MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Managed Care Plan Network Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to establish 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 a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

Drafting Note: In states that regulate prepaid health services, this model may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to enrollees.

Section 3. Definitions

For purposes of this Act:

A. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

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. "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.

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

G. "Facility" means an institution providing health care services or a health care 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.

H. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

I. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

J. "Health care provider" or "provider" means a health care professional or a facility.

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

L. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that 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 sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

M. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

N. "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

O. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

Drafting Note: The definition of "managed care plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.

P. "Network" means the group of participating providers providing services to a managed care plan.

Q. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

R. "Participating provider" means a provider who, under a contract with the 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.

S. "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.

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

Section 4. Applicability and Scope

This Act applies to all health carriers that offer managed care plans.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a managed care plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from filing an access plan as required by Section 5. States should periodically review a health carrier's private certification and eligibility for deemed compliance.

Section 5. Network Adequacy

A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: provider-covered person ratios by specialty; primary care provider-covered person ratios; 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.

(1) In any case where the health carrier has an insufficient number or type of participating provider 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.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.

B. Beginning [insert effective date], a health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

Drafting Note: Different states will set different requirements for the access plan. This model requires a health carrier to file the plan with the insurance commissioner but does not require the commissioner to take action on the plan. Some states may want to require the commissioner's approval of access plans; other states may prefer that a health carrier not file the access plan with the commissioner but instead maintain the plan on file at the carrier's place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(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 managed care 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 and their satisfaction with services;

(6) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, 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 system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(8) The health carrier's process for enabling covered persons to change primary care professionals;

(9) 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

(10) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Section 6. Requirements for Health Carriers and Participating Providers

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

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. 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, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, 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 Subsections B and C of this section.

E. 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.

F. (1) Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or

(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(2) Paragraphs (1)(a) and (1)(b) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(3) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

G. A health carrier shall make its selection standards for participating providers available for review by the commissioner.

Drafting Note: The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law. The NAIC is considering developing such a model.

H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person.

J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

K. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

Drafting Note: In order to assure continued provider participation, a state may wish to restrict the right of a health carrier to assign or delegate its contract with a provider without prior written notice to the provider.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.

R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Act.

Section 7. Intermediaries

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

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

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

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

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

F. 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 state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. 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 Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Section 8. Filing Requirements and State Administration

A. Beginning [insert effective date], a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute or implementing regulations to the commissioner for approval [cite period of time in the form approval statute] days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.

C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 9. Contracting

A. 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, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 10. Enforcement

A. If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.

Section 11. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 12. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 13. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 14. Effective Date

This Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 767, 770-777 (adopted).

This page is intentionally left blank

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

This page is intentionally left blank

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: States that have citations identified in this column have **not** adopted the most recent version of the NAIC model in a substantially similar manner. Examples of Related State Activity include but are not limited to: An older version of the NAIC model, legislation or regulation derived from other sources such as Bulletins and Administrative Rulings.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 420-5-6-.06 (1987).
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	NO CURRENT ACTIVITY	
California	NO CURRENT ACTIVITY	
Colorado	COLO. REV. STAT. §§ 10-16-701 to 10-16-709 (1997/2013).	BULLETIN B-4.54 (2013).
Connecticut	NO CURRENT ACTIVITY	
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	
Florida		FLA. STAT. § 641.512 (1991).
Georgia		GA. COMP. R. & REGS. 120-2-80-.03 Form GID-PPA1 (1998).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Idaho	NO CURRENT ACTIVITY	
Illinois		ILL. ADMIN. CODE tit. 77, § 240.60 (1990/2010).
Indiana	NO CURRENT ACTIVITY	
Iowa	NO CURRENT ACTIVITY	
Kansas		KAN. STAT. ANN. §§ 40-4601 to 40-4626 (1997).
Kentucky	NO CURRENT ACTIVITY	
Louisiana		LA. REV. STAT. ANN. §§ 22:1019.1 to 22:1019.3 (2013).
Maine		850 ME. CODE R. §§ 1 to 10 (1997/2008).
Maryland	NO CURRENT ACTIVITY	
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota	NO CURRENT ACTIVITY	
Mississippi	19-3-16 Miss. Code R. §§ 01 to 13 (2014).	
Missouri	MO. REV. STAT. §§ 354.600 to 354.636 (1997/2001).	
Montana	MONT. CODE ANN. §§ 33-36-101 to 33-36-105 (1998/1999).	
Nebraska	NEB. REV. STAT. §§ 44-7101 to 44-7112 (1998/1999).	
Nevada	NO CURRENT ACTIVITY	
New Hampshire		N.H. REV. STAT. ANN. §§ 420-J:1 to 420-J:14 (1998/2013).

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New Jersey	N.J. ADMIN. CODE § 11:4-37.4 (1998/2013) (portions of model).	
New Mexico	NO CURRENT ACTIVITY	
New York		N.Y. INS. LAW § 4804 (1996).
North Carolina		11 N.C. ADMIN. CODE 20.0201 to 20.0205 (1996).
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma	NO CURRENT ACTIVITY	
Oregon		OR. REV. STAT. § 743.817 (1997/2001); OR. ADMIN. R. 836-053-1190 (1998/2002) (Small group).
Pennsylvania		40 PA. STAT. ANN. §§ 40-39-1201 to 40-39-1293 (1998).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS §§ 23-17.13-1 to 23-17.13-6 (1996/2003).
South Carolina	NO CURRENT ACTIVITY	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	TENN. CODE ANN. § 56-7-2356 (1998) (portions of model).	
Texas	NO CURRENT ACTIVITY	
Utah	NO CURRENT ACTIVITY	

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington		WASH. ADMIN. CODE §§ 284-43-110 to 284-43-320 (1998/2014).
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	