care and maintain overall supervision of the health care services rendered to the covered person.

"Specialist" – a physician or non-physician health care professional who:

(a) Focuses on a specific area of physical, mental, or behavioral health or a group of patients;

(b) Has successfully completed required training and is recognized by the state in which he or she practices as providing specialty care; and

(c) Includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

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

"Telemedicine" – health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located, in accordance with the definition of telehealth as provided in D.C. Official Code §§ 31–3861 *et seq*.

"Tiered network" – a network that allows for different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, for the same services, as a result of grouping some or all types of providers and facilities.

"To stabilize" – with respect to an emergency medical condition, to provide medical treatment of the condition as may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or with respect to an emergency birth without complications that would result in a continued emergency, to deliver the child and the placenta.

"Transfer" – the movement, including the discharge, of an individual from a hospital's facilities at the direction of any person directly or indirectly employed by, or affiliated or associated with, the hospital, but does not include the movement of an individual who:

(a) Has been declared dead; or

(b) Leaves the facility without the permission of any such person.