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Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Request for Information Regarding State Flexibility To Establish a Basic Health Program Under the Affordable Care Act (CMS-9980-NC)

Dear Administrator Berwick:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) request for information regarding State flexibility to establish a Basic Health Program under the Patient Protection and Affordable Care Act (ACA). The Basic Health Program offers States an alternative option to provide coverage to low-income individuals who do not qualify for Medicaid (i.e., for those with family incomes up to 200 percent of the Federal Poverty Level). We have long advocated that States be given the freedom to develop and test different models for improving coverage for patients with low incomes, and believe the flexibility granted to States to establish a Basic Health Program provides another mechanism to do so.

In establishing a Basic Health Program, it is essential that patient choice of health plan and physician be preserved. As the population eligible for the Basic Health Program would otherwise receive premium tax credits to purchase health insurance of their choosing on a State health insurance exchange (Exchange), States must ensure that the intent of Section 1331(c)(3) of the ACA is carried out by offering multiple standard health plans under the Basic Health Program to guarantee ample health plan choice. These plans need to offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region, as well as provide sufficient payment rates established through meaningful negotiations and contracts.

One of the issues in moving forward with State creation of a Basic Health Program is the effect it will have on the size and strength of the risk pool of the Exchange. Establishing a Basic Health Program will clearly translate into fewer individuals seeking coverage in the Exchange. The population eligible for the Basic Health Program is projected to be younger and incur lower health care costs per capita, e.g., a key population that would otherwise help to balance out the risk in the Exchange. States need to work to implement mechanisms to ensure that this does not threaten the long-term viability of Exchanges.

The AMA has reviewed the questions posed by CMS and identified the ones about which we feel that we have valuable information to offer. We hope that CMS finds the information useful, and we look forward to a continued dialogue on these issues.

Question A(1)—General Provisions

What are some of the major factors that States are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the State and/or consumer that would make this option more or less attractive to States? If so, what are they?

AMA Response

The Basic Health Program could serve as an alternative model that States could use to improve the access to and affordability of coverage for eligible individuals with household incomes that exceed 133 percent but do not exceed 200 percent of the Federal Poverty Level. For States that choose this option, the AMA believes that it is absolutely imperative to ensure that health plan choices are maximized for individuals and families seeking coverage under a Basic Health Program. Standard health plans offered within a Basic Health Program should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features. This is especially important as there may be discontent among some State residents who would favor receiving premium tax credits and cost-sharing subsidies to purchase coverage on Exchanges rather than being limited to the coverage options offered in the Basic Health Program.

A main challenge in establishing a Basic Health Program is the inherent complexity of adding another tier of health insurance coverage in the implementation of the ACA. With Exchanges becoming operational in 2014, as well as the Medicaid expansion, establishing another tier of coverage that may operate as yet another stand-alone program will require additional outreach to and education of stakeholders, including physicians and their patients. For physicians, the establishment of a Basic Health Program in their State requires additional knowledge about the Program and will lead to decisions regarding whether to enter into meaningful negotiations and contracts with the standard health plans offered under the Program.

Question A(6)—General Provisions

What guidance or information would be helpful to States, plans, and other stakeholders as they begin the planning process? What other terms or provisions need additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

AMA Response

Successful implementation will depend on providing adequate information to patients and physicians. CMS and the States should include reasonable timelines, where possible, for the planning and implementation of Basic Health Programs. The entities planning the Basic Health Programs in the States should provide patients and physicians with adequate information and support to keep them as informed and prepared as possible for when the Program becomes operational. The population eligible for the Basic Health Program will need significant education about their health plan options and what their best choices are. Outreach and educational efforts will need to be targeted in nature in order to be successful in reaching out to racial and ethnic minorities, as well as individuals with limited English proficiency, and in assuring their enrollment in the appropriate standard health plan.

In addition, the process to establish and implement a Basic Health Program needs to include educating physicians, other health care providers, and physician and provider staff to ensure a smooth transition for when the Program becomes operational. We recommend that the Basic Health Programs or their planning entities keep these groups informed as they move forward and that they focus on how to minimize the transitional issues that could interrupt continuity of care for patients.

Question B(1)—Standard Health Plan Standards and Standard Health Plan Offerors

What additional standards, if any, should standard health plans participating in a State's Basic Health Program meet? What consumer protections should be included? How should quality and performance be measured?

AMA Response

Overall, the AMA urges that standard health plans offered in Basic Health Programs: (1) be self-supporting; (2) have uniform solvency requirements; (3) include payment rates established through meaningful negotiations and contracts; (4) not require provider participation; and (5) not restrict enrollees' access to out-of-network physicians.

The AMA recommends that standard health plans offered in Basic Health Programs, as well as qualified health plans (QHPs) in the Exchanges, be required to meet a higher threshold than the baseline requirements that the ACA requires. We have urged States to consider requiring QHPs to follow the AMA Health Insurer Code of Conduct Principles (the Code).

The Code focuses on some of the most egregious health insurance issuer abuses and provides ways to correct them. The Code calls on health insurance companies to adopt consistent corporate practices that will bring transparency and accountability to the multibillion-dollar health insurance industry. Developed by the AMA and endorsed by 68 State and specialty medical societies, the Code contains 10 clear principles critical to an efficient, patient-centered health care system. The principles shine light on health insurance issuer practices that influence the health care of patients, including cancellation of coverage, medical services spending, access to care, fair contracting, patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity, and claims processing.

Standard health plans should be required to follow all patient consumer protection laws in the State in which they are offered, such as grievance and appeals procedures, rating and underwriting rules, unfair trade practices, transparency and fair claims payment requirements, market conduct, network adequacy and transparency, and fraud. Also, such plans should be required to follow all State health care provider protection laws, such as prompt payment of claims, transparency and fair claims payment requirements, fair contracting, unfair trade practices, market conduct, network adequacy and transparency, and fraud.

In the arena of quality, we believe it is critical that States guard against cost containment mechanisms which are euphemistically termed "quality measures." The AMA defines quality of care as the degree to which care services influence the probability of optimal patient outcomes. The AMA believes that the following non-inclusive criteria for measuring health insurance issuers should be considered in evaluating a standard health plan's ability to meet that definition for quality:

- Practicing physicians, physician organizations, and consumers are involved in the development, evaluation, and refinement of the program measures (e.g., AMA Physician Consortium for Performance Improvement (PCPI) physician measures).[1]
- The measures are representative of the full range of services typically provided by health insurance issuers, including preventive services.
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers.

[1] The PCPI is a national, physician-led initiative dedicated to improving patient health and safety by: (1) identifying and developing evidence-based clinical performance measures and measurement resources that enhance quality of patient care and foster accountability; (2) promoting the implementation of effective and relevant clinical performance improvement activities; and (3) advancing the science of clinical performance measurement and improvement. The PCPI develops, tests, implements, and disseminates evidence-based measures that reflect the best practices and best interests of medicine.

- An analysis of health insurance issuer performance data collection and methodologies, including establishment of statistically significant sample sizes for areas being measured, is developed.
- Performance data used to compare performance among health insurance issuers is adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, occupation, and socioeconomic status.
- Self-reported health insurance issuer performance data are verified through external audits.
- The methods and measures used to evaluate health insurance issuer performance are disclosed to health insurance issuers, physicians and other health care providers, and the public.
- Health insurance issuers being evaluated are provided with an adequate opportunity to review and respond to proposed health insurance issuer performance data interpretations and disclosures prior to their publication or release.
- Effective safeguards to protect against the unauthorized use or disclosure of health insurance issuer performance data are developed.
- The validity and reliability of health insurance issuer performance measures are evaluated regularly.
- Health insurance issuers do not have requirements that permit third party interference in the patient-physician relationship.
- Health insurance issuers do not sponsor tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.
- Health insurance issuers provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
- Health insurance issuer benefits are designed with input from patients and actively practicing physicians.
- Treatment decisions are driven by the patient and physician.

The administrative burden of managing multiple sets of measures can have an overwhelming effect on physician practices and will greatly discourage physician participation in the Basic Health Program, QHPs, and multi-State plan networks. For more information, see the Integrated Healthcare Association (IHA) Web site (www.iha.org), which provides complete background on this issue.

The AMA recognizes the importance of ensuring that the data result in accurate evaluations of the plans. At the same time, there are concerns over the administrative burden that these evaluations may cause the health insurance issuers as well as the physicians, hospitals, and other providers which generate the data upon which these evaluations are based. Physician practices are already inundated with excessive administrative burdens, including providing chart data for Recovery Audit Contracts (RAC) audits and to Medicare Advantage plans seeking to increase their severity of illness scores. To help mitigate these burdens, the AMA recommends that States eliminate or severely limit the ability of issuers of standard health

plans to request additional chart audits from physician practices in an attempt to favorably affect their evaluation scores.

Question B(3)—Standard Health Plan Standards and Standard Health Plan Offerors

What is the expected impact of standard health plans on provider payments and consumer access?

AMA Response

A critical attribute of health care coverage is the network of contracted physicians and other health care providers, e.g., the "provider network," who have contracted to "participate" by agreeing to abide by the network's rules and accept a specified discount off their retail charges. Because, for financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access, a provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives patients of the benefit of the money they have paid for health care coverage.

Inadequate provider networks also undermine the public health and welfare by forcing patients to reduce utilization of appropriate preventive services and to fail to obtain necessary medical care, which in turn lead to reduced productivity and increased work absenteeism, unnecessary illness, and increased emergency department utilization. To assess the appropriateness of a provider network before selecting a particular standard health plan, patients must have all the information relevant to the medical needs of themselves and their families, including whether their physicians and preferred hospitals are in or out-of-network, whether these physicians and hospitals are still accepting new patients, and what the likely wait-time is for an appointment. Patients continue to need access to a robust, up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change. An important component of an up-to-date provider directory includes ensuring patients know the education and training of the physicians and other health care professionals within the network. This can be easily accomplished by including the full title of the relevant licensure description of the provider (e.g., medical doctor, nurse practitioner, physical therapist, etc.).

To ensure an adequate provider network, the AMA calls for the certification by the State department of insurance of the plan's provider network. HHS and the States should establish a similar procedure for standard health plans in Basic Health Programs. The AMA has prepared the "Meaningful Access to Physicians and other Health Care Providers: Network Standards Act" to assist States in developing a thorough certification process; a copy of the model bill is included with this letter (Attachment 1). The model bill calls on plans to disclose the geographic and population capacity of the provider network. The provider network certification should be awarded only to the extent that the provider network offers

all enrollees of a health plan product timely access to physicians and other health care providers and to all the medical care that they need on an in-network basis, including but not limited to, access to emergency services twenty-four hours a day, seven days per week. This is especially essential in the arena of the Basic Health Program, as issuers seeking to contract with States to offer standard health plans may also offer similar, or the same, plans in the Exchanges and/or State Medicaid programs. This model bill should be helpful to CMS and the States as they consider network adequacy as part of the standard health plan certification process.

To maintain adequate provider networks and access for patients to physician services in standard health plans, reasonable physician payment levels need to be assured. These payment rates should be established through meaningful negotiations and contracts. Physicians should also receive fair compensation for administrative costs when providing service to patients enrolled in standard health plans offered in the Basic Health Programs. The AMA opposes requiring provider participation in standard health plans offered in State Basic Health Programs, and it should not be used as a strategy to build adequate provider networks.

Question C(2)—Contracting Process

What considerations exist in determining whether to utilize the regional compact authority in Section 1331(c)(3)(B) of the Affordable Care Act? Are States interested in pursuing this approach?

AMA Response

Section 1331(c)(3)(B) of the ACA provides that a State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans. The AMA believes that issuers of standard health plans participating in such regional compacts should be required to follow patient consumer protection laws in the State where the patient resides (such as grievance and appeals procedures, rating and underwriting rules, unfair trade practices, transparency and fair claims payment requirements, market conduct, network adequacy and transparency, and fraud) and health care provider protection laws (such as prompt payment of claims, transparency and fair claims payment requirements, fair contracting, unfair trade practices, market conduct, network adequacy and transparency, and fraud). Further, a State should retain responsibility for enforcement of the patient and provider protections of its residents, and should also retain authority to enforce its laws and regulations relating to provider prompt payment of claims, fair claims payment requirements, market conduct, unfair trade practices, network adequacy, consumer protection standards, grievance and appeals, rate review, and fraud for all standard health plans.

Question D(1)—Coordination With Other State Programs

What is the expected impact of a Basic Health Program on the Exchange's purchasing power and viability? How might States organize a Basic Health Program with respect to purchasing structure?

AMA Response

The AMA believes that the establishment of a Basic Health Program would reduce the Exchange's purchasing power and may threaten its viability if States do not put appropriate safeguards in place. If a State chooses to establish a Basic Health Program, fewer individuals and families will seek coverage in its Exchange, which would affect the overall size of its Exchange risk pool. In addition, many healthy individuals will be enrolled in standard health plans offered in the Basic Health Program, who would otherwise contribute to the strength of the Exchange's risk pool by balancing out the higher risk of insuring individuals with health issues. The impact of the loss of these individuals from the Exchange risk pool is expected to be more acute in States that would otherwise have a smaller risk pool to begin with.

Question D(4)—Coordination With Other State Programs

How can eligibility and enrollment be effectively coordinated between the Basic Health Program and other State programs to reduce churning between programs and promote continuity of care?

AMA Response

As a first step to ensure that eligibility and enrollment can be effectively coordinated among the Basic Health Program, other State programs, and QHPs, the AMA supports efforts to create a single, streamlined application for individuals to enroll in Medicaid, Children's Health Insurance Program (CHIP), the Basic Health Program, and QHPs. As Exchanges become operational, consumers will likely expect a single access point through which to enroll in health insurance coverage. A streamlined application that is available in paper form and online will help ensure that consumers face a less confusing and complicated application process, especially as many will be unaware of the health insurance options for which they will be eligible.

The AMA also supports allowing States to use an individual's annual income to determine eligibility for the Basic Health Program, as well as for advance payment of the premium tax credit and cost-sharing reductions and Medicaid. This will help to promote coordination among the Basic Health Program, Medicaid, and the Exchange and will minimize churn for minor fluctuations in income.

The key concern for physicians with respect to the churn issue is the need to have access to real-time, accurate information regarding patient enrollment in a standard health plan under

the Basic Health Program, a Medicaid plan, CHIP plan or a QHP, and the eligibility, administrative requirements, and cost information for the various procedures and treatments that physicians may prescribe or order. As patients move through various levels/kinds of coverage, their health care options and the cost of such options will change as well. Physicians must have access to accurate, real-time coverage information, or they could end up providing treatments that are not covered by the patient's plan, which would lead to large, unexpected bills for patients that they may not be able to pay. If HHS and the States want to ensure adequate provider networks as part of Basic Health Programs, Medicaid, CHIP, and QHPs, then an effective solution for this issue must be found.

The AMA recommends that all standard health plans offered in a Basic Health Program be required to provide timely eligibility and enrollment information, including precise enrollment and disenrollment dates, for each patient-specific benefit plan and physicians within and outside of the plan's network. This information must be maintained and made available by the health insurance issuer in real-time and batch format. The best option is to require all standard health plans offered in Basic Health Programs to provide this information in all of the following methods:

- HIPAA compliant X12 271 eligibility response standard transaction, including the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) operating rules, in response to a HIPAA X12 270 eligibility request;
- Web portal; and
- Other appropriate methods.

This will allow physicians and other health care providers, and patients to be able to access accurate eligibility information prior to and at the time of a patient visit. This will require close coordination among the standard health plans offered in Basic Health Programs, QHPs, Medicaid and CHIP plans, and the Exchanges.

In order to provide patients and physicians with accurate coverage and cost information, standard health plans should also be required to implement various ASC X12 health care electronic transaction standards. One option is requiring health insurance issuers to treat the ASC X12 837 Health Care Predetermination: Professional Transaction (and any of its successors) as mandatory and require them to comply with any operating rules that may be adopted with respect to that transaction or any of its successors. A health insurance issuer's response to such a request by a physician should be returned using the same transmission method as that of the submission, that is, real-time response to real-time response or batch mode response to batch mode response. Such a process would provide valuable coverage and cost information to physicians and patients at the time of a patient visit.

Question F(1)—Eligibility

What education and outreach will be necessary to facilitate a helpful consumer experience?

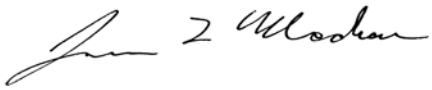
AMA Response

Patients will need significant education about their health insurance options, and what their best choices are. It would be helpful for patients to have access to side-by-side information on how standard health plans certified by and available under the Basic Health Program compare to each other. The information to be compared should include what the cost-sharing and co-payment responsibilities will be, which pharmaceuticals will be available, and information on the amount of payment provided toward each type of service identified as a covered benefit. Most importantly in terms of continuity of care, patients should know the standard health plans in which their physicians are participating before they enroll in a plan. Patients may also need additional assistance in their health plan selection, which should be available in person, online, and via a toll-free telephone assistance line, and in a manner that is accessible to individuals with disabilities and those who are limited in English proficiency.

We would further urge CMS to encourage States to place eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, worship, and receive medical care. These outreach efforts are particularly important given the low consumer awareness of the Basic Health Program, as it will be an entirely new program in the States in which it is established. Having eligibility workers at these locations will minimize any confusion among potential beneficiaries about the application and eligibility processes.

Thank you for considering our comments. We look forward to continuing to work with CMS on the implementation of additional ACA provisions to expand coverage to uninsured Americans. If you have any questions or would like to discuss our comments further, please contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



James L. Madara, MD

Attachment

IN THE GENERAL ASSEMBLY STATE OF _____

Meaningful Access to Physicians and other Health Care Providers: Network Standards Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section I. Title. This Act shall be known and may be cited as "Meaningful Access to Physicians and other Health Care Providers: Network Standards Act."

Section II. Purpose. The Legislature hereby finds and declares that:

(a) A critical attribute of health care coverage is the network of contracted physicians and other health care providers, the "provider network." The provider network is comprised of physicians and other health care providers who have contracted to "participate" by agreeing to abide by the network's rules and accept a specified discount off their retail charges. Physicians and other health care providers generally offer substantial discounts to participate in provider networks because they may receive significant benefits in return: (1) a promise of prompt payment; (2) increased patient volume by virtue of inclusion in provider directories and benefit plans that give patients a substantial financial incentive to go to in-network providers; and (3) maintenance of patient loyalty by meeting their patients' requests that they be "in-network;"

(b) Because, for financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access, a provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives consumers of the benefit of the money they have paid for health care coverage;

(c) Inadequate provider networks also undermine the public health and welfare by forcing consumers to reduce utilization of appropriate preventive services and fail to obtain necessary medical care, which in turn leads to reduced productivity and increased work absenteeism, unnecessary illness and increased emergency department utilization;

(d) To assess the appropriateness of a provider network before selecting a particular health insurance plan, consumers must have all the information relevant to the medical needs of themselves and their families, including whether their physicians and preferred hospitals are in or out-of-network, whether these physicians and hospitals are still accepting new patients, and what the likely wait-time is for an appointment;

(e) Consumers continue to need access to a robust, up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change; and

(f) Physicians and other health care providers need a robust, up-to-date provider directory so that their network participation status is accurately reflected.

Section III. Definitions.

(a) "Enrollee" means a person eligible for services covered by a specific health insurance plan.

(b) "Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.

(c) "Health care facility" means all persons or institutions, including mobile facilities which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. "Health care facility" includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities, nursing homes, home health agencies, outpatient or independent surgical, diagnostic or therapeutic centers or facilities, including, but not limited to, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories (including independent imaging facilities), cardiac catheterization laboratories and radiation therapy facilities.

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

(e) "Health insurer" means any person that offers or administers a health insurance plan.

(f) "Health insurance plan" means any hospital and medical expense incurred policy, non-profit health care service plan contract, health maintenance organization

subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.

(g) "Hospital-based physician" means any physician, excluding interns and residents, which, as either a hospital employee or an independent contractor, provides services to patients in a hospital rather than at a separate physician practice, and typically includes anesthesiologists, radiologists, pathologists and emergency physicians, but may also include other physician specialists such as hospitalists, intensivists and neonatologists among others.

(h) "Physician tiering" means a system that compares, rates, ranks, measures, tiers or classifies a physician's or physician group's performance, quality, or cost of care against objective standards, subjective standards, or the practice of other physicians, and shall include quality improvement programs, pay-for-performance programs, public reporting on physician performance or ratings, and the use of tiered or narrowed networks.

(i) "Provider" means a physician, other health care professional, hospital, health care facility or other provider who/that is accredited, licensed or certified where required in the state of practice and performing within the scope of that accreditation, license or certification.

(j) "Provider directory" means a listing of each and every participating provider within a provider network.

(k) "Provider network" means all the providers contracted to provide services to a specified group of enrollees.

Section IV. Meaningful network standards, report, approval and certification requirements. No health insurer that provides or seeks to market a health plan product in this state may do so without first obtaining a provider network certification from the Insurance Department ("the Department"). The Department's provider network certification shall set forth the geographic and population capacity of the provider network. The provider network certification shall be awarded only to the extent that the provider network offers the access to physicians and other health care providers reasonably necessary to ensure that all enrollees of a health plan product using the provider network will have timely access to all the medical care that they need on an in-network basis, including but not limited to access to emergency services twenty-four hours a day, seven days per week. The health insurer must meet the following requirements in order to obtain certification:

(a) The health insurer must provide a certified network report to the Department once a year documenting all the information contained in Section V of this Act as follows:

i) The report must be prepared by the actuary who calculated the health insurer's premium; and

ii) The report must be provided to the Department, and made available publicly on the health insurer's website, within seven days of the Department certification.

(b) A health insurer shall provide a certified network report that is specific to each health plan product it offers in the state; and

(c) A health insurer shall not change its provider network for any of its health plan products until after the Department has approved the certified network report applicable to the proposed new network.

Section V. Health insurer disclosure requirements. The Department shall evaluate certified network reports based on the following information, by county:

(a) Number of enrollees, by health plan product, including the number of:

i) Males;

ii) Females;

iii) Elders (enrollees equal to or over the age of 65); and

iv) Children (enrollees under, or equal to, 18 years of age).

(b) Number and FTE equivalent number of physicians contracted to participate in the network in each of the following areas, and as a percentage of the total number of physicians of this relevant specialty practicing in the county, by health plan product:

i) Primary care physicians to enrollee population;

ii) Geriatric medicine physicians to geriatric population;

iii) Pediatricians to pediatric population; and

iv) Women's health physicians to women.

(c) Number and FTE equivalent number of physicians contracted to participate in the network in each of the following specialties, and as a percentage of the total number of physicians of that relevant specialty practicing in the county, by health plan product:

1. Addiction Medicine;
2. Allergy and Immunology;
3. Anesthesiology;
4. Bariatric (Weight Loss) Surgery;
5. Cancer Surgery;
6. Cardiothoracic Surgery;
7. Cardiovascular Disease;
8. Cardiovascular Surgery;
9. Clinical Psychology;
10. Colorectal Surgery;
11. Critical Care Medicine;
12. Dentistry/Oral Surgery: Oral Surgery;
13. Dermatology;
14. Electrophysiology;
15. Emergency Medicine;
16. Endocrinology, Diabetes and Metabolism;
17. Family Medicine;
18. Gastroenterology;
19. Geriatric Medicine;
20. Geriatric Psychiatry;
21. Gynecologic Oncology;
22. Gynecology;
23. Hand Surgery;
24. Hematology;

25. HIV Disease Specialist;
26. Hospitalist;
27. Infectious Disease;
28. Internal Medicine;
29. Interventional Cardiology;
30. Maternal and Fetal Medicine;
31. Medical Oncology;
32. Microsurgery;
33. Neonatal-Perinatal Medicine;
34. Nephrology;
35. Neurology and Subspecialties;
36. Neurosurgery;
37. Nuclear Medicine;
38. Obstetrics and Gynecology;
39. Ophthalmology;
40. Oral and Maxillofacial Surgery;
41. Orthopaedics;
42. Orthopaedic Surgery;
43. Otolaryngology (Ear, Nose and Throat);
44. Pain Management;
45. Pathology;
46. Pediatrics;
47. Pediatric Anesthesiology;
48. Pediatric Cardiology;
49. Pediatric Ophthalmology;
50. Pediatric Surgery;
51. Pediatric Subspecialties not covered above;
52. Physical Medicine and Rehabilitation;
53. Plastic Surgery;

54. Podiatry;
55. Psychiatry;
56. Pulmonary Disease;
57. Radiation Oncology;
58. Radiology;
59. Reconstructive Surgery;
60. Reproductive Endocrinology;
61. Rheumatology;
62. Sleep Medicine;
63. Spine Surgery;
64. Sports Medicine;
65. Surgery;
66. Surgical Critical Care;
67. Thoracic Surgery;
68. Vascular Surgery; and
69. Urology.

(d) The insurer shall comply with the following:

i) If the network is tiered in a way that impacts an enrollee's financial obligations, the health insurer shall provide separate totals for both all contracted physicians and for the subset of contracted physicians that enrollees are permitted to access with the least financial obligation;

ii) With respect to hospital-based physicians, the report must indicate how many physicians of each hospital-based specialty are contracting at each participating hospital; and

iii) To the extent that the provider network includes providers that have not contracted directly with the health insurer but through a contracting agent, the report must indicate the name, website address, mailing address and telephone number of each contracting agent with whom any health provider has a direct contract as well as the percentage of each reported physician specialty with which the health insurer contracts directly.

(e) Utilization Data. The following enrollee utilization data must be reported, compared against the prior year's utilization, and assessed against regional and national benchmarks for each health plan product:

i) Number of hospital admissions per thousand enrollees in the last year for outpatient, manageable, preventable conditions, including but not limited to Community Acquired Bacterial Pneumonia, Asthma and Diabetes;

ii) Number of emergency department visits per thousand enrollees in the last year;

iii) Number of preventive services, such as immunizations, which reduce the need for later, costlier interventions;

iv) Percent of out-of-pocket costs incurred by enrollees for emergency department visits as a percentage of total enrollee out-of-pocket costs;

v) Number of visits to out-of-network providers per thousand enrollees in the last year;

vi) Percent of services received from in-network providers as a percentage of total services received by enrollees; and

vii) Percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer.

(f) Compliance Monitoring Data. The following compliance monitoring data must be reported:

i) The results of the most recent annual enrollee and provider surveys, and a comparison of those results with the results of the prior year's survey, including a discussion of any change in satisfaction levels;

ii) An analysis of the health insurer's contracting practices, including the number of new and terminated providers by specialty and geographic area, an analysis of the reasons for any contract terminations and steps the health insurer took in response, and the number of enrollees affected by each contract termination. The health insurer shall also report any significant reduction to the provider network as soon as feasible and in every case within two business days; and

iii) An analysis of all enrollee and provider grievances and complaints alleging a lack of accessibility to health care services in the prior year, including, for each such complaint: a) the county in which it arose; b) the provider type, including physician specialty for all complaints involving lack of access to a physician; c) the reason for the complaint; and d) the resolution, including whether the health insurer referred the enrollee to an out-of-network provider and whether an out-of-network provider provided services to the enrollee.

Section VI. Network Quality Assurance Processes. The health insurer shall provide the Department with its Network Quality Assurance Processes as described in this section. Each health insurer must have written quality assurance systems,

policies and procedures designed to ensure that each health plan product's network is sufficient to provide timely accessibility, availability and continuity of covered health care services for each health insurance plan's enrollees. The health insurer's network quality assurance program shall address:

(a) Standards for the provision of covered services in a timely manner consistent with the requirements of this Act;

(b) Continuity of care, referral systems and processes sufficient to ensure that, if a contracted provider is unable to deliver timely access in accordance with the standards of this section, the health insurer arranges for the provision of a timely appointment with an appropriately and similarly qualified and geographically accessible provider within the health plan product's network, on the enrollee's request and with the enrollee's consent;

(c) If no provider reasonably acceptable to the enrollee is available on a timely basis within the network, then referral to a non-contracted provider must be made. Disputes over the acceptability of a contracted provider shall be resolved following the same process applicable to disputes over experimental or investigational treatments within this state. The health insurer must indemnify the enrollee for any covered medical expenses provided by the non-contracted provider incurred over the co-payment(s) and deductibles that would apply to contracted providers, and such enrollees and non-contracting providers with an assignment of benefits shall have the ability to enforce this provision in a court of competent jurisdiction. This requirement does not prohibit a health insurer or its delegated physician group from accommodating an enrollee's written request to wait for a later appointment from a specific contracted provider;

(d) Procedures to address the needs of enrollees with limited English proficiency or literacy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities;

(e) Compliance monitoring policies, procedures and reports, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

i) Tracking and documenting network capacity and availability with respect to the standards set forth in Section V;

ii) Logging, reviewing and resolving all enrollee and provider grievances and complaints alleging lack of accessibility to health care services separate from other enrollee and provider grievances and complaints;

iii) Tracking and examining provider terminations by facility type and physician specialty, including how many enrollees were affected and the reasons for the terminations;

iv) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodologies and designed to ascertain the level of compliance with the standards set forth in this Act;

v) Conducting an annual provider survey which shall be conducted in accordance with valid and reliable survey methodologies and designed to solicit physician perspective and concerns regarding compliance with the standards set forth in this Act;

vi) Reviewing and evaluating, on not less than a quarterly basis, the information available to the health insurer regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, contract terminations, utilization of services, enrollee complaints and grievances and their resolution; and

vii) Verifying the accuracy of its own provider directory;

iv) A health insurer shall undertake a prompt investigation and implement timely corrective action when compliance monitoring discloses that a health plan product's provider network is not sufficient to ensure timely access as required by this Act, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified, timely access deficiencies and to bring its network into compliance. Health insurers shall make all necessary modifications to their contracting practices to ensure compliance; and

v) Health insurers shall give advance written notice to all contracted providers affected by a corrective action ordered by the Department to rectify an access problem. The notice shall include: a description of the identified deficiencies; the rationale for the corrective action; and the name and telephone number of the person authorized to respond to provider concerns regarding the health insurer's corrective action.

Section VIII. Enforcement. The Department shall oversee compliance with this law.

(a) Investigation. Where the Department has reason to believe that the requisite standards are not met or other indicators of lack of access exist, then the Department shall do the following:

i) Require the health insurer to conduct a statistically valid survey of a random sample of contracting physicians, approved by the Department, that is designed to determine each participating physician's full time equivalency for health plan product's enrollees. Results of the survey shall be forwarded to the Department for review, and if appropriate, investigation;

ii) Require the health insurer to conduct a statistically valid survey of a random sample of enrollees who have received services within the prior three months, including new enrollees, approved by the Department, that is designed to determine whether and to what extent enrollees are having difficulty in making timely appointments with contracted providers for medical services. Results of the survey shall be forwarded to the Department for review, and if appropriate, investigation;

iii) Examine the health insurer's contracting practices, including but not limited to the willingness of the health insurer to enter into good faith negotiations with non-contracting providers. As a part of its investigation, the Department shall interview the health insurer, contracting providers, and providers who choose not to contract with the health insurer in determining whether or not the negotiations were in good faith;

iv) Interview enrollees, including those newly enrolled, of the health insurer as to their experiences in obtaining an appointment with an established or a new provider; and

v) Any other requirements that the Department determines is necessary.

(b) Remedies. A violation of this Act constitutes an unfair and deceptive act or practice in the business of insurance under this Act. Where the Department has found or it is otherwise determined that a health insurer has failed to meet any of the standards set forth by this Act, it shall do the following:

i) Institute all appropriate corrective action and use any of its other enforcement powers to obtain the health insurer's compliance with this Act; and

ii) Where the violation results in an enrollee's use of an out-of-network provider, require the health insurer to pay the non-contracted provider's usual, customary and reasonable charge as stated on the claim form.

Section IX. Private Right of Action. Any provider or enrollee may bring an action in a court of appropriate jurisdiction against any individual or entity for any violation of this Act. The prevailing party in such an action will be entitled to any remedies contained in this Act and any other remedies available at common law, as well as reasonable attorneys' fees and costs.

Section X. Severability. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.