AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

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

Re: Letter to Issuers on Federally-Facilitated and State Partnership 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 & Medicaid Services' (CMS) Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Letter) dated March 1, 2013. CMS has provided important information and operational details that will be useful to states, issuers, consumers, and physicians and other providers and that hopefully will help lead to smooth and successful implementation of all exchanges in 2014.

Certification Standards for Qualified Health Plans: General Approach

We appreciate the tremendous efforts being made by CMS to prepare for the creation and operation of health insurance exchanges, including state-based exchanges, partnership exchanges, and federally-facilitated exchanges. The exchanges will be vital components in fulfilling the Affordable Care Act's (ACA) goal of making high quality, affordable health care available to millions of currently uninsured Americans. We support CMS' stated intent of relying on states' reviews of market reforms as part of its qualified health plan (QHP) certification process, provided that such state reviews are consistent with federal regulatory standards and operational timelines, and appreciate CMS' recognition that states are the primary regulators of health insurers and are responsible for enforcing the market reform provisions both inside and outside the exchanges. CMS notes that it will be responsible for enforcing the market reforms in a state if a state fails to do so, and that "as necessary, CMS will provide additional information on enforcement." Given the number of states in which federally-facilitated exchanges will be operating in 2014, and the continued opposition in many states to the ACA, CMS may have to assume a very active enforcement role in a number of states in order to ensure that the ACA's important market reforms are appropriately implemented. Accordingly, we urge CMS to issue additional guidance on the details of such enforcement sooner rather than later.

Network Adequacy

Under the ACA, QHPs must maintain provider networks sufficient in numbers and types of providers to ensure that all services are accessible without unreasonable delay. CMS indicates in the Letter that, for 2014, it will use state analyses and recommendations where the state has the authority and means to assess adequacy and where state standards are as stringent as the federal QHP standards. Moreover, CMS will rely on an issuer's commercial or Medicaid accreditation to ensure adequacy in states that lack sufficient network adequacy reviews. The final regulations outlining QHP minimum certification standards for network adequacy require a

QHP to maintain a network "that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay" (45 CFR 156.230). We do not believe that these standards are stringent enough, for the reasons expressed below.

We would like to reiterate the concerns that we previously expressed in our Exchange Rule Comments and in our comments on CMS' General Guidance on Federally-facilitated Exchanges on network adequacy. An important element 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 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 CMS 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 one-thousand enrollees, the percentage 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 to ensure that the adequacy of the entire provider network is evaluated, including "all providers contracted to provide services to a specified group of enrollees."

- 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 plan 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's drafted model bill, "Meaningful Access to Physicians and Other Health Care Providers: Network Standards Act" (attached), 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 CMS and the states to utilize this model bill as a baseline for, and to evaluate, network adequacy in QHPs.

Benefit Design Review: Non-discrimination and Supporting Informed Consumer Choice

Under the ACA, QHPs are prohibited from using cost-sharing designs that will have the effect of discouraging the enrollment of individuals with significant health needs. We support CMS' intended approach of performing an outlier analysis on QHP cost sharing and using the outlier analysis to target QHPs for more in-depth reviews. We also support CMS' intent to review information contained in the "explanations" and "exclusions" sections of the plans and benefits template in order to identify any discriminatory practices or wording.

As the AMA has previously commented, we support an open marketplace (e.g., "any willing plan") format for exchanges in order to maximize health insurance issuer choice for individuals and families purchasing coverage. Further, QHPs sold on exchanges should provide an array of choices for patients, in terms of benefits covered, cost-sharing levels, formularies, and other features, and the any willing plan model is the most likely model to provide health insurance issuers with needed flexibility to encourage such innovation. Although CMS has previously stated that it intends to certify as a QHP any plan that meets all certification standards, at least for the first year, CMS now indicates that it intends to review QHP benefit packages and costs to ensure a "meaningful difference" among plans. It will then decide whether consumers would likely be able to distinguish a particular plan from other plans offered by the same issuer in the same service area in deciding whether it is in the interest of federally-facilitated exchange enrollees to offer the plan. While we understand the intent of such a review, we are concerned that there is no definition of what makes QHPs "substantially" or "meaningfully" different from one another. What is meaningful or substantial to one consumer may be relatively subjective, and a differential of $100 in cost sharing could be the deciding factor for an individual when choosing a plan.

Consumer Enrollment and Premium Payment: Grace Periods and Notice to Providers

As we have indicated in previous comments to CMS, we remain very concerned about and opposed to a provision in the final exchange rule under which health insurance issuers will be allowed to pend claims for the final 60 days of the 90-day grace period when a patient is having his or her coverage terminated for non-payment of premiums. As the preamble to the final exchange rule notes, patients may potentially "game" the system which could cause health insurance issuers to potentially lose three months of premium payments. However, HHS unfairly shifts this burden to physicians and other health care providers and puts them in the position of potentially providing health care to patients for two months without payment.

We appreciate that issuers are required to notify physicians and other providers "as soon as is practicable" that an enrollee has failed to pay his/her premiums on time and has entered into the grace period. We note that CMS

will require the exchanges and QHP issuers to send and receive electronic transactions (e.g., ASC X12 834) at least once daily containing information about new enrollments, updates, cancellations, and terminations. We believe that physicians and other providers should have access to such information on a real-time basis.

Additional Guidance on Essential Health Benefits (EHB) Prescription Drug Coverage

In Appendix C of the Letter, CMS provides important new clarifications and information about the prescription drug exceptions process that issuers providing EHB should follow. We called on CMS to issue such information in our comments on the proposed EHB rule, and commend CMS for providing a recommended process for internal review and independent review for issuers that do not already have an exceptions process in place to follow. We support looking to the Medicare Part D program as a model in determining when a drug is clinically appropriate and should be covered as part of the required exceptions process, but, as we indicated in our EHB comments, we believe the Part D process should be required as a floor.

Thank you for your consideration of our comments. If you have any questions, please contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,

James L. Madara, MD

Attachment

IN THE GENERAL ASSEMBLY STATE OF _____

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

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

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

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

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

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

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

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

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

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

Section III. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Males;

ii) Females;

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

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

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

i) Primary care physicians to enrollee population;

ii) Geriatric medicine physicians to geriatric population;

iii) Pediatricians to pediatric population; and

iv) Women's health physicians to women.

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

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

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

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

(d) The insurer shall comply with the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vii) Verifying the accuracy of its own provider directory;

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

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

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

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

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

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

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

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

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

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

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

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

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

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