**2014-2015 Fiscal Year Work Plan Addition**
**Regulation of Health Plan Networks – For Action**
**Approved 11-14-14**

**For Action**

Goal: Achieve enhanced patient and provider protections for network adequacy of health insurance plans enacted by the 2014 HOD

Objective: Focus support specifically on protections related to transparency and quantitative standards for network adequacy of health insurance plans

Strategy: Lobby public officials at the state and national level, inform and enlist other stakeholders as needed

**Tactics:**

1. Set meeting with CMS leadership and Insurance Commissioner Salazar (completed)
2. Communicate CMS policy to members of the Colorado congressional delegation
3. Communicate CMS policy to all health plan CMOs
4. Other tactics that flow from DOI Commissioner meeting

**Background:**

The window of opportunity is a DOI study on narrow network adequacy and federal legislation. The 2014 HOD passed the following Reference Committee Report:

Resolved, that CMS supports enhanced beneficiary/provider protections related to transparency and quantitative standards for network adequacy of health insurance plans. CMS supports the following principles:

- Stronger transparency requirements including accurate provider directories; clear information about patient cost-sharing requirements for both in-network and out-of network care; public disclosure of provider selection standards; and public disclosure of insurers' network adequacy plans, without allowing information to be considered "proprietary" and off limits for the public;
- Establishment of quantitative standards for measuring network adequacy, moving away from provisions that allow insurers to refer to "any reasonable criteria" to prove network sufficiency, and encourage that quantitative standards be established that apply to all plans;

- Active regulator evaluation and approval, rather than insurer self-attestation of network adequacy and deference to accreditation;
- Incorporation of quality and other data safeguards that will ensure the integrity of data being used to evaluate physicians and other providers and protect them and their patients from network decisions based solely on cost; and
- Clear definitions and designations for “narrow,” “high quality,” “high value,” and “high performing” networks, in order to prevent patient confusion, and be it further

Resolved, that CMS opposes the disruption in an existing physician-patient relationship caused by plan changes to provider networks in the middle of a plan year. When an insurer terminates a physician’s participation agreement without cause, if both parties agree, the physician and patient should be allowed to continue the relationship for the remainder of that plan year as if the physician was still part of the network, and be it further

Resolved, that CMS convey support of these principles to the Colorado congressional delegation and encourage their support of legislation, which upholds these principles, and be it further

Resolved, that CMS engage with the Colorado Division of Insurance and other stakeholders to evaluate the adequacy of current standards for health plan networks and notification procedures when providers are dropped from those networks.