GOLD STANDARD

State Parity Gold Standards: Network Adequacy

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THE KENNEDY FORUM

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Contents

State Parity Gold Standards: Network Adequacy

Access to health care is determined not only by what services a health plan covers, but also whether a health plan's enrollees can realistically obtain those services from qualified providers. A health plan may cover the full set of mental health and substance use disorder (MH/SUD) services on paper, but if an enrollee cannot find a provider to deliver that care, those benefits are effectively meaningless. This failure is especially acute for MH/SUD care, where inadequate networks routinely prevent individuals from accessing timely, affordable, and clinically appropriate treatment.

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Why Network Adequacy Matters

Network adequacy standards define *minimum* expectations for whether health plans maintain a sufficient number and type of providers to ensure access to covered benefits within a reasonable:

- **Time** (appointment wait times)
- **Distance** (travel time and distance standards)
- **Availability** (providers accepting new patients)

Robust provider networks are essential for consumers to obtain accessible, timely, and affordable health care. When plans do not contract with enough providers, patients are forced to wait, travel long distances, pay higher costs for out-of-network care, or forgo care altogether.

The Problem

Inadequate MH and SUD provider networks are far more common than inadequate networks of medical and surgical providers. As a result, individuals are forced to go out-of-network to receive MH/SUD benefits much more often than they go out-of-network for medical or surgical care.[1]

While workforce shortages are real, research reveals that provider shortages alone do not explain these disparities.[2] Rather, insurer practices - including network admission standards and reimbursement methodologies - play a significant role in perpetuating inequitable access. Many of these practices are explicitly recognized as non-quantitative treatment limitations (NQTLs) that the Mental Health Parity and Addiction Equity Act (MHPAEA) prohibits from being discriminatorily designed or applied to MH/SUD benefits compared to medical and surgical benefits.[3]

Too often, regulators and plans assess network adequacy only "as written," through published provider directories, even though directory inaccuracies are another major barrier to access.[4] True compliance must also be evaluated "in operation," including the extent of these directory inaccuracies and whether enrollees can actually obtain timely appointments with in-network providers.

Core Concepts and Definitions

Network adequacy policies generally fall into two categories:

Qualitative Standards

Qualitative standards require plans to ensure "timely access" or "no unreasonable delay." While common, these standards are often vague and difficult for regulators to enforce or consumers to understand.

Quantitative Standards (Gold Standard)

Increasingly, regulators are adopting quantitative metrics that more specifically define accessibility and availability of care, including:[5]

- Travel time and distance standards
- Minimum provider counts or provider-to-enrollee ratios
- Appointment wait time standards

Geographic criteria measure whether providers are reasonably accessible, while appointment wait times measure whether care is reasonably available.

Quantitative standards are currently in used for Qualified Health Plans, Medicaid managed care, Medicare Advantage, and many state-regulated plans.

Network Adequacy and Parity

Network adequacy is explicitly identified in federal parity regulations as a plan design feature subject to MHPAEA's anti-discrimination requirements.[6]

Regulators evaluate compliance both:

- As written (network metrics, directories, standards), and
- In operation (actual provider availability, treatment access, and limitations)

Federal regulations identify network adequacy metrics - including time and distance data and data on providers accepting new patients - as key evidence for evaluating parity compliance in operation.[7]

Plans may violate parity if they adopt more restrictive processes, strategies, evidentiary standards, or other factors in building and maintaining MH/SUD networks, or in setting reimbursement rates, compared to medical/surgical networks. As the Departments of Labor, HHS, and Treasury have emphasized,[8] evaluating NQTLs related to network adequacy is essential to ensuring comparable approaches to designing MH/SUD and medical/surgical provider networks.

Quantitative network adequacy standards therefore serve three critical purposes:

- Helping plans meet parity obligations,
- Providing regulators with enforceable benchmarks for oversight, and
- Ensuring access to and availability of providers who can deliver the benefits to which plan participants are entitled.

Existing Federal Requirements

All federally regulated insurance markets include some network adequacy requirements.

Qualified Health Plans (QHPs)[9]

QHP issuers on the federal exchange must maintain a network sufficient in number and types of providers, including MH/SUD specialists, to ensure services are accessible without unreasonable delay. Compliance is demonstrated through required time/distance standards and appointment wait time standards.[10]

State Exchanges must adopt standards at least as stringent as federal QHP standards and review issuer compliance prior to certification.[11]

Medicaid Managed Care

Federal Medicaid regulations require routine behavioral health appointment wait times be no longer than 10 business days, and primary care wait times be no longer than 15 business days.[12] States must develop network adequacy standards that consider a number of elements, including "The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services," "The numbers of network providers who are not accepting new Medicaid patients," and "The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees" when setting their standards.[13]

Medicare Advantage

Medicare Advantage plans have time and distance standards by county type and must ensure for primary care and behavioral health care:[14]

- Immediate access for urgent/emergency care
- Access within 7 business days for non-urgent needs
- Access within 30 business days for routine care

However, these standards are notably weaker than QHP standards and should not serve as a ceiling for state policy, especially because these plans are not subject to parity protections.

STATE GOLD STANDARDS

Time and Distance Standards: Maryland

Maryland has some of the most specific travel time and distance standards in the country. Importantly, it **disaggregates provider categories** to prevent masking of gaps. Maryland **differentiates by specialty** (child psychiatry, geriatric psychiatry, opioid treatment providers, residential crisis services), ensuring networks are adequate across the full continuum of MH and SUD care.[15] Broad categories like "outpatient behavioral health" collapse conditions that cannot be treated by the same providers and can allow plans to meet standards without contracting with necessary SUD or specialty providers.

*Maryland's standards by provider type are included in **Appendix I**.*

Appointment Wait-Time Standards: Maryland, New York, and California

Maryland **separates MH and SUD wait time standards** and further aligns them to urgency levels,[16] ensuring that network inadequacies for one condition are not masked by the other. Maryland's standards ensure carriers maintain adequate and available networks *for each condition.*

*Maryland's waiting time standards for MH and SUD are included in **Appendix II**.*

New York provides another gold standard. Its regulations **require plans to ensure adequate behavioral health capacity across the full continuum**, including residential sub-acute care, assertive community treatment, critical time intervention, and mobile crisis services.[17]

New York also **separates out facility-affiliated providers from independent providers**, and has a shorter standard to ensure that appropriate follow-up care is received following a discharge from a hospital or emergency department visit.[18]

New York also safeguards in-person access by allowing telehealth to meet wait time standards only unless the patient specifically requests an in-person appointment.[19]

New York's Appointment Time Standards:

- 10 business days for outpatient facility/clinic behavioral health appointment.
- 10 business days for independent behavioral health provider appointment.
- 7 calendar days post-discharge follow-up.

*See **Appendix III** for language detailing New York's standards.*

California law added another important protection, which **requires that health plans do not solely meet appointment wait time standards for an initial appointment but also maintain access to follow-up care during an ongoing course of treatment**. Specifically, California requires non-physician follow-up appointments for MH/SUD care be available within 10 business days of the prior appointment.

*See **Appendix IV** for California's follow-up appointment standards.*

Affirmative Duty to Secure In-Network Care: California

California provides one of the strongest consumer-centered network adequacy remedies in the country by requiring health plans not only to maintain adequate networks on paper, but to take affirmative responsibility for ensuring that enrollees can actually access medically necessary MH/SUD treatment.

If a plan cannot provide timely in-network MH/SUD services within applicable geographic and appointment wait-time standards, the plan must arrange for out-of-network care at in-network cost-sharing levels. This "finding and securing" requirement is critical because it shifts the burden away from patients and places responsibility on the insurer to deliver meaningful access in operation, not just as written.

*California's standards are included in **Appendix V**.*

Reporting Requirements: Maryland

Strong metrics are not sufficient without enforcement. Maryland **requires carriers to submit annual Network Adequacy Access Plans demonstrating compliance**, [20] including data on:

- Out-of-network usage and referrals
- Consumer complaints regarding access and availability
- Quantitative compliance information

Public transparency is essential. Maryland requires executive summaries of access plans to be posted online, enabling advocates and consumers to meaningfully evaluate network adequacy. For example, Maryland regulations **require carriers to submit a standardized Network Adequacy Access Plan Executive Summary Form as part of their annual reports**,[21] which are all made available on the Maryland Insurance Administration's website for the public.[22]

Secret Shopper Surveys

Secret shopper surveys are the most effective tool for evaluating actual access, validating directory accuracy, and enforcing appointment wait time compliance.[23] The U.S. Department of Labor has used secret shopper surveys to assess for Parity Act compliance by comparing rates of availability for MH/SUD to medical/surgical providers.[24] Federal regulators now require QHP issuers to contract with third-party entities to administer secret shopper surveys,[25] paralleling Medicaid managed care requirements.[26]

The gold standard for regular auditing is to adopt a comparable requirement for state-regulated health plans to contract with third-party entities to administer secret shopper surveys, both for compliance with appointment wait time standards as well as for assessing – and resolving – provider directory inaccuracies.

States should:

- Adopt comparable third-party audit requirements to validate directory accuracy
- Require third-party secret shoppers for appointment wait times
- Trigger penalties, corrective action, and reimbursement obligations when plans fall short

Model secret shopper legislation is included in ***Appendix VI****,* though state regulators can adopt this approach without legislation, just as the federal government did for QHPs on the Federally-facilitated Exchange.

When Networks Fail: The Need for Consumer Protections

Consumers should not pay more when network inadequacy forces them out-of-network. Balance billing prohibitions ensure that health plans - not families - bear responsibility for insufficient networks. The National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act recommends balance billing protections when health plans are unable to meet their enrollees' needs without unreasonable travel or delay,[27] and most states have adopted similar standards.

However, the strongest consumer protection frameworks go beyond a general prohibition and establish clear, enforceable remedies for when networks fail in practice. Gold standard states pair balance billing safeguards with concrete obligations on health plans - such as step-by-step access complaint processes, automatic approval of out-of-network referrals at in-network cost-sharing, and reimbursement for the travel burdens that inadequate networks impose on rural families.

Enforceable Access Complaint and Referral Process: New York

New York provides one of the clearest and most consumer-protective models for what must happen when a plan's behavioral health network is inadequate in operation. Rather than leaving consumers to navigate directory inaccuracies or repeated denials on their own, New York regulations establish **a step-by-step access complaint process[28]** that triggers specific, enforceable obligations for health plans.

Under this framework, if an insured cannot schedule an appointment with an in-network behavioral health provider within the required appointment wait times, the consumer (or their designee) may **file an access complaint** directly with the health plan. Once the complaint is received, **the plan has three business days to locate an appropriate participating provider** who can both treat the individual's condition and meet the applicable timeliness standards. If the consumer specifically requests an in-person appointment, the **plan must ensure the provider is located within a reasonable distance**, with allowances for rural access realities.

Critically, **if the plan is unable to identify an in-network provider who can meet these requirements, New York mandates automatic approval of a referral to an out-of-network provider at in-network cost-sharing levels**, regardless of whether the individual's coverage otherwise includes out-of-network benefits. These protections remain in effect until either services are no longer medically necessary or the plan is able to transition the individual safely to an in-network provider without clinical harm.

By combining a transparent complaint pathway, strict plan response timelines, and extended continuity protections, New York ensures that network adequacy failures do not translate into delayed treatment, unaffordable costs, or disrupted care. This model represents a gold standard for making consumer remedies real, not merely theoretical.

New York's standards are included in **Appendix VII**.

Balance Billing Protections Plus Travel Reimbursement: Mississippi

Mississippi offers a particularly important gold standard for consumer protections in states where geography and rural provider scarcity create unavoidable access barriers. In addition to requiring that managed care plans maintain networks sufficient to ensure covered services are accessible without unreasonable delay, Mississippi regulations[29] explicitly address what must occur when network adequacy standards cannot be met.

When a health carrier lacks an adequate number or type of participating providers to furnish a covered benefit consistent with geographic access standards, **the plan must ensure that the enrollee can obtain the service at no greater cost than if it were received in-network**. In other words, consumers cannot be financially penalized through higher out-of-network cost-sharing when the plan's network is insufficient, as the NAIC model recommends.

Mississippi goes further by recognizing that, in rural areas, inadequate networks often impose not only higher provider charges but also substantial travel burdens. Accordingly, **if an enrollee must travel more than 100 miles one way** (or beyond the prescribed distance standard) to access medically necessary covered care, **the health plan must provide reimbursement for food, lodging, and travel expenses, including mileage** at the IRS standard rate. These reimbursement obligations are capped at $10,000 per member per year, ensuring meaningful support while maintaining clear parameters for enforcement.

These protections are particularly critical for rural access equity, where long-distance travel is often the difference between receiving timely behavioral health treatment and going without care altogether. Mississippi's model demonstrates how states can pair balance billing safeguards with practical remedies that make families whole when geographic access standards fail in operation.

Mississippi's standards are included in ***Appendix VIII****.*

Conclusion: What States Should Do to Achieve Network Adequacy

Network adequacy is only meaningful if it ensures real access to mental health and substance use disorder care in operation - not merely on paper. Research consistently shows that MH/SUD networks remain less adequate than medical/surgical networks, and that strong standards must be paired with enforcement and consumer remedies.

State policymakers and regulators have clear tools available to close these gaps. The gold standard approach requires action across three core areas: metrics, oversight, and consumer protections.

Key Levers for States

1. Adopt Clear, Quantitative Network Adequacy Standards

States should establish specific, enforceable metrics that define minimum access expectations, including:

- **Time and distance standards** that reflect meaningful geographic accessibility
- **Appointment wait-time standards** that ensure timely care
- **Provider-type and specialty breakouts** (e.g., separating MH from SUD, child psychiatry, OTPs) to prevent masking of gaps
- **Disaggregated standards** that apply across the full continuum of behavioral health services

2. Strengthen Oversight and Enforcement Mechanisms

Network adequacy standards are insufficient without continuous monitoring and accountability. States should require:

- **Annual access and compliance reporting** submitted to regulators
- **Public transparency**, including executive summaries that consumers and advocates can evaluate

- **Third-party secret shopper audits** to validate directory accuracy and real appointment availability
- **Meaningful penalties and corrective action plans** when plans fail to meet standards
- **Reimbursement obligations** for out-of-network claims when inadequacy forces consumers outside the network

3. Ensure Strong Consumer Protections When Networks Fail

States must ensure that consumers are made whole when plans do not provide adequate access. Key protections include:

- **Balance billing prohibitions** when enrollees are forced out-of-network due to insufficient networks
- **Clear access complaint processes** with enforceable plan response obligations
- **Automatic approval of out-of-network referrals at in-network cost-sharing** when timely care cannot be located
- **Continuity of care protections** until transition to an in-network provider is clinically appropriate
- **Travel reimbursement requirements** in rural areas, including coverage of mileage, lodging, and meals when long-distance travel is unavoidable

Guiding Principles for Gold Standard State Policy

Gold standard network adequacy frameworks share several core principles:

- **Specificity over generality**: Standards must be quantitative, disaggregated, and clinically meaningful
- **Access in operation, not just on paper**: Oversight must measure real appointment availability, not directory listings alone
- **Continuous enforcement, not one-time certification**: Compliance requires ongoing reporting, auditing, and corrective action
- **Meaningful remedies when plans fall short**: Consumers should never bear higher costs or delays because of insurer network failures

- **Equity-centered protections**: Rural residents and underserved communities must be protected against geographic and systemic access barriers

Closing Note

Network adequacy sits at the intersection of coverage, enforcement, and real-world access. When provider networks are thin, inaccurate, or poorly monitored, patients experience the gap between what is promised in an insurance contract and what is actually available in their communities. This disconnect is especially pronounced for mental health and substance use disorder care, where inadequate networks continue to undermine timely treatment and equitable outcomes.

Closing these gaps will require sustained state leadership to ensure that behavioral health coverage translates into meaningful access for every enrollee, in every region, when care is needed most.

APPENDIX

I. Time and Distance Standards: Maryland

COMAR § 31.10.44.05(A)(5)

Provider	Urban Maximum Distance (miles)	Suburban Maximum Distance (miles)	Rural Maximum Distance (miles)
Addiction Medicine	10	25	60
Applied Behavioral Analyst	15	30	75
Licensed Clinical Social Worker	10	25	60
Licensed Professional Counselor	10	25	60
Psychiatry-Adolescent and Child, Outpatient	10	25	60
Psychiatry-Geriatric, Outpatient	10	25	60
Psychiatry-Outpatient	10	25	60
Psychology	10	25	60
Inpatient Psychiatric Facility	15	45	75
Opioid Treatment Services Provider	15	25	60
Outpatient Mental Health Clinic	15	30	60
Outpatient Substance Use Disorder Facility	15	30	60
Residential Crisis Services	10	30	60
Substance Use Disorder Residential Treatment Facility	10	25	60

II. Appointment Wait Time Standards: Maryland

COMAR § 31.10.44.06(E)

Waiting Time Standards	
Urgent care for medical services	72 hours
Inpatient urgent care for mental health services	72 hours
Inpatient urgent care for substance use disorder services	72 hours
Outpatient urgent care for mental health services	72 hours
Routine primary care	15 calendar days
Preventitive care/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent mental health care	10 calendar days
Non-urgent substance use disorder care	10 calendar days

III. Appointment Wait Time Standards: New York

11 NYCRR § 38.4

(a) A health care plan shall ensure that its network has adequate capacity and availability of health care providers of behavioral health services to offer insureds appointments with providers that can treat insureds' behavioral health conditions within:

(1) ten business days for an initial appointment with an outpatient facility or clinic;

(2) ten business days for an initial appointment with a health care professional who is not employed by or contracted with an outpatient facility or clinic; and

(3) seven calendar days for an appointment following a discharge from a hospital or an emergency room visit.

(b) A health care plan may meet the appointment wait times set forth in subdivision (a) of this section through the use of telehealth unless the insured specifically requests an in-person appointment to treat the insured's behavioral health condition.

IV. Follow-up Appointment Standards: California

California Health & Safety Code §1367.03(a)(5)(F)

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in [paragraph (1)], a health care service plan shall ensure that its network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

…

(F) Commencing [July 1, 2022], nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H). This subparagraph does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

V. Affirmative Duty to Secure In-Network Care: California

California Health & Safety Code §1374.72

(a) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services … To "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

VI. Model Secret Shopper Survey Legislation

I. Beginning [DATE], all health carriers offering commercial health insurance coverage in this state shall implement network access compliance protocols consistent with the secret shopper audit requirements established by the Centers for Medicare & Medicaid Services (CMS) for Qualified Health Plan issuers in the "2025 Final Letter to Issuers in the Federally-facilitated Exchanges," published on April 10, 2024 and the technical guidance outlined in CMS's "Appointment Wait Time Secret Shopper

Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs)," published in April of 2024.

II. *The purpose of such audits shall be to assess and validate carrier compliance with the appointment wait time standards and provider accessibility requirements set forth in [STATUTE OR REGULATIONS].*

III. *Each carrier shall contract with an independent third-party entity to conduct annual secret shopper surveys. The surveys shall:*

   (a) *Include behavioral health and primary care providers, with specialty care providers added if directed by CMS in future guidance;*

   (b) *Follow CMS's technical guidance published in 2024 for survey timing, methodology, and reporting formats;*

   (c) *Be completed no later than April 30 of each calendar year and submitted to the [STATE DEPARTMENT OF INSURANCE] by May 31.*

IV. *The [STATE DEPARTMENT OF INSURANCE] shall adopt rules to implement this section, including:*

   (a) *Procedures for carrier reporting and data submission; and*

   (b) *Public transparency requirements for survey results.*

V. *Enforcement and Remedial Actions.*

   (a) *The [STATE DEPARTMENT OF INSURNACE] may impose civil monetary penalties on any health carrier that:*

      i) *Fails to submit a complete secret shopper audit report;*

      ii) *Submits a report in which fewer than 80 percent of contacted provider listings are confirmed to be in-network and accepting appointments; or*

      iii) *Is found to be noncompliant with network adequacy standards under [REGULATION OR STATUTE] and corresponding rules.*

   (b) *In addition to any penalties imposed under subparagraph (a), a health carrier shall reimburse all out-of-network claims incurred by enrollees for the provider type(s) for which the carrier:*

      i) *Failed to submit complete audit data;*

ii) Fell below the accuracy threshold described in subparagraph (a)(ii); or

iii) Did not meet applicable network adequacy standards during the preceding calendar year.

(a) The [STATE DEPARTMENT OF INSURNACE] shall require any noncompliant carrier to enter into a corrective action plan, signed by both the Department and the carrier, specifying the deficiencies, required remedial actions, and a timeline for achieving compliance with audit reporting and network adequacy standards.

VII. Enforceable Access Complaint and Referral Process: New York

11 NYCRR § 38.5

(a) If an insured is unable to schedule an appointment with a participating provider of behavioral health services within the appointment wait times set forth in section 38.4 of this Part because there is not a participating provider of behavioral health services available within the appointment wait times who can treat the insured's behavioral health condition, the insured, or the insured's designee, may submit an access complaint by telephone or in writing to the health care plan to resolve the access issue.

(b) The health care plan shall have three business days from receipt of the access complaint to locate a participating provider of behavioral health services that can treat the insured's behavioral health condition and is able to meet the appointment wait times set forth in section 38.4 of this Part and to give the insured or the insured's designee the name of and contact information for the provider or providers by telephone, if the request was made by telephone, and in writing. If the insured specifically requests an in-person appointment, the provider shall be located within a reasonable distance from the insured; however, the distance may be greater for insureds who reside in rural areas than for insureds who do not reside in rural areas.

(c) If the health care plan is unable to locate a participating provider of behavioral health services that can treat the insured's behavioral health condition, is able to meet the appointment wait times set forth in section 38.4 of this Part, and is located within a reasonable distance from the insured if the insured specifically requests an inperson appointment, the health care plan shall:

(1) notify the insured by telephone, if the request was made by telephone, and in writing, at the expiration of the time period in subdivision (b) of this section that the insured may obtain a referral to a non-participating provider at the in-

network cost-sharing and include contact information for the New York State Behavioral Health Ombudsman Program; and

(2) approve a referral to a non-participating provider, regardless of whether the insured's coverage includes out-of-network benefits, if the non-participating provider:

(i) can treat the insured's behavioral health condition;

(ii) is able to meet the appointment wait times set forth in section 38.4 of this Part, as measured from the insured's receipt of the notification in paragraph (1) of this subdivision;

(iii) is located within a reasonable distance from the insured if the insured specifically requests an in person appointment; and

(iv) charges rates that are not excessive or unreasonable.

(d) The approved referral shall remain in effect until the earlier of the following:

(1) the behavioral health services are no longer medically necessary; or

(2) the health care plan locates a participating provider of behavioral health services that can treat the insured's behavioral health condition, is able to meet the appointment wait times set forth in section 38.4 of this Part and is located within a reasonable distance from the insured if the insured specifically requests an in-person appointment, and the insured's treatment can be transitioned to the participating provider, unless the health care plan determines, in consultation with the insured's treating provider, as appropriate, that such transition would be harmful to the insured. If the insured or the insured's designee disagrees with the health care plan's transition of care determination, the insured or the insured's designee may request an expedited determination or appeal pursuant to Insurance Law section 4802 or 4904, as applicable.

(e) The health care plan shall not impose cost-sharing on the insured, including a copayment, coinsurance, or deductible, for the service rendered by a non-participating provider pursuant to an approved referral, that is greater than the cost-sharing that the insured would owe if the insured had received services from a participating provider. The health care plan shall apply the out-of-pocket maximum that would have applied had the services been received from a participating provider.

VIII. Balance Billing Protections Plus Travel Reimbursement: Mississippi

19 Miss. Code R. 3-14.05

A. *A health earner providing a managed care plan shall maintain a network that is sufficient in numbers and types of participating providers to ensure that all covered services to covered persons will be accessible without unreasonable delay. In the case of emergency facility services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.*

B. *The sufficiency of health carriers" networks shall be measured by the network adequacy standards outlined in 45 C.F.R. § 156.230(a)(2)(i) and associated guidance published by the Centers for Medicare and Medicaid Services.*

C. *In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit to a covered person consistent with the geographic access standards set forth in Rule 14.05(B). 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/facilities, and additionally, if the covered persons must travel more than one hundred (100) miles one way or more than the distance standard prescribed by this regulation, whichever is greater, to obtain the aforementioned covered benefit, the health carrier shall provide such persons reasonable round trip reimbursement for their food, lodging and travel. Reimbursement for food and lodging shall be at the prevailing federal per diem rates, then in effect, as set by the U.S. General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses. The health carrier's regulatory obligation in this Subsection C to provide such reimbursement shall not exceed $10,000.00 per covered person in any applicable policy year.*

Resources

1 Tami L. Mark & William Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," RTI International (Apr. 17, 2024), **https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf**.

2 Id. at 9.

3 42 U.S.C. § 300gg-26(a)(7)(C)(ii).

4 Tami L. Mark & William Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," at 13-15.

5 45 C.F.R. § 146.136(c)(4)(iii)(A)(2). The other data elements for evaluating network composition include, but are not limited to, in-network and out-of-network utilization rates (including data related to provider claim submissions) and provider reimbursement rates (for comparable services and as benchmarked to a reference standard). For more information and recommendations, see the "Data Collection, Evaluation, and Reporting" Gold Standards: **https://www.thekennedyforum.org/resource/data-collection-evaluation-and-reporting/**.

6 45 C.F.R. § 146.136(c)(4)(ii)(D) ("Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage").

7 45 C.F.R. § 146.136(c)(4)(iii)(A)(2).

8 U.S. Departments of Labor, Health & Human Services, and Treasury, "2024 MHPAEA Report to Congress" 21 (Jan. 17, 2025), **https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf**.

9 45 C.F.R. § 156.230(a)(2)(i); Centers for Medicare & Medicaid Services, "Qualified Health Plan Issuer Application Instructions: Plan Year 2026" E-2 – E-3 (Updated 2025), available for download at **https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Network-Adequacy**. These standards have remained the same since they were initially developed in 2022. See Centers for Medicare & Medicaid Services, "2023 Final Letter to Issuers in the Federally-facilitated Exchanges" 13 (Apr. 28, 2022), **https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf**.

10 45 C.F.R. § 156.230(a)(1).

11 45 C.F.R. § 155.1050(a)(2)(i) ("State Exchanges and State-based Exchanges on the Federal platform must: (A) Establish and impose network adequacy time and distance standards that are at least as stringent as standards for QHPs participating on the Federally-facilitated Exchanges"). Note: CMS has recently proposed removing this requirement for calendar year 2027 and beyond and returning to qualitative standards.

12 42 C.F.R. §§ 438.68(e), 457.1218.

13 42 C.F.R. §§ 438.68(c)(1)(iv) – (vi).

14 42 C.F.R. § 422.112(a)(6).

15 COMAR § 31.10.44.05(A)(5).

16 COMAR § 31.10.44.06(E).

17 11 NYCRR § 38.3

18 11 NYCRR § 38.4(a).

19 11 NYCRR § 38.4(b).

20 COMAR § 31.10.44.04.

21 COMAR § 31.10.44.11.

22 "Network Adequacy Regulations Information," Maryland Insurance Administration, **https://insurance.maryland.gov/Consumer/pages/network-adequacy-regulations-information.aspx**.

23 Tami L. Mark & William Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," at 10, 13-15.

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