AMA
AMERICAN
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ASSOCIATION

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October 4, 2010

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

Re: HHS Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (OCIIO-9989-NC)

Dear Secretary Sebelius:

The American Medical Association (AMA) appreciates this opportunity to comment on the U.S. Department of Health and Human Services (HHS) Office of Consumer Information and Insurance Oversight's (OCIIO) request for comments regarding exchange-related provisions in Title I of 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, as well as reforming a system that encourages health insurance issuers and plans (insurers) to recruit the healthy and avoid patients who need health insurance the most – those with chronic and acute medical conditions.

The state-based American Health Benefit Exchanges and the Small Business Health Care Options Programs (exchanges) should be vital components in fulfilling the ACA's promise to make high-quality health care available to all Americans.

- The exchanges should help to provide coverage to millions of Americans without access to affordable health care – especially those with pre-existing conditions;
- They should be a patient-friendly market for patients to purchase health care;
- They should increase competition among plans based on quality and price;
- They should facilitate eligibility determinations and tax-subsidies/credits for patients;
- They should streamline the health insurance purchasing process and reduce administrative burdens and costs; and
- Finally, they should lead to a strengthened U.S. health care system.

In addition to our comments on exchanges, we are also including issues and comments that have come up in our work with the state medical associations and the national medical

specialty societies on ACA implementation at the state level. Before addressing several of the questions posed by HHS, we would like to emphasize some key recommendations that we believe are important for exchanges to be implemented in an optimal way for patients and physicians.

Key Recommendations for HHS and States on Insurance Exchanges

First, the AMA calls for a high level of transparency for all health insurance plans, and qualified health plans participating in the exchanges should be no exception. For example, to make an informed health care purchasing decision, patients need to know how their premium dollars will be spent, what their cost-sharing and co-payment responsibilities will be, which pharmaceuticals will be available to them, and how insurers will conduct appeals for denied claims, among other things. Transparency will afford patients the opportunity to review insurer practices and to make an informed choice regarding their health insurance decisions.

Second, exchanges present a great opportunity to break the stranglehold that large insurers have on numerous markets to the detriment of patients and physicians. In our report, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update*, we reviewed data on combined HMO and PPO commercial enrollment in health insurance markets across the U.S., and based on the Department of Justice and Federal Trade Commission *Horizontal Merger Guidelines*, we concluded that 99 percent (309) of the Metropolitan Statistical Areas (MSAs) examined are highly concentrated. Moreover, in 54 percent (169) of the MSAs, at least one insurer had a market share of at least 50 percent.[1] This market concentration creates an imbalance in the negotiating power between physicians and insurers, which leads to a host of problems that in the end has a negative effect on patients. Based on these data, we urge HHS and the states to set up a framework for exchanges that promotes increased competition in the health insurance marketplace in order to alleviate the effects of marketplace concentration—including allowing all qualified health plans to participate in the exchanges.

Third, the AMA is continuing our long-term commitment to improving insurer practices that are harmful to patients and physicians. The ACA addresses some of the most troubling insurer practices, such as rescission, but more work needs to be done. The AMA has drafted an Insurer Code of Conduct (the Code) that aims to improve insurer practices. The main issues in the Code include cancellation of coverage, medical services spending, access to care, fair contracting and patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity and claims processing. We are encouraging states to require all insurers to follow these requirements, and we urge HHS and the states to specifically require them of qualified health plans that will be certified to participate in exchanges.

[1] *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update.* American Medical Association.

Fourth, exchanges will be best served with patients and practicing physicians in their governance structures. Patients will be the exchange consumers, so it is important to seek out their input and to provide them with a voice in the operation of an exchange. Having practicing physicians involved in exchange governance is critical as well. The success of exchanges could hinge on how physicians interact with them. Giving physicians a voice in the establishment and operation of an exchange will lead to a more positive reception in the physician community and will help to identify problems with the exchanges, allowing them to be rectified as quickly as possible.

Fifth, the establishment of exchanges creates a window of opportunity to improve the quality of health care provided to patients. However, HHS and the states must guard against cost containment mechanisms which are euphemistically termed "quality measures." The AMA has several key recommendations for health plan improvement measures that will be discussed in the Q&A section of this response, including: (1) practicing physicians and patients should be involved in the development, evaluation, and refinement of the program measures; (2) performance measures must include an appropriate mix of those that are process-oriented and outcomes-oriented; and (3) the capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians should be publicly revealed in understandable terms to patients.

Finally, adequate physician payment, particularly for primary care, is crucial to the success of exchanges. Exchanges will provide patients with an array of coverage options, but even the lower cost options will need to provide physicians with adequate payment in order to have robust, high quality provider networks.

HHS Questions on Exchanges

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

Question A(2)(a) - State Exchange Planning and Establishment Grants

What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

AMA Response to Question A(2)(a)

As stated above, the AMA urges HHS and the states to include patients and actively practicing physicians in the governance structures of the exchanges. This will be essential in numerous aspects of exchange implementation, including: benefit structures, qualified health plan certification, marketing practices and physician payment, just to name a few. Exchanges

will need input from numerous stakeholders, but input from patients and physicians is critical to ensuring the success of exchanges. They 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 entities, then patient and physician input is even more necessary to ensure that they are accountable to the patients that they serve.

Question B(2) - Implementation Timeframes and Considerations

What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

AMA Response to Question B(2)

In short, the more information for patients and physicians, the better. HHS and the states should include reasonable timelines, where possible, for the planning and implementation of exchanges. The exchange planning entities should provide patients and physicians with adequate information and support to keep them as informed and prepared as possible for when the exchanges go into effect in 2014. The Medicaid, Children's Health Insurance Program (CHIP), and exchange plan populations will need significant education about their health insurance options, how to utilize the exchanges, and what their best choices are. Outreach and educational efforts will need to be targeted in nature in order to be successful in reaching out to racial and ethnic minorities, as well as individuals who do not speak English, and assuring their enrollment in the appropriate health plan. Further, a significant portion of this population will need more fundamental education on how health insurance works, so exchanges will have to take appropriate steps to reach out to those individuals with limited health literacy skills.

Exchanges will also be a transition for physicians. Educating physicians, other health care providers, and physician and provider staff will be a major undertaking to ensure a smooth transition to the exchanges. We recommend that the exchanges or their planning entities keep these groups informed as they move forward and that they focus on how to minimize the transitional issues that could interrupt continuity of care for patients.

Question C(2) - State Exchange Operations

For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

AMA Response to Question C(2)

(1) Administrative Simplification

Administrative simplification is a major policy objective for the AMA, and we contend that the implementation and enforcement of national standards will lead to an improved health care delivery system. With greater competition, we can envision physicians needing to work with a greater number of companies and plans, making standardization even more important. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 and $210 billion.[2] In the physician practice, this expense comprises 10-14 percent of practice revenue.[3] The administrative simplification objective within the physician practice is to encourage automated, real-time health plan transactions, along with the reduction of manual processes throughout the physician's claims management revenue cycle and increased insurer claims payment process transparency and reduced ambiguity. The AMA is committed to addressing and advocating for the following solutions to the ongoing problems in the claims management revenue cycle that contribute to increased complexity and expense.

(2) Transparency and Disclosure

All health plans need to disclose to their beneficiaries and the physicians, other healthcare professionals and health facilities providing services to those beneficiaries, all information necessary to determine the relative financial rights and responsibilities of all parties prior to the provision of a healthcare service. This includes full, complete transparency of the contract-specific payer fee schedule, payer medical payment policies, reimbursement rules, and other payment reductions.

(3) Standard Code Editing Package

Counting all payers' proprietary edits, there are more than two million edits currently being used by payers to deny physicians' claims. The only edits that are transparent, easily available, and developed with broad participation of all interested parties are those included in the National Correct Coding Initiative (CCI). Requiring all edit packages to be transparent and to be consistent with CPT coding rules would result in substantial administrative savings by allowing all stakeholders to have a complete understanding of the rules for applying Current Procedural Terminology (CPT) codes. Further, physicians should be permitted to review and comment on the edits before they are put into place. The ACA requested the Secretary of HHS to identify by no later than September 1, 2010, the methodologies of the CCI edits - or any successor initiative to promote correct coding - to be incorporated into claims filed by states for medical assistance. We encourage exchanges to include this requirement.

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[2] PNC Bank (2007), Commonwealth Fund (2007); RAND Corporation (2005), PricewaterhouseCoopers, 2008.

[3] Kahn, J. G., "Billing and Insurance-Related Administrative Costs: Burden to Health Care Providers", IOM Roundtable: The Healthcare Imperative, May 2009

(4) Current Procedural Terminology (CPT)

Standard implementation guidelines for code sets are essential for uniform national application of the code sets. Currently, insurers and physicians are permitted to implement and interpret the CPT code set as they see fit; only ICD-9 implementation rules are required to be followed. While CPT was adopted as a standard code set under HIPAA, the CPT coding guidelines and conventions were not; these should be adopted as well to reduce inconsistencies in the recognition and reporting of physician procedures and services. This oversight significantly undermines administrative simplification and pricing transparency efforts since stakeholders do not have consistent and standard guidelines and instructions for applying CPT. We would encourage the exchanges to mandate that CPT codes, guidelines, and instructions be adhered to by all stakeholders. Visit www.ama-assn.org/go/simplify to access the AMA white paper, *Standardization of CPT codes, guidelines and conventions*.

(5) Eligibility Information

Due to patient movement from one plan to another through the exchange, timely eligibility information, including precise enrollment and disenrollment dates, for each patient specific benefit plan must be maintained and made available by the insurer in a real time and batch format through a: (1) HIPAA compliant X12 271 eligibility response standard transaction in response to a HIPAA X12 270 eligibility request; (2) Web portal; and (3) other appropriate methods, so that physicians, other health care providers, and patients will be able to access accurate eligibility information prior to and at the time of a patient visit. We anticipate that this will require close coordination between the insurers, Medicaid and CHIP plans, and the exchange. This will also require employers to electronically submit enrollment information that includes secondary and tertiary health insurance, as well as electronically submit disenrollment information, including dependents, 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 insurer. The ability for physicians and other healthcare providers to receive accurate patient eligibility information that they can count on and which will not be reversed at a later date is essential.

(6) HIPAA Compliance

In order to simplify current health care billing processes and reduce the associated administrative costs for all stakeholders, the AMA recommends focusing on compliance with HIPAA transaction and code set standards in order to achieve greater administrative simplification and increased transparency for patients.

And finally, from a state flexibility perspective, the AMA recommends that HHS permit states to add on to the requirements for qualified health plans, as the ACA intends. We also recommend that the role of state insurance commissioners be safeguarded with regards to consumer protections, such as grievance procedures, external review and oversight of agent practices, training, and conduct. Further, state insurance commissioners should maintain their

role as regulators for physician protections, including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

Question C(6)- State Exchange Operations

What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

AMA Response to Question C(6)

The AMA recommends that any type of rate review process be as transparent as possible. The key is to provide patients with a clear understanding of how insurers are spending their premium dollars, so that patients can make informed decisions on which policies to purchase.

The AMA has offered comments to the National Association of Insurance Commissioners (NAIC) as they develop a rate review form to be used by insurance companies once HHS has determined a rate increase to be "unreasonable." We have called for the reporting of extensive information in this form to provide patients with the information that they need, and we have urged NAIC, and will urge HHS, to make the rate review form public once an insurer files it with HHS, the state or both. This information could be very beneficial to patients and patient advocates as they seek to ensure a fair result for patients' premiums.

Further, HHS and the states should consider giving the entity conducting the rate reviews the authority to order an actuarial review of any proposed insurer rate filing at the expense of the insurer. This practice has worked in California and helped to root out computational errors that led to erroneous rate increases. It may work at the Federal level or in other states as well as to the benefit of patients.

Question C(8) - State Exchange Operations

What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

AMA Response to Question C(8)

The elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA. We support 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. The cost and coverage of interpretive services is one hurdle that has hindered physicians' ability to care for the hearing impaired and non-English speaking patients. Adequate coverage and payment for interpretive services is a solution to

one health care disparity problem. Also, the streamlined enrollment process for Medicaid, CHIP, and exchange plans will help to address health care disparities by enrolling more patients and by promoting continuity of care for these patients.

Question D(1) - Qualified Health Plans (QHPs)

What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

AMA Response to Question D(1)

Overall, the AMA urges that insurance coverage options offered in a health insurance exchange: (1) be self-supporting; (2) have uniform solvency requirements; (3) not receive special advantages from government subsidies; (4) include payment rates established through meaningful negotiations and contracts; (5) not require provider participation; and (6) not restrict enrollees' access to out-of-network physicians.

Further, in 2010, the AMA released its Health Insurer Code of Conduct Principles (the Code) and called on all U.S. 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 insurer practices that influence the health care of patients, including cancellation of coverage, medical services spending, access to care, fair contracting and patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity, and claims processing.

AMA Health Insurer Code of Conduct Principles

Standards for health insurers' administrative and clinical processes

(1) Health Insurance Cancellation and Rescission

- Health insurer decisions to cancel a person's coverage must be subject to independent, outside review.
- Rescission of coverage should not be permitted for innocent mistakes on applications, nor after significant delay.
- Health insurers must not cancel policies of patients who become injured or severely ill after the policy is issued.
- Paying employees or contractors bonuses or rewards for rescinding the policies of sick consumers, our patients, must be prohibited.

(2) Health Insurance Premiums and Spending on Medical Services

- Health insurers must calculate health insurance premiums fairly, and different products must be priced proportionate to their actuarial value.
- Health insurers must spend the substantial bulk of the premium dollar on direct medical care.
- Health insurer expenditures on profit and on administrative, non-medical costs (salaries and bonuses, advertising, utilization review, etc.) must be transparent to the public, based on a single standard definition and reporting mechanism.
- Clear information on covered benefits, including co-payments, co-insurance and other information affecting patient financial responsibility must be readily available to patients and their physicians.
- Consumers must receive written justification for premium quotes or renewal increases, and be provided with a fair opportunity and forum to seek redress.

(3) Access to Medical Care

- Health insurance benefits, including all medically necessary and emergency care, must be available to all enrollees on a timely and geographically accessible basis at the preferred, in-network rate.
- Provider directories must be easily accessible in paper and electronic formats and clearly and accurately provide consumers with all information relevant to fulfilling the medical needs of themselves and their families. This includes which physicians (including hospital-based physicians), hospitals, and other health care providers are in-network and accepting new patients.
- Directories which include listings for providers who are not freely accessible, such as providers 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, such as increased co-payment, co-insurance or other patient financial responsibility.

(4) Respectful Relations

- Health insurers must treat all enrollees, physicians and other trading partners respectfully.
- Health insurers must protect the confidentiality of each enrollee's medical information, and must give appropriate deference to the treating physician's skill and professional judgment.
- Patients must be confident that the physicians and other health care professionals in the network may talk freely, without fear of retaliation.
- Health insurers must cease such unfair practices with physicians as demanding unreasonable contract terms, improperly applying contractual discounts, unilaterally amending contracts or refusing to acknowledge contract terminations.

(5) Medical Necessity

- Medical care is "necessary" when a prudent physician would provide it to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- All emergency screening and treatment services (as defined by the prudent layperson standard) provided by physicians and hospitals to patients must be covered without regard to prior authorization or the treating physician's or other health care provider's contractual relationship with the payer.
- Health insurers must not use financial incentives that discourage the rendering, recommending, prescribing of, or referral for medically necessary care.
- No care may be denied on the grounds it is not "medically necessary" except by a physician qualified by education, training and expertise to evaluate the specific clinical issues.
- Patients and their physicians must have the right to a transparent appeal process and obtain a free, timely, external review of any adverse benefit decision based on "medical necessity" or a claim the service is "investigational" or "experimental."

(6) Benefit Management

- Clear information on benefit restrictions must be readily available to patients and physicians.
- Decisions based on formularies or other benefit management tools must be consistent with clinically appropriate medical guidelines, and physicians must have a simple, fast way to get exceptions when warranted by their patients' medical needs.
- Adverse changes to formularies or other benefits must not be made during the plan coverage year, and physicians who have stabilized a patient on a particular medication or other treatment regime must not be forced to change those medications or other treatments, nor should these patients be required to incur additional costs based upon such changes.
- Financial incentives must not corrupt benefit decisions, and all financial incentives potentially impacting benefit decisions must be fully disclosed.

(7) Administrative Simplification

- Health insurers must eliminate complexity and confusion from their processes and communications.
- Health insurers must comply with all laws governing the use of electronic transactions, and should participate in efforts to improve these transactions.

- Health insurers must provide clear, timely, and accurate eligibility and benefit information on request.
- Requirements imposed on patients, physicians and other health care providers to obtain approvals and respond to information requests must be minimized and streamlined, and health insurers must maintain sufficient staff and infrastructure to respond promptly.

(8) Physician Profiling

- Physician profiling systems must be focused primarily on improving the provision of quality care - not on reducing the cost of care.
- Profiling systems must use good and relevant data and produce accurate, statistically valid results reflecting matters within the physician's control.
- Profiling systems must be appropriately risk-adjusted to account for patient variation for co-morbidities, severity of illness, racial/ethnic factors, compliance and other mitigating factors.
- Physicians must be given a meaningful opportunity to review their data, challenge the insurers' profiles and be afforded due process to remedy incorrect profiles prior to their publication or use in determining incentives or network placement.

(9) Corporate Integrity

- Health insurers must conduct their business in compliance with the highest levels of corporate citizenship, consistent with their fiduciary obligations to their enrollees.
- Health insurers must comply with the letter and spirit of all laws that protect the clinical and business integrity of their dealings with their enrollees and their dealings with physicians and other health care providers.
- Policies prohibiting conflicts of interest, retaliation against whistleblowers and sharp business practices must be established and aggressively enforced.
- The corporate compliance officer must be adequately funded and staffed, and be given direct and open access to the health insurer's Board of Directors.

(10) Claims Processing

- Health insurers must pay claims accurately and timely, and provide clear and comprehensive explanations of how each claim was handled, including the specific reason for any denial of, or reduction in payment.
- All fee schedules, claim edits and payment policies which may affect payment for a service or a patient's financial responsibility must be disclosed in a reasonably understandable, downloadable format.
- Requests for refunds after payment must occur rarely, and then only within a reasonable time after making the initial payment.

- Patients and their physicians must have a fair, fast and cost-effective right to appeal any contested claim.

Our goal is to have all U.S. health insurance companies follow the Code. Requiring qualified health plans in the exchanges to follow the Code in order to be certified would be a very positive step for both patients and physicians. It could also drive states to require insurers operating outside of the exchanges to abide by it as well to ensure a level playing field for all plans, whether they are in the exchange or are offering policies outside of it. It is important for states to maintain a level playing field in order to avoid adverse selection, which could cause the exchanges to fail.

Question D(2)(a) - Qualified Health Plans (QHPs)

What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

AMA Response to Question D(2)(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. Because, for financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access, a provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives patients of the benefit of the money they have paid for health care coverage.

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

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

To ensure an adequate provider network, the AMA calls for the certification by the state department of insurance of the plan's provider network. HHS and the states should establish a similar procedure for qualified health plans in the exchanges. The AMA has prepared the "Meaningful Access to Physicians and other Health Care Providers: Network Standards Act" to assist states develop a thorough certification process, and a copy of the model bill is included with this letter. (Attachment 1) The model bill calls on plans to disclose the geographic and population capacity of the provider network. The provider network certification 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. This model bill should be helpful to HHS and the states as they consider network adequacy as part of the qualified health plan certification process.

Further, to maintain adequate provider networks and access for patients to physician services, reasonable physician payment levels need be assured for mandated benefits in health insurance policies offered by qualified health plans. These payment rates should be established through meaningful negotiations and contracts. Physicians should also receive fair compensation for administrative costs when providing service to patients enrolled in qualified health plans. The AMA opposes requiring provider participation in qualified health plans, and it should not be used as a strategy to build adequate provider networks.

Another point of information for patients is if physician supervision of non-physicians is required in the state. HHS and states should require this disclosure from qualified health plans.

Question D(5) – Qualified Health Plans (QHPs)

What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

AMA Response to Question D(5)

The AMA believes that exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. In establishing minimum requirements for the actuarial value and level of coverage, the AMA urges HHS to maintain and strengthen the vital role in the health insurance marketplace of high-deductible health insurance plans issued to individuals and families in conjunction with Health Savings Accounts (HSAs). Offering a range of health plan choices in exchanges that

includes high-deductible health insurance plans coupled with HSAs enables patients to select health plans that meet their health care needs and budgetary realities. The AMA believes that the scope of the essential benefits package, which will include the general categories of services outlined in the ACA, should not further impede private market innovation in product development, benefit packages, and purchasing arrangements.

Question D(8) – Qualified Health Plans (QHPs)

Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

AMA Response to Question D(8)

Multi-state plans 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 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 allowing a multi-state plan to participate in its exchange should retain responsibility for the patient and provider protections of its residents, and should 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.

Question E(1-2) - Quality

The Affordable Care Act requires the Secretary to develop a health plan rating system on the basis of quality and prices that would be used by the Exchanges and to establish quality improvement criteria that health plans must meet in order to be qualified plans for Exchanges.

1. What factors are most important for consideration in establishing standards for a plan rating system?
    a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?
    b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?
    c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

AMA Response to Question E(1-2)

The AMA supports the development and appropriate use of health plan performance standards and appreciates the value of assessing the quality of care that is delivered through health plans participating in the forthcoming exchanges. The AMA defines quality of care as the degree to which care services influence the probability of optimal patient outcomes. We believe that the following noninclusive criteria for measuring health plans should be considered in evaluating their 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. Physician Consortium for Performance Improvement's physician measures);
- The measures include an appropriate mix of those that are process-oriented and outcomes-oriented;
- The measures shall be representative of the full range of services typically provided by health plans, 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 plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed;
- Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status;
- Health plan performance data that are self-reported by health plans shall be verified through external audits;
- The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public;
- Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release;
- Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed;
- The validity and reliability of health plan performance measures shall be evaluated regularly;
- Health plans do not have requirements that permit third party interference in the patient-physician relationship;

- Health plans 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 plans provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features;
- Health plan benefits are designed with input from patients and actively practicing physicians; and
- Treatment decisions are driven by the patient and physician.

We also recognize 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 plans 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 RAC audits and to Medicare Advantage plans seeking to increase their severity of illness scores. To help mitigate these burdens, regulations should be promulgated to eliminate or severely limit the ability of health plans to request additional chart audits from physician practices in an attempt to favorably affect their evaluation scores.

Question G - Enrollment and Eligibility

Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for Exchange participation, premium tax credits and cost-sharing reductions, and individual responsibility exemptions. Additionally, Sections 1412, 1413 and 2201 contain additional requirements to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions; providing for residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in applicable State health subsidy programs; and simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP).

AMA Response to Question G

The AMA is very pleased that under the ACA patients will have the opportunity to go to one central point to determine their eligibility for Medicaid, CHIP or exchange plans. This is a major improvement for patients over previous state systems, but it is also a highly complicated project for states to tackle. The AMA urges HHS to provide financial resources and tools to states to assist them with the programmatic and technological issues that they will face in establishing this centralized eligibility guide.

However, the initial eligibility determination is just the start of this process. Patients will cycle through various eligibility levels over time, and physicians will need to have real time information regarding what coverage a patient currently has. This will affect numerous

patient/physician issues. Addressing patient eligibility churn will be one of the most important issues that exchanges will face once they are up and running. States must handle this well if they want to promote continuity of care for their residents participating in Medicaid, CHIP, and the exchanges.

Question J(1) – Consumer Experience

What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

AMA Response to Question J(1)

We urge HHS to make the insurer information that is available on exchange Web sites to be as patient-friendly as possible in order to comply with the ACA's intent to provide patients with accessible and transparent insurer information. A standardized comparison tool that allows patients to compare plans offered on the exchange is essential to fulfilling this goal. This concept has been included in legislation at both the Federal and State levels.[4] The Texas Medical Association (TMA) developed a template to accompany the legislation introduced in Texas (Attachments 2 and 3), and it could serve as an excellent example of the type of information and the format that exchanges should be required to provide to patients. The template required 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;

[4] H.R. 2427 - *Informed Consumer Choices in Health Care Act of 2009 and* Texas Senate Bill 815 of 2009

- Emergency room visit copayment;
- Mental health;
- Outpatient surgery copayment; and
- Inpatient cost sharing.

The sample template from Texas 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 template for the exchanges to follow.

Further, plans offered on an exchange should also be required to disclose additional utilization data on the exchange Web site for patients to review, 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 insurer.

Finally, insurers should also be required to disclose their methodology for covering out-of-network care, including estimated amount of patient liability using a true usual customary and reasonable (UCR) standard each time a patient is to be treated by an out-of-network provider.

Question J(3) - Consumer Experience

What are best practices in implementing consumer protections standards?

AMA Response to Question J(3)

When a health plan places restrictions on patient choice of physicians, hospitals, other providers of care, or treatment options, such restrictions should be clearly, and understandably, identified to the individual prior to their selection of that health plan. These plans should also make available, in a standard format, to enrollees and prospective enrollees, information on the amount of payment provided toward each type of service identified as a covered benefit.

We also advocate that all insurers follow our Health Insurer Code of Conduct Principles (the Code) that are included in our response to Question D(5). The Code creates a fairer system for patients and would end some of the worst insurer abuses.

Conclusion

In closing, we are optimistic about the opportunities that the ACA, and in particular the exchanges, present for America's patients and physicians. We hope that our comments are helpful in your work on these issues. If you need further information, please contact Michael Glasstetter, JD, at michael.glasstetter@ama-assn.org or 312-464-5033, and he will be glad to assist.

Sincerely,

Michael D. Maves, MD, MBA

Attachments

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.

Insurance Facts

Preferred Provider Benefit Plan*	
Monthly Premium	**$385.95**
Percent of Expense Paid by Plan In-Network	**80%**
Percent of Expense Paid by Plan Out-of-Network	**60%**
Annual Out-of-Pocket Expense (est.)	**$2,750**
Your Total Annual Cost (est.)	**$5,500**
Justified Complaints	**-**
Premium to Direct Patient Care Ratio	**80%**
Expected Profit	**-**
Benefit Levels	
Annual Deductible	**$750**
Annual Family Deductible	**$2,250**
Annual In-Network Deductible	**$750**
Annual Out-of-Network Deductible	**$250 per admission**
Out-of-Pocket Maximum	**$5,500**
Office Visit Copayment (Primary/Specialist)	**$25/$25**
Rx Copayment	**$20/$40/$60**
Lifetime Maximum Benefit	**$2 million**
Emergency Room Visit Copayment	**$50 + 20%**
Mental Health	**$**
Outpatient Surgery Copayment	**20% after deductible**
Inpatient Cost Sharing	**20%**

*Based on an health plan from an Austin-based employer

By: _____ S.B. No. 815

A BILL TO BE ENTITLED

AN ACT

relating to consumer labeling requirements for certain health benefit plans; providing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. PURPOSE AND FINDINGS. The legislature finds that health care coverage is one of the most important purchases many Texans make, yet basic information that allows comparison between health benefit plans is difficult to find, if the information is available at all. Further, the large number of health benefit plans available in Texas with differing benefits, exclusions, and costs creates a complex array of information that complicates consumer decision making. The legislature further finds that important information typically considered to be indecipherable in health benefit plan documents must be brought to consumers' attention. A standard labeling requirement is, therefore, necessary to allow consumers to gain the information needed to make reasoned health benefit plan purchases.

SECTION 2. Chapter 541, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. REQUIRED LABELING FOR HEALTH BENEFIT PLANS

Sec. 541.501. DEFINITIONS. In this subchapter:

(1) "Direct losses incurred" means the sum of direct losses paid plus an estimate of losses to be paid in the future for all claims arising from all prior and current reporting periods,

minus the corresponding estimate made at the close of business for the preceding period. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(2) "Direct losses paid" means the sum of all payments made during the reporting period for claimants before reinsurance has been ceded or assumed. This amount does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

(3) "Direct premiums earned" means the amount of premium attributable to the coverage already provided in a given period before reinsurance has been ceded or assumed.

(4) "Enrollee" means an individual who is eligible to receive health care services under a health benefit plan.

(5) "Insurance facts label" means a notice that complies with the requirements of this subchapter.

Sec. 541.502. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation

operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843;

(F) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(G) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(H) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Sec. 541.503. INSURANCE FACTS LABEL REQUIRED; NOTICE OF LABEL REQUIRED. (a) The following written communications must contain an insurance facts label:

(1) a document used by a health benefit plan issuer to advertise a health benefit plan;

(2) a written communication, other than an explanation of benefits, from a health benefit plan issuer to an enrollee; and

(3) a written communication from a health benefit plan

issuer to a potential enrollee.

(b) The following communications, if made for the purpose of advertising a health benefit plan, must include the phrase "Check our label at:" followed by the Internet website address where a health benefit plan issuer's insurance facts label can be viewed:

(1) a television or radio advertisement;

(2) a billboard advertisement;

(3) an advertisement published or posted on the Internet; and

(4) any nonwritten media not otherwise described in this section.

Sec. 541.504. GENERAL FORMAT OF INSURANCE FACTS LABEL. (a) An insurance facts label must include a box outline that contains only white background.

(b) An insurance facts label must:

(1) be conspicuous and not less than three inches in height and two inches in width;

(2) be enclosed by a one-half point box rule within three points of text measure; and

(3) separate all lines of text by two points, leading above and below.

(c) The phrase "Insurance Facts" must:

(1) appear in a widely used sans serif font that is no smaller than 13 point; and

(2) be located inside and at the top of the box to fit the width of the label flush left and right.

(d) The health benefit plan name and the name of the company

must:

(1) appear in a widely used sans serif font that is no smaller than 10 point; and

(2) be located immediately below the phrase "Insurance Facts" and separated from the phrase "Insurance Facts" by a seven-point rule.

(e) Any disclaimer or other information not otherwise required to appear at a specific location on the label by this subchapter must appear in a widely used sans serif font that is no smaller than six point and located at the bottom of the label box.

Sec. 541.505. REQUIRED HEADINGS; FORMAT. (a) An insurance facts label must contain the following headings:

(1) "Monthly Premium";

(2) "Percent of Expense Paid by Plan In-Network";

(3) "Percent of Expense Paid by Plan Out-of-Network";

(4) "Annual Out-of-Pocket Expense (est.)";

(5) "Your Total Annual Cost (est.)";

(6) "Justified Complaints";

(7) "Premium to Direct Patient Care Ratio";

(8) "Expected Profit"; and

(9) "Benefit Levels."

(b) The headings described by this section must be flush left in the label box and appear in a widely used sans serif font that is no smaller than eight point.

(c) "Monthly Premium" must be the first heading and must be:

(1) located immediately below the health benefit plan and health benefit plan issuer name; and

(2) separated from all other headings by a three-point rule.

(d) A numeric value that corresponds to a heading must appear flush right in a widely used sans serif font that is no smaller than eight point.

(e) Any heading that is immediately followed by a disclaimer or information other than another heading or a subheading must be separated from the disclaimer or other information by a seven-point rule.

(f) Each heading must be separated from another heading and any applicable subheadings by a one-quarter-point rule.

Sec. 541.506. REQUIRED HEADINGS; DEFINITIONS. For the purposes of Section 541.505, the following terms have the following meanings:

(1) "Monthly Premium" means the average dollar amount an enrollee pays each month for coverage under a health benefit plan.

(2) "Percent of Expense Paid by Plan In-Network" means the percentage of a submitted charge for an in-network service that a health benefit plan pays.

(3) "Percent of Expense Paid by Plan Out-of-Network" means the percentage of a submitted charge a health benefit plan pays for services provided out-of-network.

(4) "Annual Out-of-Pocket Expense (est.)" means the estimated dollar amount of the cost incurred by a consumer with average health care needs over 12 months. "Average health care need" means health care service required by a health benefit plan's

enrollees under 60 years of age who:

(A) were not required to pass a medical examination for coverage; or

(B) were required to pass a medical examination by the health benefit plan, if the plan requires all enrollees to pass a medical examination.

(5) "Your Total Annual Cost (est.)" is the dollar amount of the sum of annual out-of-pocket expense estimate and annual premium.

(6) "Justified Complaints" means complaints for the previous two years submitted to the department against a health benefit plan issuer for which the department determined that:

(A) after examination and investigation, a violation of a policy provision, contract provision, rule, or statute occurred; or

(B) a prudent layperson may regard a practice or service below customary business practice.

(7) "Premium to Direct Patient Care Ratio" means the ratio of a health benefit plan's direct losses incurred to the direct premiums earned.

(8) "Expected Profit" means the actuarially set percentage of premium allowed for profit.

(9) "Benefit Levels" means the dollar value of the items listed in Section 541.507(a)(1)-(13).

Sec. 541.507. REQUIRED SUBHEADINGS; FORMAT. (a) Subheadings under the "Benefit Levels" heading must disclose the dollar value provided by the underlying certificate, policy, or

contract, and must be as follows:

(1) "Annual Deductible";

(2) "Annual Family Deductible";

(3) "Annual In-Network Deductible";

(4) "Annual Out-of-Network Deductible";

(5) "Out-of-Pocket Maximum";

(6) "Office Visit Copayment" listed separately for primary care providers and specialists;

(7) "Prescription Copayment";

(8) "Lifetime Maximum Benefit";

(9) "Emergency Room Visit Copayment";

(10) "Number of Electric Wheelchairs per Lifetime";

(11) "Outpatient Surgery Copayment";

(12) "Inpatient Cost Sharing"; and

(13) "Number of Justified Complaints."

(b) Each subheading required by this section must be indented six points from the left and appear in a widely used sans serif font that is no smaller than eight point.

(c) A numeric value that corresponds to a subheading must appear flush right in a widely used sans serif font that is no smaller than eight point.

(d) Each subheading must be separated from another subheading and the heading "Monthly Premium" by a one-quarter-point rule.

Sec. 541.508. RULES. (a) The commissioner may:

(1) require differing titles, headings, and subheadings as may otherwise be required by this subchapter as

necessary to prevent confusion between insurance and noninsurance products; and

(2) adopt rules as necessary to implement and administer this subchapter.

(b) The commissioner shall adopt rules regulating:

(1) the use of insurance and noninsurance terms in the insurance facts label to prevent confusion in the marketplace between insurance and noninsurance products;

(2) the manner in which a health benefit plan may use space available in the label box after disclosure of the consumer information required by this subchapter;

(3) allowable disclaimers below the headings and subheadings on the label; and

(4) the format for a label containing information about a multiple health benefit plan.

Sec. 541.509. REMEDIES AND ENFORCEMENT. (a) A violation of this subchapter is an unfair and deceptive act or practice in the business of insurance under this chapter.

(b) The department may examine records and investigate to determine whether a violation of this subchapter has occurred.

(c) All procedures, settlements, sanctions, and penalties provided under Subchapters C, E, G, and H are available under this subchapter.

SECTION 3. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this

Act takes effect September 1, 2009.