



ADMINISTRATIVE RULES OF MONTANA



6.6.5902 NETWORK ADEQUACY

- (1) The commissioner may determine that an insurer has an adequate network, even if the network does not meet all of the percentages for various types of providers or facilities specified in 33-22-1706(4)(c), MCA.
- (2) As used in 33-22-1706(4)(c), MCA, and this chapter, the terms "physician" and "provider" include a specialty health care provider that delivers necessary medical services.
- (3) For the purposes of determining network adequacy when the total percentage of any type of provider or facility is less than the minimum adequacy percentage set forth in 33-22-1706(4)(c), MCA, the commissioner shall review the insurer's network to determine if it is sufficient in numbers and types of providers and facilities to assure that all covered health plan services to covered persons are accessible without unreasonable delay, within a reasonable proximity, and with sufficient provider choice, based on the availability of those types of providers and facilities.
- (4) All insurers' networks must ensure that each covered person shall have adequate choice of each type of provider and facility, including but not limited to the following types:
 - (a) physicians;
 - (b) mental health and chemical dependency treatment providers;
 - (c) pharmacies;
 - (d) hospitals;
 - (e) surgi-centers; and
 - (f) residential treatment centers.
- (5) Sufficiency and adequacy of choice for each type of provider or facility must be demonstrated to the commissioner by reasonable criteria. "Reasonable criteria" may include provider to covered person ratios by specialty, primary care provider to covered person ratios, geographic accessibility, waiting times for appointments with participating providers, and the volume of specialty services available to serve the needs of covered persons requiring specialty care.
- (6) If the insurer has an absence or insufficient number or type of participating providers or facilities qualified to provide necessary specialty care for a particular covered health care service within a reasonable proximity, regardless of whether adequacy was determined by a threshold percentage or other criteria listed in (3), the insurer shall ensure that the covered person obtains the covered service from a qualified provider or facility within reasonable proximity of the covered person at no greater level of cost-sharing to the covered person than if the service were obtained from an in-network provider or facility. The requirements of this section apply only if:

- (a) the care the covered person is seeking is medically necessary; and
- (b) the insurer:
 - (i) does not have a participating provider with the training and certification required to provide the necessary health care services, including access to specialty pediatric services, within a reasonable proximity; or
 - (ii) cannot provide reasonable access to a participating provider with the necessary expertise without unreasonable delay.
- (7) The commissioner shall determine what constitutes reasonable proximity and appropriate access according to the availability of providers with the necessary expertise in that area.
- (8) When providing access to a nonparticipating provider or facility pursuant to (6), an insurer is not responsible for amounts that the nonparticipating provider may charge to the patient for a service that is above the reasonable "allowable charge," as determined under 33-15-308, MCA.
- (9) An insurer shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons.
 - (a) An insurer shall include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits, based on the relative availability of providers and the geographic barriers existing in that particular area; and
 - (b) Relative availability includes the willingness of providers or facilities in the service area to contract with the insurer under reasonable terms and conditions.
- (10) An insurer shall monitor, on an ongoing basis, the ability and capacity of its network providers and facilities to furnish health plan services to covered persons.
- (11) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to accept the rate that is negotiated with the insurer as payment in full under that contract, and the participating provider may not bill the patient for charges above that amount for medically necessary covered services.
- (12) This rule does not prohibit an insurer from using restricted networks, as long as that insurer otherwise meets the network adequacy requirements set forth in these rules. This rule does not prohibit an insurer from placing reasonable requirements on providers with whom it contracts.

Authorizing statute(s): 33-22-1707, MCA

Implementing statute(s): 33-22-1706, MCA

History: NEW, 2015 MAR p. 565, Eff. 5/15/15.