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The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: HHS Proposed Rule Regarding Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)

Dear Secretary Sebelius:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the U.S. Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (Proposed Rule) regarding establishment of the new Affordable Insurance Exchanges (Exchanges) and Qualified Health Plans (QHPs) pursuant to the Patient Protection and Affordable Care Act (ACA).

The ACA will bring about a new paradigm by extending health care coverage and benefits to millions of individuals who are currently uninsured. The Exchanges are intended to be vital components in fulfilling the ACA's promise to make high-quality health care available to all Americans by: 1) helping to provide coverage to millions of Americans without access to affordable health care—especially those with pre-existing conditions; 2) providing a patient-friendly market for patients to purchase health care; 3) increasing competition among plans based on quality and price; 4) facilitating eligibility determinations and tax-subsidies/credits for patients; 5) streamlining the health insurance purchasing process and reducing administrative burdens and costs; and 6) leading to a strengthened U.S. health care system.

The AMA envisions Exchanges as maximizing health insurance issuer choice for individuals and families purchasing coverage. We believe the Proposed Rule generally is a significant step forward in implementing the critical role envisioned for Exchanges to provide coverage to millions of currently uninsured Americans. We have provided comments below on sections of the Proposed Rule that we believe need clarification or could benefit from modifications, particularly regarding Exchange and QHP transparency, adequate and real-time information to physicians and their patients, Exchange governance boards, network adequacy, and uniformity of standards for State and Federal Exchanges.

Transition from a Federal Exchange to a State Exchange (§155.106)

In §155.106 of the Proposed Rule, HHS proposes that States that elect to operate an Exchange after 2014 must work with HHS to develop a plan to transition from a Federally-facilitated Exchange to a State Exchange. With patients needing to transition from a QHP certified by the Federally-facilitated Exchange to a QHP certified by a State Exchange, it will be imperative for patients to have the appropriate information from which to make an informed health care purchasing decision in the State Exchange.

Patients must be given adequate notice of the transition to the State Exchange, and educational materials, in plain language, of how the transition will affect their current health plan enrollment. For patients who need to select a new QHP in which to enroll, it would be helpful to have access to side-by-side information on how QHPs certified by and available on the State Exchange compare to the QHP in which they were enrolled on the Federally-facilitated Exchange, so they can decide which plan offers the most comparable coverage. 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 QHPs in which their physicians are participating before they enroll in a QHP certified by the State Exchange. Patients may also need additional assistance in their health plan selection during the transition, which should be available in person, online, and via a toll-free telephone assistance line.

The transition plan from a Federally-facilitated Exchange to a State Exchange is also expected to impact physician practice, especially in the areas of care management (to the extent the QHPs have retained different out-sourced benefit managers for such services, as well as mental health, pharmacy, and imaging or have different prior authorization requirements), claims processing and adjudication and securing payment for services rendered. Overall, physicians must be provided with sufficient notice of the transition, and will need to be engaged in meaningful negotiations with QHPs certified by the State Exchange to determine in which QHPs they will participate. Also, physicians will need to be educated on issues related to patients transitioning from QHPs certified by the Federally-facilitated Exchange to QHPs certified by a State Exchange. Essential to the transition from a Federally-facilitated Exchange to a State Exchange are systems that allow for real-time patient eligibility information. Physicians will need to have real-time access to information detailing in which QHP a patient is enrolled, as well as details relating to the coverage afforded by the QHP, including patient cost-sharing. Also, physicians will need to be aware of how the Federally-facilitated Exchange will be involved in claims processing and adjudication once the State Exchange is operational. For example, physicians should be aware of how the transition to a State Exchange will impact the process of filing an appeal with a QHP certified by the Federally-facilitated Exchange that may not also be certified by the State Exchange.

Federal/State partnerships in Exchange operations (§155.110)

In its discussion of §155.110 of the Proposed Rule, HHS notes that there may be ways in which a State Exchange and the Federal government can work in partnership to carry out certain activities. More recently, HHS released additional guidance on different models for such operations. While the AMA would welcome such partnerships so that the States and the Federal government could take advantage of their respective areas of expertise, such partnerships should be seamless on the front end to patients and physicians to minimize confusion and ensure that Exchange operations are consumer-friendly. In other words, while a State and the Federal government may be undertaking various

activities on the back end, this division of labor should not be noticeable to the patients and physicians interacting with and getting information from Exchanges. In addition, there should be uniformity of standards for Exchanges, whether they are being primarily operated under State or Federal authority.

Transparency and consumer information (§155.205 and §156.220)

The AMA has long advocated for transparency of health benefit information. In 2010, the AMA was appointed to the National Association of Insurance Commissioners (NAIC) Consumer Information Subgroup, charged with developing standardized summary of benefit information, a consumer-friendly health insurance glossary, and explanation of coverage documents. The purpose of these documents is to increase consumer understanding of health insurance benefit information, costs, and access. The Subgroup completed its work in July, 2011. The August 22, 2011 Federal Register included a Notice of Proposed Rulemaking (NPRM) on the Summary of Benefits and Coverage and the Uniform Glossary. The AMA supports the NPRM and the use of its proposed standardized summary of benefit information, health insurance glossary, and explanation of coverage documents in Exchanges.

In §155.205 of the Proposed Rule, HHS outlines the standards for a number of consumer assistance tools and activities that Exchanges must provide, including an up-to-date Internet website. The AMA applauds HHS for recognizing the integral role of Exchange websites in the QHP enrollment process by providing patients with comparative information on each available QHP. We agree that Exchange websites are appropriate venues to post QHP information that would be helpful for patients in comparing QHPs. The AMA welcomes the list proposed by HHS of the variety of disclosures of QHP information to be included on Exchange web sites to assist patients in comparing available QHPs as a starting point moving forward.

If, however, HHS or the States wish to include additional data elements for QHP disclosure, including the information disclosed in §156.220, the Texas Medical Association has developed a template for a standardized health insurance comparison tool that helps to ensure that patients have the information they need to make an informed health care purchasing decision. The template, introduced in 2009 in the Texas Legislature as Senate Bill 815, requires the reporting of:

- Monthly premium;
- Percent of expense paid by plan in-network;
- Percent of expense paid by plan out-of-network;
- Annual out-of-pocket cost (est.);
- Patient total annual cost (est.);
- Justified complaints;
- Premium-to-direct patient care ratio;
- Expected profit; and
- Benefit levels, including:

    - Annual deductible;
    - Annual family deductible;
    - Annual in-network deductible;
    - Annual out-of-network deductible;

- Out-of-pocket maximum;
- Office visit copayment (primary/specialist);
- Rx co-payment;
- Lifetime maximum benefit;
- Emergency room visit copayment;
- Mental health;
- Outpatient surgery copayment; and
- Inpatient cost sharing.

The sample Texas template is created to look like a "soup can label" in order to provide patients with a comfortable and familiar format. The Texas legislation also includes font and spacing requirements for the form to ensure that it is patient-friendly. The AMA believes that this is an excellent model for the Exchanges to follow if they want QHPs to provide additional information to patients.

Further, plans offered on an Exchange could also be required to disclose on the Exchange web site, for patients to review, additional utilization data relevant to the adequacy of the QHP's network, including:

- 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;
- Number of emergency department visits per thousand enrollees in the last year;
- Number of preventive services, such as immunizations, which reduce the need for later, costlier interventions;
- Percent of out-of-pocket costs incurred by enrollees for emergency department visits as a percentage of total enrollee out-of-pocket costs;
- Number of visits to out-of-network providers per thousand enrollees in the last year;
- Percent of services received from in-network providers as a percentage of total services received by enrollees; and
- Percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurance issuer.

Finally, Exchanges should consider providing patients with more information on a QHP's out-of-network parameters. A health insurance issuer utilizing either a charge-based or non-charge based methodology to determine payment due to an out-of-network physician should include the following information as part of the QHP information on the Exchange web site or have such information available on its own site and easily linked to from the Exchange web site:

- Allow subscribers, prospective purchasers, and physicians to select medical services by Current Procedural Terminology (CPT) Code, physician specialty, and the zip codes for the areas where the services are sought;
- The search result must clearly indicate the usual, customary, and reasonable (UCR) charge amount for at least the 50th, 80th, and 90th percentiles in a given geographic area for a physician specialty;
- The website must advise users of the website to refer to applicable benefit plan documents or the respective plan administrator for further information concerning the applicable benefit

plan, including, with respect to charge-based out-of-network methodologies, the percentile of the UCR that will be applied to determine the applicable out-of-network benefit amount;

- The search result must also remind website users that they may be financially responsible for the balance of the out-of-network physician's retail charges that exceed the amount paid by the health insurer;
- The website must describe in a transparent manner the purpose of the website, and its search function; and
- A description of the average percentage of an out-of-network physician's charge that the website user will likely still owe even after the physician receives the out-of-network benefit payment, so that the user will understand what the user's payment obligation will likely be as a percentage of usual, customary, and reasonable charges.

Rate increase transparency (§155.1020 and §156.220)

In §155.1020(b)(1) of the Proposed Regulation, HHS would require Exchanges to consider QHP rate increase justifications and ensure that they are prominently displayed on QHP web sites. We believe that such transparency is important to patients as they shop for the QHP that best fits their needs. While we understand HHS' concern about duplicating the rate review procedures that States or HHS will be conducting, we encourage HHS and the States to use this second bite at the transparency apple to require further disclosures by health insurance issuers seeking to offer QHPs. Such items could include:

- CEO and executive salaries and benefits;
- Commissions and other broker fees;
- Utilization and other benefit management expenses;
- Advertising and marketing expenses;
- Insurance (including, but not limited to, reinsurance, general liability and professional liability insurance);
- Taxes (including, but not limited to, State and local insurance, State premium, payroll, and Federal and State income and real estate);
- Travel and entertainment expenses;
- State and Federal lobbying expenses; and
- Other (including, but not limited to, non-executive salaries, wages, and other benefits, rent and real estate expenses, certification, accreditation, board, and bureau and association fees; auditing and actuarial fees, collection and bank service charges, occupancy, depreciation, and amortization; cost or depreciation of electronic data processing, claims, and other services, regulatory authority licenses and fees, investment expenses, and aggregate write-ins for expenses).

Physicians in Exchange governance and as stakeholders (§155.110 and §155.130)

In §155.110 of the Proposed Rule, HHS discusses requirements for Exchange governance structures. We applaud HHS' focus on patients in this subsection and agree that patients' needs should come first in the Exchanges. Further, we applaud HHS for not conflating physicians and other health care providers with health insurance issuers and health insurance brokers or agents when discussing potential conflicts of interest. In comments to HHS, NAIC, State officials and others, the AMA has called for the inclusion of actively practicing physicians, along with patients, in the governance structures of the Exchanges.

Including physicians is essential in numerous aspects of Exchange implementation, including, but not limited to: care management, benefit structures, QHP certification, network adequacy, marketing practices and adequate physician payment. Exchanges will need input from numerous stakeholders with expertise on various matters, but input from physicians is critical to ensuring that Exchanges and the QHPs sold through them meet their patients' needs. Practicing physicians will be able to provide important information in the establishment of the Exchanges, and they will be able to offer frontline feedback once the Exchanges are operational, including helping them to change course as needed. Also, if Exchanges are established as independent, non-profit entities, then patient and physician input is even more necessary to ensure that they are accountable to the patients that they serve.

There has been an effort in 2011 in several States to exclude physicians from Exchange governance structures through misguided conflict of interest provisions. If States are concerned about a potential conflict of interest for a physician on an Exchange board, then standard recusal procedures invoked at appropriate times should quell any conflict of interest concerns. Excluding physicians from Exchange leadership would remove an important part of the health care expertise pool that States will need in order to operate Exchanges successfully.

Further, in §155.130(h), HHS includes "health care providers" on the list of stakeholders that Exchanges must consult with on an ongoing basis. We are pleased that HHS included health care providers on this list and urge the inclusion of practicing physicians if this provision is clarified further. Gaining the type of input that only actively practicing physicians can offer is vital to Exchanges being responsive to the needs of the patients utilizing them.

Exchange establishment, governance, and operations transparency (§155.110)

In §155.110(c), HHS proposes several requirements for Exchanges that will ensure that their creation, governance, and operations are transparent. Having a transparent process that is open to the public is critical to the creation and operation of Exchanges. Public notice and access to Exchange governance meetings will provide Exchanges with a strong level of public trust and accountability. These transparency requirements must transfer to all quasi-public and private entities with which an Exchange may contract to carry out various functions. Such organizations should not be shielded from the transparency requirements that are required of public agencies in the State.

HHS review of Exchange accountability and governance principles (§155.110)

In §155.110(f), the Proposed Rule provides HHS with the authority to periodically review the accountability structure and governance principles of State Exchanges. We encourage HHS to use this authority robustly. HHS should consider conducting reviews on an annual basis or requiring States to submit information regarding various provisions on an annual basis. Annual reports from Exchanges, particularly as they get up and running, would be helpful. Issues for such a report should include: whether they are including appropriate members in their governance structure; whether their governance procedures are transparent; whether the QHPs in their Exchanges are meeting network adequacy requirements; and whether their interactions with outside vendors are transparent. Many of these issues will be addressed as States submit information to HHS for the initial certification, but an ongoing compliance requirement would help ensure that patient interests remain the primary mission of Exchanges.

Ongoing review of QHPs by Exchanges (§155.1010)

Section 155.1010 of the Proposed Rule requires Exchanges to monitor QHP issuers for demonstration of ongoing compliance with the certification requirements. We believe that such a process is a necessary component for Exchanges to ensure that QHPs maintain their focus on improving the health insurance marketplace for patients.

Maintenance of current State health insurance issuer requirements (Subpart K of part 155 and Subpart C of part 156)

In Subpart K of part 155 and Subpart C of part 156, HHS emphasizes that the standards for QHPs do not supersede existing State laws or regulations applicable to health insurance issuers. Further, these subparts ensure that QHP requirements do not exempt health insurance issuers from any State laws or regulations that generally apply to them. HHS also provides States with discretion to mandate additional QHP requirements as part of the certification process.

The AMA strongly agrees with the Proposed Rule that current State laws should not be preempted for health insurance issuers. Patients and physicians have made significant strides in ensuring fair health insurance issuer coverage and business practices at the State level. It would be a major step backward if any of these hard-fought gains were weakened or reversed by Federal regulation or statute. We applaud HHS for proposing a Federal floor, rather than a Federal ceiling, for health insurance issuers and the QHPs that they plan to offer through the Exchanges.

Multi-state plans (§155.140 and §155.1000)

The Proposed Rule in §155.140 contemplates regional and subsidiary Exchanges. Multi-state plans that participate in regional Exchanges 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 QHPs, including multi-state plans deemed certified because of contracts with the U.S. Office of Personnel Management (OPM).

Moreover, Section 1324 of the ACA requires a level playing field with respect to laws regulating private insurance issuers. This section requires that alternatives to private insurance, including multi-state plans, must be subject to certain Federal and State laws that also apply to private health insurers. These laws govern the following areas: guaranteed renewal; rating; pre-existing conditions; nondiscrimination; quality improvement and reporting; fraud and abuse; solvency and financial requirements; market conduct; prompt payment; appeals and grievances; privacy and confidentiality; licensure; and benefit plan material or information. As we pointed out in our September 6, 2011 letter to OPM, there is a strong possibility of unlevel playing fields occurring in Exchanges if multi-state plans are not required to follow Federal or State requirements regarding these patient and physician protections. If multi-state plans are exempt from such consumer protection laws and regulations,

other plans within Exchanges that are subject to different regulatory standards would be competing against the multi-state plans; if the standards are more stringent for the non-multi-state plans, multi-state plans could have an unfair competitive advantage. In addition, if multi-state plans are not subject to the above Federal and State protections, then under Section 1324, it could have the unintended result of all private health insurance issuers being exempt as well.

Ultimately, multi-state plans have the potential to undermine the health insurance market reforms and gains in patient protections and benefits that are key elements of the ACA. Therefore, we urge Federal and State officials to require that any multi-state plan with which they certify or contract be subject to the same patient and physician protections to which private health insurance plans are subject. Since the multi-state plans will be deemed certified, this action by OPM is very important.

Exchange funding (§155.160 and §156.50)

§155.160 of the Proposed Rule discusses financial support for continued operations of the Exchanges. Exchanges must be self-supporting after the Federal planning and establishment grants subsidize their creation and initial operations. There are many ways for States to accomplish this, including imposing fees on health insurance issuers who participate in the Exchanges or those who sell plans in the outside-the-Exchange market, earmarking funds from general revenues and/or using proceeds from tobacco taxes. We are concerned about the discussion in the Proposed Rule that includes provider taxes as a possible funding stream for Exchanges; the AMA strongly opposes the imposition of provider taxes. Physicians provide millions of dollars in uncompensated care and serve as the safety net for our most vulnerable citizens. As small business owners, they set up infrastructure, buy medical equipment, employ staff, provide health insurance to their employees, and pay medical liability premiums. By adding to a physician's practice costs with a provider tax, this would make it harder for small physician practices to survive, especially in light of the on-going implementation of numerous delivery and payment reforms under the ACA, such as electronic health records, 5010, and ICD-10.

Quality (§155.200 and §156.200)

The establishment of Exchanges creates an opportunity to improve the quality of health care provided to patients. The Proposed Rule mentions quality briefly in §155.200 and in §156.200, and notes that a separate proposed rule will be issued in the future specifically on standards for Exchanges and QHPs related to quality. We offer the following comments and recommendations to help guide HHS in developing the proposed rulemaking on quality standards, and look forward to commenting in more depth when the rulemaking is published.

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 noninclusive criteria for measuring health insurance issuers should be considered in evaluating a QHP'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.
- 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, and 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.

In addition, if physicians are to be successful, the quality measures need to be consistent across all plans in the Exchange. The administrative burden of managing multiple sets of measures can have an overwhelming effect on physician practices and will greatly discourage physician participation in

[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.

QHP 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 health insurance issuers to request additional chart audits from physician practices in an attempt to favorably affect their evaluation scores.

Security, privacy, and administrative simplification (§155.205 and §155.260)

The AMA strongly supports effective privacy and security requirements to safeguard personally identifiable information from inappropriate uses and disclosures. Exchanges should be required to implement privacy and security safeguards to protect personally identifiable information that is received, used, stored, transferred, or prepared for disposal by the Exchange or any of its contractors or sub-contractors. Although HHS is proposing to provide States with the flexibility to create their own tailored privacy and security requirements, HHS should urge States to consider privacy and security safeguards that are effective yet are not overly burdensome for the Health Insurance Portability and Accountability Act (HIPAA) covered entities (e.g., physicians, health plans, clearinghouses) and their business associates to implement, and should not hinder the necessary flow of health information for treatment, payment, and health care operations purposes. Physicians, health plans, and clearinghouses and their business associates are already required to comply with HIPAA as well as state privacy and security requirements, so we further recommend that HHS require Exchanges to adopt privacy and security requirements that are consistent with existing rules so that HIPAA-covered entities are not challenged with complying with inconsistent or conflicting privacy and security requirements.

The AMA strongly supports the requirement for Exchanges to adhere to the HIPAA administrative simplification requirements for electronic transactions, which are designed to standardize and improve electronic health care transactions.

Health disparities (§155.205 and §155.230)

The elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA. We agree with the requirement in the Proposed Rule that Exchange websites must provide meaningful access to information for individuals with limited English proficiency and disabilities. The AMA supports the importance of culturally effective health care in eliminating disparities and exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. Also, the streamlined enrollment process for Medicaid, the Children's Health Insurance Program (CHIP), and Exchange plans will help to address health care disparities by enrolling more patients and by promoting continuity of care for these patients.

Navigators (§155.210)

In §155.210, HHS includes several requirements that will promote a high level of accountability among Exchange navigators. Prohibiting conflicts of interest for navigators and requiring them to be State-licensed should offer protections to patients seeking coverage through an Exchange. One further duty that navigators should be required to perform is to assist patients find their physicians in QHPs' provider networks before enrolling them. Many patients pick various health insurance issuer products based on their physicians being in a provider network. Navigators are in an excellent position to assist patients with many parts of the QHP enrollment process, and ensuring desired physician-patient continuity of care is one of the most important.

Availability of patient coverage and cost to physicians (§155.400, §155.410, §155.420, §155.1080, §156.220, §156.265, §156.270, §156.290)

One of the biggest challenges facing implementation of Exchanges is the patient "churn" issue. Millions of patients will cycle through Medicaid, CHIP, and QHPs (subsidized and unsubsidized) on an annual basis. While the primary focus should be on patients in trying to address the churn issue, how HHS and the States address this issue will have a major effect on physicians as well. 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 Medicaid plan, a QHP or a multi-state plan, and the eligibility, administrative requirements, and cost information for the various procedures and treatments that physicians may prescribe or order. For patients, eligibility information is not enough; they need to know if a physician is in or out of the plan's network and be able to obtain accurate cost estimates as well. For physicians, this issue is vital. 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 or may not be able to pay. If HHS and the States want to ensure adequate provider networks as part of Exchanges, then an effective solution for this issue must be found.

Suggested eligibility and enrollment process

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 must be maintained and made available by the health insurance issuer in real-time and batch format. The best option is to require all QHPs offered through an Exchange, including multi-state plans, 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 health insurance issuers, Medicaid and CHIP plans, and the Exchanges.

Employers should be required to electronically submit enrollment information that includes secondary and tertiary health insurance, as well as to electronically submit disenrollment information, prior to or within 24 hours of an employee's hiring, termination, change in dependents, new open enrollment selection or other relevant change in status which impacts eligibility to the health insurance issuer. The current monthly eligibility update process used by many employers is entirely inadequate, as it results in numerous retroactive additions or deletions. These retroactive eligibility changes are tremendously disruptive for patients and their physicians and will be entirely unmanageable in the context of Exchanges. It is essential for physicians and other health care providers to receive accurate patient eligibility information that they can count on and which will not be reversed at a later date. Because of the disruption that is created for both patients and physicians when eligibility determinations are retroactively reversed, we urge consideration of a requirement that eligibility determinations be binding on all plans offered through the Exchanges, such as in Texas.[2] If States permit retroactive enrollment and coverage decisions, then at a minimum, there should be strict requirements placed upon this practice, such as providing time limits and physicians with due process rights.

Predetermination and cost information

In order to provide patients and physicians with accurate coverage and cost information, QHPs 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 mandated and requiring 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.

Enrollment process and transparency in coverage (§155.400 and §156.220)

Section 155.400 of the Proposed Rule proposes Exchange requirements for enrollment of patients in QHPs, while §156.220 proposes QHP requirements for enrolling individuals. We urge HHS to require real-time information to be available to physicians once a patient has enrolled. The process described above in the previous section could be used as a verification method by a physician before providing treatment.

§156.220(d) of the Proposed Rule requires QHP issuers to make available cost-sharing information in a timely manner. We recommend that either the patient or the patient's physician should be able to make this request, and that the information should be available in real-time to the patient and the physician.

Enrollment and termination of patients (§156.265 and §156.270)

In §156.265 and §156.270, the Proposed Rule establishes enrollment and termination procedures for individuals in QHPs. Again, we stress the need for real-time information for patients and physicians for both procedures. Section 156.270(b) requires a QHP issuer to offer notice to the patient and the

[2] V.T.C.A., Insurance Code § 843.347

Exchange when a termination occurs. We recommend that QHPs should be responsible for providing similar notice of the termination to a patient's physicians as well.

We also recommend that careful thought be given to the implementation of the three-month grace period for non-payment of premium prior to coverage termination, which is required under the ACA to be provided to enrollees receiving advance payments of the premium tax credit. While we appreciate the importance of continuity of care for patients, QHPs, physicians, and other health care providers must have structures in place to cover the cost of the medical care provided to patients during this period. It is critical that physicians and other health care providers not be left "holding the bag" for this care. One option would be to require the Exchange to maintain reinsurance for all QHPs to cover these uncompensated costs. This may be the best option, at least until more experience is obtained as to how often this situation arises. Another alternative is to require QHPs to maintain such reinsurance. In no event, should QHPs be allowed to transfer the cost to physicians and other health care providers.

QHP decertification and non-renewal (§155.1080 and §156.290)

In §155.1080(e), an Exchange is required to provide notice to several parties when a QHP is decertified. We recommend that either the Exchange or the health insurance issuer offering the decertified QHP must notify all physicians treating patients covered by the decertified QHP that it has been decertified. Further, the health insurance issuer should be responsible for all eligible claims until physicians receive proper notice of the decertification, and such payments should not be subject to retrospective audit.

Section 156.290 of the Proposed Rule discusses QHP notice requirements when QHPs seek non-renewal or are decertified. QHPs should be required to provide notice to physicians treating their covered patients. This is another situation where physicians having real-time coverage information for patients would be very helpful for both patients and physicians. Finally, health insurance issuers should be required to continue to pay for claims submitted by physicians on behalf of covered patients until the physician has notice, either from the QHP or through real-time access, that the QHP did not renew its certification or that it has been decertified. Establishing a short grace period until the patient has been enrolled in another QHP could also prevent any potential gaps in coverage caused by the QHP non-renewal or decertification and claims should continue to be paid and not be subject to retrospective audit. Again, it may make sense for Exchanges to maintain reinsurance covering the costs of medical care which a QHP is unable to cover due to insolvency or bankruptcy.

Enrollment periods (§155.410 and §155.420)

In §155.410 and §155.420, the Proposed Rule provides information on various open and special enrollment periods. Once again, physicians will need real-time information regarding patient enrollment and coverage to ensure that the health care provided is consistent with the appropriate QHP's plan details. It is imperative that Exchanges coordinate this enrollment information and require insurers to make it available to physicians on behalf of their patients in real-time.

Calculators in Small Business Health Options Programs (SHOPs)(§155.705)

In §155.705 of the Proposed Rule, HHS encourages a SHOP Exchange to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium

amount. The AMA agrees with HHS that conveying the net premium to SHOP enrollees will make the SHOP Exchange web sites more consumer-friendly and will help to ensure that employees are fully informed before making a health care purchasing decision, as the net premium constitutes the true perceived cost of the plan to the employee.

Patient choice of plan in SHOPs (§155.705)

In §155.705 of the Proposed Rule, HHS provides flexibility for Exchanges and their SHOPs to choose additional ways for qualified employers to offer one or more plans to their employees. The AMA believes that Exchanges should maximize health plan choice for individuals and families purchasing coverage, and believes that the flexibility provided to employers outlined in §155.705 ultimately has the potential to limit patient choice of health plan. Rather, the AMA believes Exchanges should allow employees to choose any QHP offered in the SHOP at any level to maximize employee choice of health plan. This will ensure that employees are provided an array of QHP choices in terms of benefits covered, cost-sharing levels, and other features.

Additional requirements for QHPs (Subpart K, Subpart C, and §155.1000)

The AMA recommends that QHPs be required to meet a higher threshold than the baseline requirements that the ACA or this Proposed Rule 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 ACA addresses some of the most troubling insurer practices, such as rescission, but more work needs to be done. 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. The Code, developed by the AMA and endorsed by 68 state and specialty medical societies, 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.

Exchange format (§155.1000)

In §155.1000, the Proposed Rule provides States with discretion regarding establishing their Exchange as an "any willing plan" Exchange or a "competitive bidding" or "active purchaser" Exchange. We agree with this recommendation to provide States with flexibility on this choice. The AMA has encouraged States to establish "any willing plan" Exchanges, such as the one in Utah, rather than the "competitive bidding" Exchange, such as the Massachusetts Connector. The AMA envisions Exchanges as maximizing health insurance issuer choice for individuals and families purchasing coverage, and the "any willing plan" model fits this vision better than other options. Further, QHPs sold on Exchanges should provide an array of choices for patients, in terms of benefits covered, cost-sharing levels, and other features, and "any willing plan" models are the most likely model to provide health insurance issuers with needed flexibility to encourage such innovation. If State officials are negotiating price and other issues with plans seeking to be QHPs, then they are likely to eliminate certain options for patients and may restrict the benefit structures or cost-sharing levels available to patients, and these actions could limit a patient's choices regarding health insurance coverage options. One of the options that should be available in Exchanges is high-deductible plans coupled with health savings accounts, as well as other consumer-driven health plans.

AMA research indicates that many insurance markets across the country are dominated by one major health insurance issuer.[3] Patients and their physicians face limited choice in those markets. This market concentration creates an imbalance in the negotiating power between physicians and health insurance issuers, which leads to a host of problems for physicians and patients. Exchanges can help to correct this imbalance by creating a marketplace for new entrants to sell health insurance products and for patients to shop for and compare health insurance products. And the best option for accomplishing this goal is an "any willing plan" Exchange. Such an Exchange would force health insurance issuers to compete based on price, quality and transparency, and it would allow smaller health insurance issuers to challenge the monopolies that large health insurance issuers have in many markets now.

Network adequacy (§155.1050 and §156.230)

One of the most important elements of adequate health care coverage is that a health insurance issuer offers an adequate network of contracted physicians and other health care providers, e.g., the "provider network." Inadequate provider networks deprive consumers of the benefit of the money they have paid for health care coverage and undermine the public health and welfare by forcing consumers to reduce utilization of appropriate preventive services and forgo necessary medical care. They also have the perverse effect of driving the sickest patients—those who need health insurance the most—out of the health plan with the worst network, thus potentially benefitting the health insurance issuer with the less risky patients. To meet consumers' reasonable expectations and maximize their welfare, health insurance benefits, including all medically necessary and emergency care, must be available at the preferred in-network rate on a timely and geographically accessible basis to all enrollees. Consumers and State insurance regulators need meaningful measures of network adequacy covering all aspects of the network, including emergency and other hospital-based physicians, taking into account any tiering or other network restrictions.

In addition to subjective satisfaction data, there is a need for objective data on critical access metrics, such as the number of visits to out-of-network providers per thousand enrollees, the percent of services received from in-network providers as a percentage of total services received by enrollees, and the percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer. As health insurers' actuaries must evaluate the provider network to make premium determinations, these actuaries are positioned to provide reliable network reports to insurance regulators relatively efficiently.

The AMA supports adequate provider networks that ensure insurance regulators and consumers have access to the information necessary to determine whether the provider network includes a sufficient number of primary care and specialty physicians and other health care providers so that all enrollees will be able to receive all covered services in a timely and geographically accessible basis at the preferred in-network rate. Such requirements and information should include:

- Definitions that ensure that the adequacy of the entire provider network is evaluated, including "all providers contracted to provide services to a specified group of enrollees," including emergency and other hospital-based physicians.
- Network certification by the State Insurance Department setting forth the geographic and population capacity of the provider network to the extent it offers adequate access to physicians

[3] *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2010* American Medical Association

and other health care providers reasonably necessary to ensure that any enrollees of the product will have timely access to care needed in-network. The Insurance Department must base its assessment on the detailed, product specific report certified by the health insurer's actuary who calculated the premium for that product.

- Specific requirements that the Insurance Department must use in evaluating the actuary's certified network report, including:

    - Detailed enrollee demographic and physician workforce data;
    - Any physician tiering data that impacts enrollee financial obligation;
    - The contracting status of hospital-based physicians as it relates to participating hospitals;
    - The extent the insurer is dependent on rental networks;
    - Utilization data that may indicate undue use of out-of-network providers; and
    - Compliance monitoring data, including enrollee and provider satisfaction surveys.

- Network quality assurance processes requirements for health insurers, including:

    - Standards for the timeliness of covered services;
    - Continuity of care and referral criteria for care out-of-network when necessary;
    - Provisions to address linguistic, physical, and cultural diversity or needs;
    - Compliance monitoring policies to measure accessibility and availability of contracted providers, including enrollee and provider grievance systems and satisfaction surveys and review of provider terminations and accuracy of the provider directory; and
    - Timely implementation of appropriate corrective action plans.

- Meaningful enforcement, private right of action, and severability provisions.

The AMA drafted a model bill, "Meaningful Access to Physicians and Other Health Care Providers: Network Standards Act" (attached), that includes specific legislative language that can be implemented to ensure that health insurance issuers develop adequate provider networks, and that these networks are well-regulated to ensure that consumers have the necessary access. We urge HHS and the States to utilize this model bill as a baseline for, and to evaluate, network adequacy in QHPs.

Finally, we believe an important issue related to adequacy of provider networks and QHPs' capacity has been overlooked in the Proposed Rule. While QHPs are required to enroll qualified individuals and honor individuals' choice of plan, HHS acknowledges in the preamble that section 2702(c) of the ACA, which sets out special guaranteed issue rules for network plans, allows plans to deny enrollment to individuals if they lack capacity to serve them. However, the Proposed Rule does not address how the Exchanges should address this situation, nor how the Exchange will ensure that all qualified individuals seeking to enroll in a plan can do so, even if it is an alternative choice. We believe this issue needs to be addressed in the final rule.

Provider directory (§156.230)

In addition to ensuring that health insurance issuers offer consumers an adequate provider network, it is also important that consumers have access to current, accurate information about which physicians and other health care providers are available to them in a QHP. To be able to assess the value of a health plan, consumers must have all the provider network information relevant to the medical needs

of themselves and their families, including whether their physicians and preferred hospitals are in- or out-of-network and whether these physicians and hospitals are still accepting patients insured by the health plan.

To navigate increasingly complex health insurance products, consumers need access to a robust, up-to-date directory that covers all contracted health facilities and professionals, including hospital-based physicians, and that provides all information that may impact a consumer's financial responsibility when seeking medical care including hospital affiliations, tiering arrangements, rental network relationships, and out-of-network status. Moreover, this information needs to be easily accessible in an online, interactive map that allows consumers to search the provider network using their home or work address.

The AMA drafted a model bill, "Meaningful Access to Physicians and Other Health Care Providers: Accurate Provider Directories Act" (attached), that includes specific legislative language that can be implemented to ensure that health insurers offer consumers the most current and relevant information about their health care benefits. The model bill includes provisions designed to ensure that consumers can easily access accurate information concerning the provider network in a format which is meaningful to their decisions, including but not limited to:

- Definitions that ensure the provider directory includes "a listing of each and every participating provider within a provider network;"
- A requirement for Insurance Department review and approval of any provider directory prior to marketing and annually thereafter;
- Provider directory requirements as follows:

    - Physician information, including, in addition to demographic and contact information, hospital affiliations, rental network affiliation if relevant, and network status;
    - Listings for physicians who are not freely accessible, such as physicians who are in a restricted "tier" or "out-of-network," must clearly and conspicuously disclose the specific terms of any financial or other access limitations which may apply;
    - Similarly detailed information about other health care professionals within the network;
    - Hospital/health care facility information, including appropriate contact information, emergency department data and contracting and tiering information;
    - The relevant network restrictions applicable to other services such as pharmacy benefit managers and clinical laboratories;
    - A requirement that there be an online, interactive map where current and prospective enrollees may locate providers by name, specialty, subspecialty, and distance and view all the information set forth above; and
    - A requirement that the provider directory be provided to enrollees at time of enrollment in hard copy, posted on the insurer's web site, and kept current.
- Meaningful enforcement, private right of action, and severability provisions.

Physician-led team based care (§155.1050)

The AMA agrees that America's patients benefit when they have access to high quality, cost-effective primary care. This is why the AMA supports physician-led, team-based care for America's patients. This model of care enables physicians and other members of the health care team to practice at the top of their abilities while having the appropriate and necessary oversight from higher-skilled

practitioners. While advanced practice nurses and other non-physicians provide primary care services to patients, patients deserve to have their care overseen by a physician to ensure the most appropriate care is provided in a timely manner.

Along these lines, the AMA encourages increased clarity for the Proposed Rule, which provides that "An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees." Specifically, while the discussion in the Preamble suggests that the goal of the section is to broadly define who provides "primary care services," the Proposed Rule only says "provider," as though all providers offer the same range of services and are licensed or otherwise authorized to provide the same level of care.

Accordingly, the AMA recommends that this section be modified to: 1) specify the professional licensure type and level of the health care provider in the network (e.g., medical doctor; advanced practice nurse; physician assistant); 2) that physicians are the preferred leader of the health care team; and 3) provide further definition for what constitutes "primary care services."

Essential community providers (§156.235)

The AMA supports efforts to recognize the significant problem of access to health care in rural and urban underserved areas and to develop incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide better access to necessary medical services in these areas. In making determinations on how to define what constitutes "a sufficient number of essential community providers," however, the AMA strongly encourages close examination of available data showing which providers and entities are not only geographically located in an area, but also who are actively providing care and what type and level of care as well. In addition, the AMA strongly supports that every effort be made to use physician-led health care teams to ensure that patients receive optimal care in the most appropriate setting in the most cost-effective manner. When all health care professionals work together pursuant to their specific education and training, patients receive the optimal care coordination. While looking at "other types of providers" to potentially increase access to care may be appropriate in certain circumstances, the AMA cautions that while some providers may be willing to provide care, they may not have the necessary education and training to provide the level of care needed in a community.

Dental benefits (§155.1065)

In §155.1065, HHS requests comment on whether the Proposed Rule should require that all dental benefits be offered and priced separately from medical coverage, even when offered by the same issuer. In the arena of child dental coverage, the AMA believes that HHS should require that no dental benefits be priced separately from medical coverage when offered by the same health insurance issuer. We believe that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program should be used as the model for any essential health benefits package for children. As dental benefits are an integral part of EPSDT for children, QHP issuers should be able to offer a "bundled" QHP that covers all essential health benefits, including the pediatric dental benefit, under one premium. This ultimately helps to support the continuum of care provided to children that is guaranteed under the EPSDT benefit. Also, it would help to minimize confusion amongst parents who are seeking coverage in the Exchange that would meet the essential health benefit package standards for their children. We also share the concerns of HHS about the administrative burdens that requiring a QHP to price and offer dental benefits separately could impose on Exchanges and QHP issuers.

Medical homes in Exchanges (§156.245)

We support HHS' efforts to allow a QHP issuer to provide coverage through a primary care medical home. In developing the requirements of a medical home, we encourage HHS or the States to follow the guidelines established in the Joint Principles of the Patient-Centered Medical Home (Joint Principles). The Joint Principles were released in 2007 by four primary care specialties—American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA)—and endorsed by the AMA and 18 other medical associations.

These principles include the following:

- *Personal Physician* - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- *Physician Directed Medical Practice* - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- *Whole Person Orientation* - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end-of-life care.
- *Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information Exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- *Quality and safety* are hallmarks of the medical home:

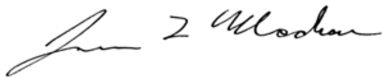
    - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
    - Evidence-based medicine and clinical decision-support tools guide decision making.
    - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
    - Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
    - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
    - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
    - Patients and families participate in quality improvement activities at the practice level.
- *Enhanced access* to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.

- *Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

  - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
  - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
  - It should support adoption and use of health information technology for quality improvement.
  - It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
  - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
  - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
  - It should recognize case mix differences in the patient population being treated within the practice.
  - It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
  - It should allow for additional payments for achieving measurable and continuous quality improvements.

Thank you for considering our comments. We look forward to continuing to work with HHS on 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

Attachments

IN THE GENERAL ASSEMBLY STATE OF ______________

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

1 Be it enacted by the People of the State of ______________, represented in the General
2 Assembly:
3
4 **Section I. Title.** This Act shall be known and may be cited as "Meaningful Access to
5 Physicians and other Health Care Providers: Network Standards Act."
6
7 **Section II. Purpose.** The Legislature hereby finds and declares that:
8
9 (a) A critical attribute of health care coverage is the network of contracted physicians
10 and other health care providers, the "provider network." The provider network is
11 comprised of physicians and other health care providers who have contracted to
12 "participate" by agreeing to abide by the network's rules and accept a specified
13 discount off their retail charges. Physicians and other health care providers generally
14 offer substantial discounts to participate in provider networks because they may
15 receive significant benefits in return: (1) a promise of prompt payment; (2) increased
16 patient volume by virtue of inclusion in provider directories and benefit plans that
17 give patients a substantial financial incentive to go to in-network providers; and (3)
18 maintenance of patient loyalty by meeting their patients' requests that they be "in-
19 network;"

1 (b) Because, for financial reasons, patients are most likely to obtain medical care from
2 physicians and other health care providers who have contracted with a provider
3 network to which the patient has a right of access, a provider network that does not
4 have an adequate number of contracted physicians and other health care providers in
5 each specialty and geographic region deprives consumers of the benefit of the money
6 they have paid for health care coverage;
7
8 (c) Inadequate provider networks also undermine the public health and welfare by
9 forcing consumers to reduce utilization of appropriate preventive services and fail to
10 obtain necessary medical care, which in turn leads to reduced productivity and
11 increased work absenteeism, unnecessary illness and increased emergency
12 department utilization;
13
14 (d) To assess the appropriateness of a provider network before selecting a particular
15 health insurance plan, consumers must have all the information relevant to the
16 medical needs of themselves and their families, including whether their physicians
17 and preferred hospitals are in or out-of-network, whether these physicians and
18 hospitals are still accepting new patients, and what the likely wait-time is for an
19 appointment;
20
21 (e) Consumers continue to need access to a robust, up-to-date provider directory to
22 enable them to determine which physicians, other health care professionals, and
23 health facilities remain in the network as their medical needs change; and
24
25 (f) Physicians and other health care providers need a robust, up-to-date provider
26 directory so that their network participation status is accurately reflected.

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1 **Section III. Definitions.**
2
3 (a) "Enrollee" means a person eligible for services covered by a specific health
4 insurance plan.
5
6 (b) "Contracting entity" means any person or entity that enters into direct contracts
7 with providers for the delivery of health care services in the ordinary course of
8 business.
9
10 (c) "Health care facility" means all persons or institutions, including mobile facilities
11 which offer diagnosis, treatment, inpatient or ambulatory care to two or more
12 unrelated persons, and the buildings in which those services are offered. "Health
13 care facility" includes hospitals, chronic disease facilities, birthing centers,
14 psychiatric facilities, nursing homes, home health agencies, outpatient or
15 independent surgical, diagnostic or therapeutic centers or facilities, including, but
16 not limited to, kidney disease treatment centers, mental health agencies or centers,
17 diagnostic imaging facilities, independent diagnostic laboratories (including
18 independent imaging facilities), cardiac catheterization laboratories and radiation
19 therapy facilities.
20
21 (d) "Health care services" means services for the diagnosis, prevention, treatment or
22 cure of a health condition, illness, injury or disease.
23
24 (e) "Health insurer" means any person that offers or administers a health insurance
25 plan.
26
27 (f) "Health insurance plan" means any hospital and medical expense incurred policy,
28 non-profit health care service plan contract, health maintenance organization

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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.

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<u>Section IV</u>. <u>Meaningful network standards, report, approval and certification requirements</u>. 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

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(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.

<u>Section V</u>. <u>Health insurer disclosure requirements</u>. 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.

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1 (c) Number and FTE equivalent number of physicians contracted to participate in the
2 network in each of the following specialties, and as a percentage of the total
3 number of physicians of that relevant specialty practicing in the county, by health
4 plan product:
5
6 1. Addiction Medicine;
7 2. Allergy and Immunology;
8 3. Anesthesiology;
9 4. Bariatric (Weight Loss) Surgery;
10 5. Cancer Surgery;
11 6. Cardiothoracic Surgery;
12 7. Cardiovascular Disease;
13 8. Cardiovascular Surgery;
14 9. Clinical Psychology;
15 10. Colorectal Surgery;
16 11. Critical Care Medicine;
17 12. Dentistry/Oral Surgery: Oral Surgery;
18 13. Dermatology;
19 14. Electrophysiology;
20 15. Emergency Medicine;
21 16. Endocrinology, Diabetes and Metabolism;
22 17. Family Medicine;
23 18. Gastroenterology;
24 19. Geriatric Medicine;
25 20. Geriatric Psychiatry;
26 21. Gynecologic Oncology;
27 22. Gynecology;
28 23. Hand Surgery;
29 24. Hematology;

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1 25. HIV Disease Specialist;
2 26. Hospitalist;
3 27. Infectious Disease;
4 28. Internal Medicine;
5 29. Interventional Cardiology;
6 30. Maternal and Fetal Medicine;
7 31. Medical Oncology;
8 32. Microsurgery;
9 33. Neonatal-Perinatal Medicine;
10 34. Nephrology;
11 35. Neurology and Subspecialties;
12 36. Neurosurgery;
13 37. Nuclear Medicine;
14 38. Obstetrics and Gynecology;
15 39. Ophthalmology;
16 40. Oral and Maxillofacial Surgery;
17 41. Orthopaedics;
18 42. Orthopaedic Surgery;
19 43. Otolaryngology (Ear, Nose and Throat);
20 44. Pain Management;
21 45. Pathology;
22 46. Pediatrics;
23 47. Pediatric Anesthesiology;
24 48. Pediatric Cardiology;
25 49. Pediatric Ophthalmology;
26 50. Pediatric Surgery;
27 51. Pediatric Subspecialties not covered above;
28 52. Physical Medicine and Rehabilitation;
29 53. Plastic Surgery;

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1 54. Podiatry;
2 55. Psychiatry;
3 56. Pulmonary Disease;
4 57. Radiation Oncology;
5 58. Radiology;
6 59. Reconstructive Surgery;
7 60. Reproductive Endocrinology;
8 61. Rheumatology;
9 62. Sleep Medicine;
10 63. Spine Surgery;
11 64. Sports Medicine;
12 65. Surgery;
13 66. Surgical Critical Care;
14 67. Thoracic Surgery;
15 68. Vascular Surgery; and
16 69. Urology.
17
18 (d) The insurer shall comply with the following:
19
20 i) If the network is tiered in a way that impacts an enrollee's financial
21 obligations, the health insurer shall provide separate totals for both all
22 contracted physicians and for the subset of contracted physicians that
23 enrollees are permitted to access with the least financial obligation;
24
25 ii) With respect to hospital-based physicians, the report must indicate how
26 many physicians of each hospital-based specialty are contracting at each
27 participating hospital; and

1 iii) To the extent that the provider network includes providers that have not
2 contracted directly with the health insurer but through a contracting agent,
3 the report must indicate the name, website address, mailing address and
4 telephone number of each contracting agent with whom any health provider
5 has a direct contract as well as the percentage of each reported physician
6 specialty with which the health insurer contracts directly.
7
8 (e) Utilization Data. The following enrollee utilization data must be reported,
9 compared against the prior year's utilization, and assessed against regional and
10 national benchmarks for each health plan product:
11
12 i) Number of hospital admissions per thousand enrollees in the last year for
13 outpatient, manageable, preventable conditions, including but not limited to
14 Community Acquired Bacterial Pneumonia, Asthma and Diabetes;
15
16 ii) Number of emergency department visits per thousand enrollees in the last
17 year;
18
19 iii) Number of preventive services, such as immunizations, which reduce the
20 need for later, costlier interventions;
21
22 iv) Percent of out-of-pocket costs incurred by enrollees for emergency
23 department visits as a percentage of total enrollee out-of-pocket costs;
24
25 v) Number of visits to out-of-network providers per thousand enrollees in the
26 last year;
27
28 vi) Percent of services received from in-network providers as a percentage of
29 total services received by enrollees; and

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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,

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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;

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1 (d) Procedures to address the needs of enrollees with limited English proficiency or
2 literacy, with diverse cultural and ethnic backgrounds, and with physical or
3 mental disabilities;
4
5 (e) Compliance monitoring policies, procedures and reports, filed for the
6 Department's review and approval, designed to accurately measure the
7 accessibility and availability of contracted providers, which shall include:
8
9 i) Tracking and documenting network capacity and availability with respect to
10 the standards set forth in Section V;
11
12 ii) Logging, reviewing and resolving all enrollee and provider grievances and
13 complaints alleging lack of accessibility to health care services separate
14 from other enrollee and provider grievances and complaints;
15
16 iii) Tracking and examining provider terminations by facility type and physician
17 specialty, including how many enrollees were affected and the reasons for
18 the terminations;
19
20 iv) Conducting an annual enrollee experience survey, which shall be conducted
21 in accordance with valid and reliable survey methodologies and designed to
22 ascertain the level of compliance with the standards set forth in this Act;
23
24 v) Conducting an annual provider survey which shall be conducted in
25 accordance with valid and reliable survey methodologies and designed to
26 solicit physician perspective and concerns regarding compliance with the
27 standards set forth in this Act;

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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.

<u>Section VIII</u>. <u>Enforcement</u>. The Department shall oversee compliance with this law.

(a) <u>Investigation</u>. 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:

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1 i) Require the health insurer to conduct a statistically valid survey of a
2 random sample of contracting physicians, approved by the Department, that
3 is designed to determine each participating physician's full time
4 equivalency for health plan product's enrollees. Results of the survey shall
5 be forwarded to the Department for review, and if appropriate,
6 investigation;
7
8 ii) Require the health insurer to conduct a statistically valid survey of a
9 random sample of enrollees who have received services within the prior
10 three months, including new enrollees, approved by the Department, that is
11 designed to determine whether and to what extent enrollees are having
12 difficulty in making timely appointments with contracted providers for
13 medical services. Results of the survey shall be forwarded to the
14 Department for review, and if appropriate, investigation;
15
16 iii) Examine the health insurer's contracting practices, including but not
17 limited to the willingness of the health insurer to enter into good faith
18 negotiations with non-contracting providers. As a part of its investigation,
19 the Department shall interview the health insurer, contracting providers,
20 and providers who choose not to contract with the health insurer in
21 determining whether or not the negotiations were in good faith;
22
23 iv) Interview enrollees, including those newly enrolled, of the health insurer as
24 to their experiences in obtaining an appointment with an established or a
25 new provider; and
26
27 v) Any other requirements that the Department determines is necessary.

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(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.

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IN THE GENERAL ASSEMBLY STATE OF ______________

Meaningful Access to Physicians and other Health Care Providers: Accurate Provider Directories

1 Be it enacted by the People of the State of ______________, represented in the General
2 Assembly:
3
4 **Section I. Title.** This Act shall be known and may be cited as the "Meaningful Access to
5 Physicians and other Health Care Providers: Accurate Provider Directories Act."
6
7 **Section II. Purpose.** The Legislature hereby finds and declares that:
8
9 (a) A critical attribute of health care coverage is the network of contracted physicians and
10 other health care providers, the "provider network." The provider network is comprised
11 of physicians and other health care providers who have contracted to "participate" by
12 agreeing to abide by the network's rules and accept a specified discount off their retail
13 charges. Physicians and other health care providers generally offer substantial discounts
14 to participate in provider networks because they may receive significant benefits in
15 return: (1) a promise of prompt payment; (2) increased patient volume by virtue of
16 inclusion in provider directories and benefit plans that give patients a substantial financial
17 incentive to go to in-network providers; and (3) maintenance of patient loyalty by
18 meeting their patients' requests that they be "in-network;"

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(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.

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1 **Section III. Definitions.**
2
3 (a) "Enrollee" means a person eligible for services covered by a specific health insurance
4 plan.
5 (b) "Contracting entity" means any person or entity that enters into direct contracts with
6 providers for the delivery of health care services in the ordinary course of business.
7
8 (c) "Health care facility" means all persons or institutions, including mobile facilities
9 which offer diagnosis, treatment, inpatient or ambulatory care to two or more
10 unrelated persons, and the buildings in which those services are offered. This
11 includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities,
12 nursing homes, home health agencies, outpatient or independent surgical, diagnostic
13 or therapeutic center or facility, including, but not limited to, kidney disease treatment
14 centers, mental health agencies or centers, diagnostic imaging facilities, independent
15 diagnostic laboratories (including independent imaging facilities), cardiac
16 catheterization laboratories and radiation therapy facilities.
17
18 (d) "Health care services" means services for the diagnosis, prevention, treatment or cure
19 of a health condition, illness, injury or disease.
20
21 (e) "Health insurer" means any person that offers or administers a health insurance plan.
22
23 (f) "Health insurance plan" means any hospital and medical expense incurred policy,
24 non-profit health care service plan contract, health maintenance organization
25 subscriber contract or any other health care plan or arrangement that pays for or
26 furnishes medical or health care services, whether by insurance or otherwise.

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1 (g) "Hospital-based physician" means any physician, excluding interns and residents,
2 which, as either a hospital employee or an independent contractor, provides services
3 to patients in a hospital rather than at a separate physician practice, and typically
4 includes anesthesiologists, radiologists, pathologists and emergency physicians, but
5 may also include other physician specialists such as hospitalists, intensivists and
6 neonatologists among others.
7
8 (h) "Physician tiering" means a system that compares, rates, ranks, measures, tiers or
9 classifies a physician's or physician group's performance, quality or cost of care
10 against objective standards, subjective standards or the practice of other physicians,
11 and shall include quality improvement programs, pay-for-performance programs,
12 public reporting on physician performance or ratings and the use of tiered or
13 narrowed networks.
14
15 (i) "Provider" means a physician, other health care professional, hospital, health care
16 facility or other provider who/that is accredited, licensed or certified where required
17 in the state of practice and performing within the scope of that accreditation, license
18 or certification.
19
20 (j) "Provider directory" means a listing of each and every participating provider within a
21 provider network.
22
23 (k) "Provider network" means all the providers contracted to provide services to
24 specified group of enrollees.
25
26 **Section IV. Approval required.** No health insurer that provides or seeks to market a health
27 insurance plan in this state may do so without first submitting its provider directory to the
28 Insurance Department ("the Department") for review and approval. Once the Department's

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initial approval has been obtained, approval of the updated provider directory must be obtained annually.

<u>Section V</u>. <u>Provider directory requirements</u>. The Department shall promulgate regulations to create a process to review each provider directory submitted pursuant to Section IV of this Act. These regulations shall require that provider directories comply with all of the following:

(a) <u>Physician information</u>. The provider directory must list all the following information concerning each participating physician:

i) Physician specific demographic information as follows:

1. Physician name, practice address, county, office telephone number, and Web site address or other link to more detailed individual physician information, if available;

2. Specialty and/or subspecialty information;

3. Indication of whether the physician may be selected as a primary care physician;

4. The physician's license number;

5. The hours that the physician is available to treat patients;

6. The names and locations of the hospitals where the physician has medical staff privileges;

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1 7. Whether the physician is accepting new patients;
2
3 8. Information about the method used to compensate the physician, e.g. by
4 indicating whether the physician is reimbursed on a fee-for-service or
5 capitated basis; and
6
7 9. If the provider network includes providers that have not contracted directly
8 with the health insurer but through a contracting agent, the provider
9 directory must indicate the name, Web site address, mailing address, and
10 telephone number of any contracting agent with whom the provider has a
11 direct contract.
12
13 ii) A notice regarding the availability of the listed physicians. The notice must be in
14 12 point type or greater and be placed in a prominent place in the directory. The
15 notice shall state: "This directory does not guarantee services by a particular
16 provider on this list. If you wish to receive care from any of the specific
17 providers listed, you should contact those providers to be sure that they are
18 accepting additional patients";
19
20 iii) Information about how to select a primary care physician, change a primary care
21 physician and how to use the primary care physician for access to other care;
22
23 iv) If the network is tiered in a way that impacts enrollee obligations, enrollees shall
24 be provided a conspicuous disclaimer in bold, 12 point type, indicating which
25 physicians are in which tier and how that physician tier impacts the enrollee's
26 financial or other obligations; and

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1 v) If the provider directory includes the name of any physician to which the
2 enrollee has no right to access on an in-network basis, the director must contain a
3 conspicuous disclaimer in bold, 12 point type, which states: "This physician is
4 not an in-network physician with respect to this health insurance plan."
5
6 (b) Other health care professionals. For each participating non-physician health care
7 professional who bills independently for health care services, the provider directory
8 must list that professional's licensure type and all of the information set forth above
9 in subsection (a), to the extent that information is relevant to that professional.
10
11 (c) Hospital/health care facility information. A provider directory must list all the
12 following information about each participating hospital and other health facility:
13
14 i) Hospital/health facility contact information as follows:
15
16 1. Information concerning all contracted hospital and/or health care facility
17 services, including but not limited to name and health facility type; address
18 and telephone number; and Web site address, if available;
19
20 2. Availability of emergency department services; and
21
22 3. If the network is tiered in a way that impacts enrollee obligations, enrollees
23 shall be provided clear information indicating which hospital or health
24 facility is in which tier, and how that tier impacts the enrollee's financial or
25 other obligations.
26
27 (d) Other services information. A provider directory must list the following information:

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i) Participating pharmacies and pharmacy benefit managers;

ii) Participating durable medical equipment providers;

iii) Participating clinical laboratories; and

iv) Participating ancillary service providers.

(e) Online graphic interactive map capability requirement. The health insurance plan must offer an online graphic interactive map that will provide current and prospective enrollees the means to input a reference address and locate providers within the provider directory by name, type, specialty, subspecialty and distance. All of the following shall be displayed for each provider identified by each search:

i) Whether the provider is participating, accepting new patients and if the network is tiered, which tier the provider is in and how that impacts enrollees' financial or other obligations;

ii) Distance from input location;

iii) Provider type, specialty and/or subspecialty;

iv) Provider contact information; and

v) With respect to hospital-based physicians, the physician specialty, the name(s) of the hospital(s) where each hospital-based physician is contracted and whether each of those hospitals is participating in the network.

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1 (f) <u>Publication and updating of provider directory</u>. The provider directory shall be:
2
3 i) Provided to the enrollee at the time of enrollment in hard copy;
4
5 ii) Posted on the health insurer's public Web site;
6
7 iii) Kept current and accurate as required by the regulations adopted by the
8 Department, including at a minimum: maintenance of an easy mechanism
9 enabling providers to update their own information in the directory; an
10 ongoing provider survey mechanism to confirm the continued accuracy of the
11 directory; an easy mechanism enabling enrolless to report directory errors; and
12 updating the online provider directory at least every thirty days.
13
14 **<u>Section VI</u>. <u>Enforcement provisions</u>.** A violation of this Act constitutes an unfair and
15 deceptive act or practice in the business of insurance under this Act. Where the Department
16 has found or it is otherwise determined that the health insurer has failed to meet any of the
17 standards set forth by this law, the Department shall do the following:
18
19 a) Institute all appropriate corrective action and use any of its other enforcement powers
20 to obtain the health insurer's compliance with this section; and
21
22 b) Where the violation results in an enrollee's use of an out-of-network provider despite
23 the enrollee's reasonable efforts to remain in network, require the health insurer to
24 pay the non-contracted provider's usual, customary and reasonable charge as stated
25 on the claim form.
26
27 **<u>Section VII</u>. <u>Private right of action</u>.** Any provider or enrollee may bring an action in a
28 court of appropriate jurisdiction against any individual or entity for any violation of this Act.

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1 The prevailing party in such an action will be entitled to any remedies contained in this Act
2 and any other remedies available at common law, as well as reasonable attorneys' fees and
3 costs.
4
5 **<u>Section VIII</u>. <u>Severability</u>.** If any provision of this Act or the application thereof to any
6 person or circumstance is held invalid, such invalidity shall not affect other provisions or
7 applications of the Act which can be given effect without the invalid provision or application,
8 and to this end the provisions of this Act are declared to be severable.

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