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June 18, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: General Guidance on Federally-Facilitated Exchanges

Dear Acting Administrator Tavenner:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' "General Guidance on Federally-Facilitated Exchanges" (Guidance Document), which was issued on May 16, 2012. We support the Department of Health and Human Services' (HHS) general approach to implementing a Federally-Facilitated Exchange (FFE) in any state where a state-based exchange is not operating or the state chooses the partnership route. HHS has provided important information and details that will be useful to states as they decide on which exchange route to take.

General Approach

The Affordable Care Act (ACA) will bring about a new paradigm by extending health care coverage and benefits to millions of individuals who are currently uninsured. The health insurance exchanges are intended to be vital components in fulfilling the ACA's promise to make high-quality health care available to all Americans, and the arrangements described in the Guidance Document provide additional options for states to consider as ACA implementation moves forward. We strongly support the four guiding principles for FFEs, as outlined in the Guidance Document, i.e., commitment to consumers, market parity, leveraging the traditional state role (particularly state insurance commissioners), and engagement with states and other stakeholders. We also support HHS' decision to certify any plan as a qualified health plan (QHP) if it meets all certification standards, at least for the first year of operation. As we indicated in our previous comments in response to HHS' proposed rule on the establishment of exchanges (Exchange Rule Comments) and qualified health plans, we believe an open marketplace will best ensure a robust and competitive market, as well as consumer choice, and we urge HHS to continue this approach beyond the first year of a FFE.

Transition from a Federal Exchange to a State Exchange

We note that there is no mention in the Guidance Document about transitioning from a FFE to a state exchange after 2014. As we indicated in our Exchange Rule Comments, with patients needing to transition from a QHP certified by the FFE 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, describing 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 FFE, 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 FFE 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 FFE to QHPs certified by a state exchange. Essential to the transition are systems that allow for real-time patient eligibility information, so that physicians 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 FFE 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 FFE that may not also be certified by the state exchange.

Plan Management in a FFE-QHP Certification Process and Network Adequacy

The Guidance Document indicates that HHS will evaluate each potential QHP against all applicable certification standards, either by confirming the outcome of a state's review or by performing the review, including the certification standard for network adequacy. We would like to reiterate the concerns we previously expressed in our Exchange Rule Comments on network adequacy. 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, state insurance regulators, and HHS 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 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;
 - Timely implementation of appropriate corrective action plans; and
 - 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.

Eligibility for Insurance Affordability Programs and Enrollment in the Individual Market

HHS acknowledges in the Guidance Document the importance of coordination across a FFE, Medicaid, and the Children’s Health Insurance Program (CHIP). We strongly agree, especially with regard to adequate and real-time information to physicians and their patients with respect to enrollment status, as well as with regard to churning of patients between a FFE and Medicaid/CHIP. 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.

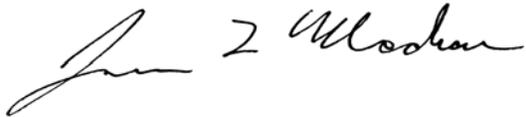
While the primary focus should be on patients in trying to address the churn issue, how HHS and the states address this issue will have a major effect on physicians as well. The key concern for physicians with respect to the churn issue is the need to have access to real-time, accurate information regarding 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

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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.

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.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and a long horizontal stroke.

James L. Madara, MD

Attachment



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.

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

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

3
4 (g) “Hospital-based physician” means any physician, excluding interns and residents,
5 which, as either a hospital employee or an independent contractor, provides
6 services to patients in a hospital rather than at a separate physician practice, and
7 typically includes anesthesiologists, radiologists, pathologists and emergency
8 physicians, but may also include other physician specialists such as hospitalists,
9 intensivists and neonatologists among others.

10
11 (h) “Physician tiering” means a system that compares, rates, ranks, measures, tiers or
12 classifies a physician’s or physician group’s performance, quality, or cost of care
13 against objective standards, subjective standards, or the practice of other
14 physicians, and shall include quality improvement programs, pay-for-performance
15 programs, public reporting on physician performance or ratings, and the use of
16 tiered or narrowed networks.

17
18 (i) “Provider” means a physician, other health care professional, hospital, health care
19 facility or other provider who/that is accredited, licensed or certified where
20 required in the state of practice and performing within the scope of that
21 accreditation, license or certification.

22
23 (j) “Provider directory” means a listing of each and every participating provider
24 within a provider network.

25
26 (k) “Provider network” means all the providers contracted to provide services to a
27 specified group of enrollees.

1 **Section IV. Meaningful network standards, report, approval and certification**

2 **requirements.** No health insurer that provides or seeks to market a health plan product
3 in this state may do so without first obtaining a provider network certification from the
4 Insurance Department (“the Department”). The Department’s provider network
5 certification shall set forth the geographic and population capacity of the provider
6 network. The provider network certification shall be awarded only to the extent that the
7 provider network offers the access to physicians and other health care providers
8 reasonably necessary to ensure that all enrollees of a health plan product using the
9 provider network will have timely access to all the medical care that they need on an in-
10 network basis, including but not limited to access to emergency services twenty-four
11 hours a day, seven days per week. The health insurer must meet the following
12 requirements in order to obtain certification:

13
14 (a) The health insurer must provide a certified network report to the Department once
15 a year documenting all the information contained in Section V of this Act as
16 follows:

17
18 i) The report must be prepared by the actuary who calculated the health
19 insurer’s premium; and

20
21 ii) The report must be provided to the Department, and made available publicly
22 on the health insurer’s website, within seven days of the Department
23 certification.

24
25 (b) A health insurer shall provide a certified network report that is specific to each
26 health plan product it offers in the state; and

1 (c) A health insurer shall not change its provider network for any of its health plan
2 products until after the Department has approved the certified network report
3 applicable to the proposed new network.
4

5 **Section V. Health insurer disclosure requirements.** The Department shall evaluate
6 certified network reports based on the following information, by county:
7

8 (a) Number of enrollees, by health plan product, including the number of:
9

10 i) Males;

11

12 ii) Females;

13

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

15

16 iv) Children (enrollees under, or equal to, 18 years of age).
17

18 (b) Number and FTE equivalent number of physicians contracted to participate in the
19 network in each of the following areas, and as a percentage of the total number of
20 physicians of this relevant specialty practicing in the county, by health plan
21 product:
22

23 i) Primary care physicians to enrollee population;

24

25 ii) Geriatric medicine physicians to geriatric population;

26

27 iii) Pediatricians to pediatric population; and

28

29 iv) Women's health physicians to women.

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;

- 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;

- 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.

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(d) The insurer shall comply with the following:

- i) If the network is tiered in a way that impacts an enrollee’s financial obligations, the health insurer shall provide separate totals for both all contracted physicians and for the subset of contracted physicians that enrollees are permitted to access with the least financial obligation;
- ii) With respect to hospital-based physicians, the report must indicate how many physicians of each hospital-based specialty are contracting at each participating hospital; and

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

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

3
4 (f) Compliance Monitoring Data. The following compliance monitoring data must
5 be reported:

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

9
10 ii) An analysis of the health insurer's contracting practices, including the
11 number of new and terminated providers by specialty and geographic area,
12 an analysis of the reasons for any contract terminations and steps the health
13 insurer took in response, and the number of enrollees affected by each
14 contract termination. The health insurer shall also report any significant
15 reduction to the provider network as soon as feasible and in every case
16 within two business days; and

17
18 iii) An analysis of all enrollee and provider grievances and complaints alleging
19 a lack of accessibility to health care services in the prior year, including, for
20 each such complaint: a) the county in which it arose; b) the provider type,
21 including physician specialty for all complaints involving lack of access to a
22 physician; c) the reason for the complaint; and d) the resolution, including
23 whether the health insurer referred the enrollee to an out-of-network
24 provider and whether an out-of-network provider provided services to the
25 enrollee.

26
27 **Section VI. Network Quality Assurance Processes.** The health insurer shall
28 provide the Department with its Network Quality Assurance Processes as described in
29 this section. Each health insurer must have written quality assurance systems,

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

- 5
- 6 (a) Standards for the provision of covered services in a timely manner consistent
7 with the requirements of this Act;
- 8
- 9 (b) Continuity of care, referral systems and processes sufficient to ensure that, if a
10 contracted provider is unable to deliver timely access in accordance with the
11 standards of this section, the health insurer arranges for the provision of a timely
12 appointment with an appropriately and similarly qualified and geographically
13 accessible provider within the health plan product's network, on the enrollee's
14 request and with the enrollee's consent;
- 15
- 16 (c) If no provider reasonably acceptable to the enrollee is available on a timely basis
17 within the network, then referral to a non-contracted provider must be made.
18 Disputes over the acceptability of a contracted provider shall be resolved
19 following the same process applicable to disputes over experimental or
20 investigational treatments within this state. The health insurer must indemnify
21 the enrollee for any covered medical expenses provided by the non-contracted
22 provider incurred over the co-payment(s) and deductibles that would apply to
23 contracted providers, and such enrollees and non-contracting providers with an
24 assignment of benefits shall have the ability to enforce this provision in a court of
25 competent jurisdiction. This requirement does not prohibit a health insurer or its
26 delegated physician group from accommodating an enrollee's written request to
27 wait for a later appointment from a specific contracted provider;

- 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;

- 1 vi) Reviewing and evaluating, on not less than a quarterly basis, the information
2 available to the health insurer regarding accessibility, availability and
3 continuity of care, including but not limited to information obtained through
4 enrollee and provider surveys, contract terminations, utilization of services,
5 enrollee complaints and grievances and their resolution; and
6
7 vii) Verifying the accuracy of its own provider directory;
8
9 iv) A health insurer shall undertake a prompt investigation and implement
10 timely corrective action when compliance monitoring discloses that a health
11 plan product's provider network is not sufficient to ensure timely access as
12 required by this Act, including but not limited to taking all necessary and
13 appropriate action to identify the cause(s) underlying identified, timely
14 access deficiencies and to bring its network into compliance. Health
15 insurers shall make all necessary modifications to their contracting practices
16 to ensure compliance; and
17
18 v) Health insurers shall give advance written notice to all contracted providers
19 affected by a corrective action ordered by the Department to rectify an
20 access problem. The notice shall include: a description of the identified
21 deficiencies; the rationale for the corrective action; and the name and
22 telephone number of the person authorized to respond to provider concerns
23 regarding the health insurer's corrective action.
24

25 **Section VIII. Enforcement.** The Department shall oversee compliance with this law.
26

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

- 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.

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

5
6 i) Institute all appropriate corrective action and use any of its other enforcement
7 powers to obtain the health insurer's compliance with this Act; and

8
9 ii) Where the violation results in an enrollee's use of an out-of-network
10 provider, require the health insurer to pay the non-contracted provider's
11 usual, customary and reasonable charge as stated on the claim form.

12
13 **Section IX. Private Right of Action.** Any provider or enrollee may bring an action in a
14 court of appropriate jurisdiction against any individual or entity for any violation of this
15 Act. The prevailing party in such an action will be entitled to any remedies contained in
16 this Act and any other remedies available at common law, as well as reasonable attorneys'
17 fees and costs.

18
19 **Section X. Severability.** If any provision of this Act or the application thereof to any
20 person or circumstance is held invalid, such invalidity shall not affect other provisions or
21 applications of the Act which can be given effect without the invalid provision or
22 application, and to this end the provisions of this Act are declared to be severable.