Michael D. Maves, MD, MBA, Executive Vice President, CEO

May 13, 2010

Kathleen Sebelius
Secretary
Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Secretary Sebelius:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the U.S. Department of Health and Human Services (HHS) with comments and recommendations in response to Section 2718 of the Public Health Services Act governing premium transparency and medical loss ratios, as mandated in the Patient Protection and Affordable Care Act (PPACA). During the health care reform debate, the AMA repeatedly expressed support for establishing greater transparency in the health insurance market. Health insurance is too expensive and important to be confusing. Premium transparency and medical loss ratio information is extremely valuable for patients and the AMA supports patients receiving the maximum value for the premium they pay. Mandating premium transparency is an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

The AMA has studied the issues of premium transparency and medical loss ratios in great detail. In January of 2009, we introduced model state legislation entitled the "Health Insurance Premium Transparency Act" to our component medical associations and physician members. In order to ensure that the model legislation reflected industry best practices and would not be unduly burdensome, we worked closely with a health insurance actuary when writing this and all of our related model bills. By simply making public the work that health plan actuaries already perform to set the premiums of each health plan in a standardized "Premium Transparency Report," the model legislation establishes a regulatory approach that would greatly enhance transparency and accountability in the pricing of health insurance premiums, while at the same time not imposing an undue burden on health insurers.

Not surprisingly, our members' interest in the bill has been significant. In the last year alone, over fifteen state legislatures have considered legislation to increase price transparency and/or regulate medical loss ratios for health insurance. Most recently, Governor Richardson of New Mexico signed H.B. 12, which establishes a new medical loss ratio requirement for health insurers in that state. Attached are several AMA model bills and resources that we urge you to consider along with this comment letter when finalizing regulations. Together, they directly address many of the issues identified in your public comment request in the April 14, 2010 Federal Register.

Actual Medical Loss Ratio Experience and Minimum Medical Loss Ratio Standards

Full transparency of how health insurance premiums are spent is necessary to empower enrollees to make informed purchasing decisions and to reward health insurance companies that minimize administrative waste. To permit comparison shopping, health insurer expenditures on profit and on administrative, non-medical costs (e.g., salaries and bonuses, advertising, utilization review, etc.) must be transparent to the public, based on a single standard definition and reporting mechanism. Moreover, this information should be available at the level that is meaningful to consumers - for each product sold. Health plans already have the information at the product level, as it is necessary to set the premium that will be charged for that product.

As a general matter, we believe that health plans should meet the 80-85 percent medical loss ratio requirement as specified in PPACA, and that they should meet that medical loss ratio based on the amount they spend on direct medical expenses, exclusive of whatever is spent on "activities to improve health care quality." This is because a medical loss ratio is intended to measure the insurer's promise to pay an amount to or on behalf of the insured person, contingent upon a loss caused by a medical condition, disorder, or preventive care. Moreover, we do not think this requirement is unduly high, particularly for large, established health insurers. For example, on a $10,000 premium, a health insurer would still have $1500 to cover its administrative costs and profit.

As long as there is complete transparency on where the premium dollars are being spent, we believe there can be some flexibility in the application of the mandate that 80 or 85 percent of the premium be spent on direct medical services and "activities to improve health care quality." Specifically, it may be appropriate to relax this requirement as necessary to allow for new entrants into the marketplace (e.g., those who have been in business fewer than five years), or to permit the continuation of smaller health insurers that still serve an important niche in a particular market. Studies have shown that a health insurer with fewer than 100,000 lives will be unlikely to be as efficient as a larger insurer; yet a more local plan may offer benefits that the community wants to see continued to maximize access.

On the other hand, if the Exchanges prove effective at reducing the marketing and broker costs associated with the individual and small group market, an increase above the 80 percent threshold may be warranted. In any event, so long as there is complete transparency of how premium dollars are spent, consumers will be able to make a meaningful choice as to whether or not they wish to purchase a plan which is spending less on direct medical care.

Uniform Definitions and Calculation Methodologies

The AMA strongly supports a requirement for insurers to use a uniform, consistent standard for reporting how premium dollars are spent. Comparison shopping is not possible unless apples can be compared to apples. In addition, the premium that an enrollee pays must reasonably reflect the actuarial value of the in-network and out-of-network benefits provided, drilled down to the plan cost for the enrollee. Out-of-network benefits must be paid at the level that the health insurer has promised.

Definitions

The AMA recommends that HHS consider using the following standard definitions that are easy for enrollees to understand when drafting its regulations. We realize that there are more definitions to be developed under other aspects of PPACA, especially section 2715, and we strongly encourage that terms used in various aspects of PPACA be defined in the same way. We look forward to working with HHS on these definitions in the future.

- The AMA supports PPACA's definition for "health insurance issuer," as outlined in Section 2718.

- A "claim" is a request for payment submitted to a health insurance issuer by health care facilities, enrollees, physicians, or other health care providers for direct medical or other health care services provided to plan enrollees.

- A "medical expense" is the amount of money that the insurer pays for direct medical services provided by physicians, hospitals, and other health care providers to enrollees during a calendar year. This includes the insurer's total financial obligation for physician services, non-physician health care professional services, hospital and other health care facility services, drugs and medical devices and other health care services that the health insurer incurs on behalf of its enrollees, and shall include, in addition to fee-for-service payments, amounts paid to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives. "Medical expense" does not include amounts which are the financial responsibility of the enrollee, the insurer's administrative costs, or expenditures for which the insurer is reimbursed by an enrollee's other insurance coverage or other third party liability.

- A "premium" is the amount of money that the insurer earns in a calendar year from the sale of health insurance, excluding dividends or credits applicable to prior years.

- "Administrative costs" means all expenditures associated with the administration of health benefit coverage, including but not limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, fraud and abuse detection, clinical health policy development, network contracting and management and state and federal regulatory compliance.

- "Medical loss ratio" is the quotient, to the nearest one percent, of the total medical expenses divided by the total premiums.

- A "multiple employer arrangement" is an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan. In a multiple employer arrangement, the employer assumes all or a substantial portion of the risk and shall include, but is not limited to, a multiple employer welfare arrangement, multiple employer trust or other form or benefit trust.

- "Interest" means the interest earned on the premiums by the insurer.

Defining Quality

At the outset, we must emphasize the AMA's firm commitment to quality improvement efforts, and ensuring that regulations governing medical loss ratios not improperly chill appropriate efforts by health insurers to engage in such efforts. At the same time, we understand that the term "quality improvement" is subject to widely varying definitions, and we are concerned that patients and other health care consumers not be misled into equating expenditures on "quality improvement" with expenditures on direct services. We are also very concerned about recent efforts by the health insurance industry related to medical loss ratios to "reclassify" administrative expenses and otherwise promote "creative accounting." For example, according to one source, America's Health Insurance Plans (AHIP) recently urged its members to notify NAIC that fraud and abuse reduction activities may be considered "activities that improve health care quality" for the purpose of calculating medical loss ratios under PPACA.[1] While the AMA abhors fraud, and fully supports appropriate efforts to ferret out fraud and abuse, this is a quintessential administrative activity.

For these reasons, we strongly recommend that expenditures on direct medical services be disclosed separately from expenditures on "quality improvement activities." Further, we recommend that the definition of "quality improvement activities" be narrowly defined to include only expenditures that are unambiguously identifiable. Specifically, in the definition below, we include only the actual costs incurred by the health insurance issuer on direct services and educational materials provided to patients and health care providers designed primarily to maintain or improve the overall health status of the health plan's subscribers.

We believe it is important to focus on the purpose of these expenditures, rather than the name that a particular health insurer may use to categorize them. In particular, those initiatives which are truly designed primarily to improve or maintain the health status of patients should be distinguished from those that, while using a "quality improvement" rubric, are fundamentally an effort to achieve program savings.

While we understand that some health insurers have suggested that this approach may create some disincentive to health insurer investment in quality improvement activities, we believe that risk will be low given the return on appropriate quality improvement investments in both

[1] "AHIP Urges Members To Reach Out To State Insurance Commissioners On MLR," May 7, 2010, A. Lotven, InsideHealthPolicy.com.

increased efficiency and reputation. On the other hand, the risk that a broader definition will be applied differently by different health insurers is high, and such variability would undermine the ability of health insurance purchasers to shop comparatively. Finally, as noted above, a broader definition also raises a significant risk that at least some health insurance issuers will game the system.

Thus, we recommend the following definition of quality improvement activities:

> For the purposes of this section, "activities that improve health care quality," are defined to include the actual cost incurred by the health insurance issuer of direct services and educational materials provided to patients and health care providers designed primarily to maintain or improve the overall health status of the health plan's subscribers.
>
> - This definition does not include any other expenditures, including but not limited to those associated with the costs of: (1) quality assurance programs; (2) utilization review and management; (3) pharmacy or other benefit management; (4) network contracting and management; (5) fraud and abuse programs; (6) state and federal regulatory compliance; (7) administrative, data management and profiling activities that support, but are not an actual component of, the provision of patient or physician educational materials and services designed primarily to maintain or improve the overall health status of the health insurer's subscribers (which educational materials and services are accounted for under the heading "Activities that improve health care quality") or payments to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives (which payments are accounted for as a "medical expense"); (8) development of clinical health policies; and (9) any home office or other overhead costs associated with either "medical expenses" or "activities that improve health care quality."
>
> - This definition also does not include any of the other expenditures listed below as an "administrative expense" section of the "Premium Transparency Report" described below.[2]

Calculations and Methodologies for Medical Loss Ratios

According to a recent Kaiser Family Foundation survey of employers, health insurance premiums have increased 131 percent, more than three times worker wages and four times general inflation, since 2001. Among those employers surveyed offering health benefits, 21 percent report that they have "reduced the scope of health care benefits or increased cost sharing due to the economic downturn."[3]

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[2] For an example of a state law that exempts similar costs from its medical loss calculations, see 28 Texas Administrative Code section 3.3307.
[3] 2009 Employer Health Benefits Survey, Kaiser Family Foundation.

One of the ways to ensure that health insurance costs are controlled is to require that health insurers show exactly how their actuary calculated each enrollee's premium. The AMA supports mandating a "Premium Transparency Report," which would require insurers to report annually on how health insurance premiums are spent. This report would require insurers to document how health insurance premiums were spent for preferred provider organizations, health maintenance organizations, point-of-service and high deductible health plans – each product for which a different premium is charged.

The Premium Transparency Report would require insurers to annually report a detailed breakdown of administrative costs for the preceding calendar year as follows:

- CEO and executive salaries and benefits;
- Commissions and other broker fees;
- Advertising and marketing costs;
- Insurance expenses, including reinsurance, general liability, professional liability and other types of insurance;
- Taxes, including state and local insurance, state premium, payroll, federal and state income, real estate and other taxes;
- Travel and entertainment expenses;
- State and federal lobbying expenses;
- Utilization and other benefit management expenses, including but not limited to expenditures on: (1) quality assurance programs; (2) utilization review and management; (3) pharmacy or other benefit management; (4) network contracting and management; (5) fraud and abuse programs; (6) state and federal regulatory compliance; (7) administrative, data management and profiling activities that support, but are not an actual component of, the provision of patient or physician educational materials and services primarily designed to maintain or improve the overall health status of the health insurer's subscribers (which educational materials and services are accounted for under the heading "Activities that improve health care quality") or payments to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives (which payments are accounted for as a "medical expense"); (8) development of clinical health policies; and (9) any home office or other overhead costs associated with either "medical expenses" or "activities that improve health care quality."
- Other expenses, including but not necessarily limited to non-executive salaries, wages and other benefits, rent and real estate expenses, certification, accreditation, board, bureau and association fees, auditing and actuarial fees, collection and bank service charges, occupancy, depreciation and amortization,

cost or depreciation of electronic data processing, claims and other services, regulatory authority licenses and fees, investment expenses and aggregate write-ins for expenses, and total expenses incurred for all of the previous items.

In addition to providing detailed administrative expense details, the annual report would also require the following information be included:

- The insurer's total earned premiums for the preceding calendar year, before dividends or credits applicable to prior years;
- The amount of interest earned on premiums for the preceding calendar year;
- The amount recovered from uninsured motorist insurance, accident insurance, workers compensation insurance and other third party liability during the preceding calendar year;
- The total "medical expense" incurred during the preceding calendar year;
- The total expense incurred for "activities that improve health care quality";
- Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the insurer is in compliance with all legal requirements;
- The reporting insurer's name and address; and
- Such other information as the state Insurance Commissioner may request.

National Health Plan Identifier

The AMA notes that the creation of a standard national health plan identifier (NHPI) which clearly identifies all the information necessary to automatically adjudicate claims, including the relevant entity involved in each aspect of the claims adjudication process and product type, should assist tremendously in simplifying and standardizing the reporting and auditing of amounts spent on medical services by health insurers at the product level. The AMA has developed a white paper on this topic which discusses the confusion and additional cost resulting from the current system in which the term "health plan" is used generically to describe the many different roles of the health plan in the claims payment process, including the entity that actually pays the claim, the entity that administers the health plan, the entity that contracts with the physician or other health care provider for discounted services, or the specific product that the enrollee has purchased. These roles may all be performed by one health plan, or more commonly by additional entities that are contracted by the health plan to take over one or more of these roles. Regardless, to ensure that the correct payments are being attributed to the correct payer and product, this ambiguity needs to be eliminated.

We strongly encourage the expedited adoption of a HIPAA standard health plan identifier as provided for in Section 1104(c)(1) of PPACA that will uniquely identify each of the entities involved in the claims adjudication process, along the lines set forth in the attached white paper. Such a HIPAA standard NHPI will significantly increase the accuracy and auditablity of PPACA's premium transparency and medical loss ratio requirements.

Additional Related Disclosures

There are additional disclosures which, if included within the "Premium Transparency Report," would assist health insurance purchasers in evaluating the value of each product offering and putting the medical loss information in perspective. The AMA worked closely with a health plan actuary in drafting our model state legislation and associated resources, and it is our understanding that all the information necessary to each of these proposed disclosures is routinely collected by actuaries when analyzing health plan information and setting health insurance premiums.

First, it is important to understand how the adequacy of the provider network may have impacted the health plan's expenditures. The AMA recommends consideration be given to requiring the reporting by the health plan's actuary of relevant utilization data along with the premium expenditure information in order to assess provider network adequacy. As an example, the AMA's model state legislation entitled "Meaningful Access to Physicians and other Healthcare Providers Act" includes the following section:

> Utilization Data. To help assess provider network adequacy, 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;
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> 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;
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> 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.

Second, and particularly in light of the recent disclosures of significant abuse by health insurers with respect to out-of-network benefits, the AMA recommends consideration be given to requiring the reporting by the health plan's actuary of information relevant to the out-of-network benefit. As an example, the AMA's model state legislation entitled "Truth in Out-of-Network Benefits" requires that an actuary provide an annual certification to the state Insurance Commissioner of:

i) The difference in value for the purchaser between: (a) the in-network coverage without the out-of-network coverage; and (b) the in-network and out-of-network coverage combined; and

ii) That the difference between: (a) the premium that the purchaser will be charged for in-network coverage without the out-of-network coverage; and (b) the premium that the purchaser will be charged for in-network and out-of-network coverage combined, reasonably reflects the difference in the value certified above.

Moreover, the AMA model bills require that these certifications be made in easily understood language, in a uniform, clearly organized manner, and be of sufficient detail and comprehensiveness as to provide for full and fair disclosure to an average consumer. The difference between the value of the in-network benefit coverage and the combined in-network/out-of-network coverage must be expressed in terms of a percentage, although use of a percentage alone will not be sufficient to satisfy these obligations.

Calculating a Medical Loss Ratio

As discussed above, the AMA supports the PPACA's requirement for an 80-85 percent medical loss ratio and believes that health insurers should generally be required to meet the medical loss ratio requirement based solely on incurred medical expenses. As provided in the "Definitions" section above, the AMA defines a medical loss ratio as the quotient, to the nearest one percent, of the total medical expenses divided by the total premiums. We understand that PPACA adjusts this definition somewhat, to include "activities to improve health care quality" in addition to direct medical expense in the numerator. If consumers are to be able to compare policies, medical loss ratios must be based on a fair, accurate and actuarially sound methodology, which is applied consistently across the industry. The authority to enforce the methodology for calculating and reporting medical loss ratios and issuing dividends and credits belongs with each state's Insurance Commissioner.

The AMA also believes that a legitimate rationale supports the application of a lower medical loss ratio on individual and small group product health insurance coverage (at least until there is evidence of the efficiencies to be gained from the Exchanges), for new entrants into the marketplace (those that have been in existence fewer than five years), and for smaller health insurers that are serving an important market niche as determined by the state Insurance Commissioner. Greater administrative costs are typically associated with individual coverage

compared to group coverage, due largely to the fact that it costs more to market and sell health insurance coverage to individuals than it does to sell coverage to group purchasers. New health insurance issuers bear significant start up costs when attempting to enter a market that are not incurred by incumbent health insurers. Finally, health insurers with fewer than 100,000 enrollees may not be able to achieve the economies of scale of larger health insurers. To foster a competitive market that provides greater choice of products, we agree that some flexibility in meeting the medical loss ratio requirement is warranted for health insurance issuers in these categories. The AMA firmly believes that health insurance competition is essential for many reasons, including but not limited to, the ability of physicians and other health care providers to contract fairly and the ability of enrollees to afford health insurance.

The AMA supports reporting medical loss ratios based on product type, as this information needs to be available to consumers at the level at which it is meaningful to them when they are making purchasing decisions. Consistent with our model bill, "Health Insurance Premium Transparency Act," we support the current PPACA requirement that individual and small market product insurers generally meet an 80 percent ratio and large employer product insurers generally meet an 85 percent requirement. Since this differential is largely based on higher marketing costs for insurers in the individual and small group markets, which may well be ameliorated in the context of a fully functioning health insurance exchange, we believe that the lower threshold afforded to the individual market insurers should be reassessed once each state Exchange is fully operational.

Level of Aggregation

The most important tenant of the AMA's Health Insurance Premium Transparency model state legislation is that transparency of premium information must be understandable, meaningful and accessible to enrollees and other purchasers of health insurance at the product level. Enrollees need to understand the value of the benefits they pay for through their health insurance premium. Medical loss ratio information provided to enrollees must reflect the actual product that they select and pay for.

Data Submission and Public Reporting

The AMA supports actuarially sound, accurate, timely and consumer-meaningful data submission. Any data that is used to set premiums and determine medical loss ratios must be publicly available. To the extent the data to be reported is that which is already compiled by health plan actuaries to set the premium, we believe the administrative burden to health plans should be minimal.

Rebates

The AMA supports the requirement that health insurers rebate enrollees for any amount of money that exceeds the medical loss ratio standard. Our Health Insurance Premium Transparency model state legislation includes detailed recommendations based on existing

New Jersey law which we urge HHS to consider:

- In the case where the insurer fails to comply with the medical loss ratio, the insurer in violation must issue a dividend or credit toward future premiums for the policyholder that is not less than an amount that would meet the applicable minimum requirement;

- Regulatory approval should be necessary prior to distributing any dividend or credit;

- The AMA recommends that if this is necessary, the insurer provide the state Insurance Commissioner with a detailed plan for how it will distribute all required dividends and credits as part of the required annual medical loss ratio;

- The state Insurance Commissioner may determine a fair dividend or credit amount;

- If a dividend or credit distribution is necessary, it shall be made to each employer that was covered for any period in the preceding calendar year;

- Insurers that issue health insurance policies through out-of-state trusts, purchasing alliances or other group purchasing organizations, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends or credits that the dividends or credits for such health insurance policies shall be paid or credited, as applicable, to the covered employers, not the trust, association, purchasing alliance or other group purchasing organization, or other multiple employer arrangement; and

- If an insurer is required to issue a dividend or credit, the insurer shall include the insurer's calculations of the dividend or credits to be issued due to failure to satisfy the minimum medical loss ratio and an explanation of the insurer's plan to issue these dividends and credits in its Premium Transparency Report.

Enforcement

In order to ensure that insurers comply with medical loss ratio and transparency of premium information regulations, vigorous enforcement provisions are necessary. The AMA recommends the following provisions:

- The state Insurance Commissioner should require that each insurer is audited annually. If the audit shows that the insurer violated any part of the law, it will be subject to penalties and fines;

- If an insurer fails to comply with the reporting requirements of this law, or of any rules promulgated pursuant to the law, it will be subject to a fine of no less than $1,000, and no more than $10,000, per day of violation; and

- Any consumer, employer, or their representatives, shall be entitled to seek an injunction to enforce any obligation established by the law or any regulation promulgated under the law.

Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Our recommendations are consistent with the goals of the PPACA ─ to promote affordable, efficient and accessible health care. As noted above, we believe that the burden on health plans will be limited to the extent that the regulations simply require the publication of information these plans already must obtain from their actuaries in order to set health plan premiums. Moreover, we believe the benefit of complete premium transparency to purchasers of health insurance, including individuals and small employers will be enormous, particularly if coupled with initiatives designed to increase competition in the health insurance marketplace. Only with full transparency of how health insurance premiums are allocated by health insurance companies will health insurance purchasers be empowered to make informed decisions, and reward companies that are more efficient.

Conclusion

The AMA appreciates the opportunity to provide its views on medical loss ratios and transparency of health premium spending. We look forward to working further with HHS on this important matter. Should you have any questions regarding these comments, please contact Margaret Garikes at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Enclosures: AMA Model State Bill: Health Insurance Premium Transparency Act
AMA Model State Bill: Meaningful Access to Physicians and Other Healthcare Providers Act, Accurate Provider Directories Act
AMA Model State Bill: Meaningful Access to Physicians and other Health Care Providers, Network Standards Act
AMA Model State Bill: Truth in Out-of-Network Healthcare Benefits Act
AMA National Health Plan Identifier White Paper

IN THE GENERAL ASSEMBLY STATE OF____________________

Health Insurance Premium Transparency Act

1 Be it enacted by the People of the State of______________________, represented in the
2 General Assembly:
3
4 **Section 1. Title.** This act shall be known as and may be cited as the "Health Insurance
5 Premium Transparency Act."
6
7 **Section 2. Purpose.**
8
9 (a) There is a vital need for employers and consumers to have a clear understanding of
10 how health care premiums are allocated by health insurance companies ("insurers")
11 in this state, and particularly how much of their premium dollars are spent on health
12 care services as opposed to administration, profit or for other purposes. Full
13 transparency of how health care insurance premiums are spent will empower health
14 insurance purchasers to make more informed decisions, and reward companies that
15 minimize administrative waste;
16
17 (b) According to the Kaiser Family Foundation, since 1999, average premiums for
18 family coverage have increased 119 percent - from $5,791 in 1999 to $12,680 in
19 2008. Worker premium contributions have similarly increased from $1,543 to
20 $3,354;
21
22 (c) According to the Commonwealth Fund, the fastest rising component of health care
23 spending is administrative overhead. Between 2000 and 2005, the net insurance
24 administrative overhead, including both administrative expenses and insurance
1 industry profits, increased by 12 percent per year. This increase is 3.4 percent points

faster than the average health expenditure growth of 8.6 percent; and

(d) A minimum medical expense threshold is necessary to maximize the value of health insurance premiums, and an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

Section 3. Definitions.

(a) "Medical expense" The amount of money that the insurer spends on direct medical care services for enrollees during a calendar year. This includes the insurer's total financial obligation for physician services, non-physician health care professional services, hospital and other health facility services, drugs and medical devices and other health care services that the health insurer incurs on behalf of its enrollees, and shall include amounts paid to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives. Medical expense does not include amounts which are the financial responsibility of the enrollee, the insurer's administrative costs, or expenditures for which the insurer is reimbursed by an enrollee's other insurance coverage or other third party liability.

(b) "Premiums" The amount of money that the insurer earns in a calendar year from the sale of health insurance, excluding dividends or credits applicable to prior years..

(c) "Health Insurer" Any entity, including an insurance company authorized to issue health insurance, a Health Maintenance Organization (HMO), or any other entity providing a plan of health insurance, health benefits or health care services, who is subject to the insurance laws and regulations of this state or subject to the jurisdiction of the Commissioner of Insurance of this State andt contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(d) "Administrative Costs" All expenditures associated with the administration of health benefit coverage, including but not limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management,

5 pharmacy and other benefit management, network contracting and management and
6 state and federal regulatory compliance.
7
8 (e) "Medical Expense Threshold" The quotient, to the nearest one percent, of the total
9 medical expenses divided by the total premiums.
10
11 (f) "Multiple Employer Arrangement" An arrangement established or maintained to
12 provide health benefits to employees and their dependents of two or more employers,
13 under an insured plan. In a multiple employer arrangement, the employer assumes
14 all or a substantial portion of the risk and shall include, but is not limited to, a
15 multiple employer welfare arrangement, multiple employer trust or other form of
16 benefit trust.
17
18 (g) "Interest" The interest earned on the premiums by the insurer.

19 **Section 4. Annual Premium Transparency Report.**
20
21 (a) Requirement to Report How Health Insurance Premiums Are Spent. Insurers shall
22 report how health care premiums are spent no later than March 1 of each year for the
23 premiums earned for the immediately preceding calendar year.
24
25 (b) Report Contents. Insurers shall report how health insurance premiums were spent for
26 each of the following categories of insurance provided by the insurer: Preferred
27 Provider Organization (PPO), HMO, Point of Service (POS) and High Deductible
28 Health Plan (HDHP). This report shall include the following information for each
29 category of insurance:
1 (1) A specific breakdown of administrative costs for the preceding calendar year as
2 follows:
3 i) CEO and executive salaries and benefits;
4
5 ii) Commissions and other broker fees;
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7 iii) Utilization and other benefit management expenses;
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9 iv) Advertising and marketing expenses;
10
11 v) Insurance, including the following categories of commercial insurance:
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13 a) Reinsurance;
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15 b) General liability;
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17 c) Professional liability insurer; and
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19 d) Other insurance types.
20
21 vi) Taxes, including:
22
23 a) State and local insurance;
24
25 b) State premium;
26
27 c) Payroll;
28
29 d) Federal and state income;
30
31 e) Real estate; and
1 f) Other taxes.
2
3 vii) Travel and entertainment expenses;
4
5 viii) State and federal lobbying expenses;
6
7 ix) Other expenses, including but not necessarily limited to non-executive
8 salaries, wages and other benefits, rent and real estate expenses,
9 certification, accreditation, board, bureau and association fees;
10 auditing and actuarial fees, collection and bank service charges,
11 occupancy, depreciation and amortization; cost or depreciation of

electronic data processing, claims and other services, regulatory authority licenses and fees, investment expenses and aggregate write-ins for expenses; and

x) Total expenses incurred (subsections 1(i)-(ix) above).

(2) The reporting insurer's name and address;

(3) The insurer's total earned premiums for the preceding calendar year, before dividends or credits applicable to prior years;

(4) The amount of interest earned on premiums for the preceding calendar year;

(5) The amount recovered from uninsured motorist insurance, accident insurance, workers compensation insurance and other third party liability during the preceding calendar year;

(6) The total medical expense incurred during the preceding calendar year;

(7) Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the insurer is in compliance with this Act and regulations promulgated by this Act; and

(8) Such other information as the Insurance Commissioner may request.

(c) Public Record. All data or information required to be filed with Insurance Commissioner pursuant to the Act shall be deemed a public record.

Section 5. Medical Expense Threshold Percentage Requirements.

(a) Insurers. Insurers must spend a minimum of the health insurance premiums earned in a calendar year on medical expense as follows: 80 percent for individual and small employer products, and 85 percent for large employer products.

(b) Report Instructions and Methodology. The instructions and methodology for

calculating and reporting medical expense threshold levels and issuing dividends or credits shall be specified by the Insurance Commissioner.

Section 6. Dividend or Credit Distribution.

(a) Distribution of Dividend or Credit for Failure to Comply with Medical Expense Threshold. In each case where the insurer fails to comply with the medical expense threshold requirements set forth in this Act, the insurer shall issue a dividend or credit toward future premiums for the policyholder that is not less than an amount that would meet the applicable minimum requirement.

(b) Regulatory Approval Necessary Prior to Distribution of Dividend or Credit. Prior to distributing any dividend or credit, an insurer must provide the Insurance Commissioner with its plan for the distribution of all required dividends and credits as part of the required annual medical expense threshold. No distributions of required dividends or credits may be made without prior approval from the Insurance Commissioner.

(c) Calculation of Dividends or Credits. The dividend or credit required to be distributed pursuant to this Act shall be determined by the Insurance Commissioner.

(d) Distributions to Any Covered Employer. The distribution of dividends or credits required under this law shall be made to each employer that was covered for any period in the preceding calendar year.

(e) Distribution to Employers. Insurers that issue health insurance policies through out-of-state trusts, purchasing alliances or other group purchasing organizations, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends or credits that the dividends or credits for such health insurance policies shall be paid or credited, as applicable, to the covered employers, not the trust, association, purchasing alliance or other group purchasing organization, or other multiple employer arrangement.

(f) Reporting of Distribution. If an insurer is required to issue a dividend or credit, the

20 insurer shall include the insurer's calculations of the dividend or credits to be issued
21 due to failure to satisfy the minimum medical expense ratio threshold and an
22 explanation of the insurer's plan to issue these dividends and credits in its Premium
23 Transparency Report.
24
25 **Section 7. Compliance Audit.** The Insurance Commissioner has the authority to perform
26 an audit of any insurer. If the audit shows that an insurer has violated any part of this law,
27 the insurer will be subject to the appropriate penalties and fines.
1 **Section 8. Penalties for Violating Reporting Requirements.** Any insurer failing to
2 comply with the reporting requirements of this Act or of any rules promulgated pursuant to
3 the Act, will be subject to a fine of no less than $1,000, and no more than $10,000, per day of
4 violation.
5
6 **Section 9. Consumer and Employer Rights.** Any consumer, employer, or their
7 representatives, shall be entitled toseek an injunction to enforceany obligation established by
8 this Act or any regulation promulgated under this Act.
9
10 **Section 10. Severability.** If any provision of this Act is held by a court to be invalid, such
11 invalidity shall not affect the remaining provisions of this Act, and to this end the provisions
12 of this Act are hereby declared severable.

IN THE GENERAL ASSEMBLY STATE OF ______________

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

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

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

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

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

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

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

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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. This includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities, nursing homes, home health agencies, outpatient or independent surgical, diagnostic or therapeutic center or facility, 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.

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

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

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

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

i) Physician specific demographic information as follows:

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

2. Specialty and/or subspecialty information;

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

4. The physician's license number;

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

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

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7. Whether the physician is accepting new patients;

8. Information about the method used to compensate the physician, e.g. by indicating whether the physician is reimbursed on a fee-for-service or capitated basis; and

9. If the provider network includes providers that have not contracted directly with the health insurer but through a contracting agent, the provider directory must indicate the name, Web site address, mailing address, and telephone number of any contracting agent with whom the provider has a direct contract.

ii) A notice regarding the availability of the listed physicians. The notice must be in 12 point type or greater and be placed in a prominent place in the directory. The notice shall state: "This directory does not guarantee services by a particular provider on this list. If you wish to receive care from any of the specific providers listed, you should contact those providers to be sure that they are accepting additional patients";

iii) Information about how to select a primary care physician, change a primary care physician and how to use the primary care physician for access to other care;

iv) If the network is tiered in a way that impacts enrollee obligations, enrollees shall be provided a conspicuous disclaimer in bold, 12 point type, indicating which physicians are in which tier and how that physician tier impacts the enrollee's financial or other obligations; and

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v) If the provider directory includes the name of any physician to which the enrollee has no right to access on an in-network basis, the director must contain a conspicuous disclaimer in bold, 12 point type, which states: "This physician is not an in-network physician with respect to this health insurance plan."

(b) Other health care professionals. For each participating non-physician health care professional who bills independently for health care services, the provider directory must list that professional's licensure type and all of the information set forth above in subsection (a), to the extent that information is relevant to that professional.

(c) Hospital/health care facility information. A provider directory must list all the following information about each participating hospital and other health facility:

i) Hospital/health facility contact information as follows:

1. Information concerning all contracted hospital and/or health care facility services, including but not limited to name and health facility type; address and telephone number; and Web site address, if available;

2. Availability of emergency department services; and

3. If the network is tiered in a way that impacts enrollee obligations, enrollees shall be provided clear information indicating which hospital or health facility is in which tier, and how that tier impacts the enrollee's financial or other obligations.

(d) Other services information. A provider directory must list the following information:

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1 i) Participating pharmacies and pharmacy benefit managers;
2
3 ii) Participating durable medical equipment providers;
4
5 iii) Participating clinical laboratories; and
6
7 iv) Participating ancillary service providers.
8
9 (e) Online graphic interactive map capability requirement. The health insurance plan
10 must offer an online graphic interactive map that will provide current and prospective
11 enrollees the means to input a reference address and locate providers within the
12 provider directory by name, type, specialty, subspecialty and distance. All of the
13 following shall be displayed for each provider identified by each search:
14
15 i) Whether the provider is participating, accepting new patients and if the
16 network is tiered, which tier the provider is in and how that impacts enrollees'
17 financial or other obligations;
18
19 ii) Distance from input location;
20
21 iii) Provider type, specialty and/or subspecialty;
22
23 iv) Provider contact information; and
24
25 v) With respect to hospital-based physicians, the physician specialty, the name(s)
26 of the hospital(s) where each hospital-based physician is contracted and
27 whether each of those hospitals is participating in the network.

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

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

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IN THE GENERAL ASSEMBLY STATE OF ______________

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

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

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

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

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

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

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

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

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1 subscriber contract or any other health care plan or arrangement that pays for or
2 furnishes medical or health care services, whether by insurance or otherwise.
3
4 (g) "Hospital-based physician" means any physician, excluding interns and residents,
5 which, as either a hospital employee or an independent contractor, provides
6 services to patients in a hospital rather than at a separate physician practice, and
7 typically includes anesthesiologists, radiologists, pathologists and emergency
8 physicians, but may also include other physician specialists such as hospitalists,
9 intensivists and neonatologists among others.
10
11 (h) "Physician tiering" means a system that compares, rates, ranks, measures, tiers or
12 classifies a physician's or physician group's performance, quality, or cost of care
13 against objective standards, subjective standards, or the practice of other
14 physicians, and shall include quality improvement programs, pay-for-performance
15 programs, public reporting on physician performance or ratings, and the use of
16 tiered or narrowed networks.
17
18 (i) "Provider" means a physician, other health care professional, hospital, health care
19 facility or other provider who/that is accredited, licensed or certified where
20 required in the state of practice and performing within the scope of that
21 accreditation, license or certification.
22
23 (j) "Provider directory" means a listing of each and every participating provider
24 within a provider network.
25
26 (k) "Provider network" means all the providers contracted to provide services to a
27 specified group of enrollees.

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1 **<u>Section IV</u>. <u>Meaningful network standards, report, approval and certification</u>**
2 **<u>requirements</u>.** No health insurer that provides or seeks to market a health plan product
3 in this state may do so without first obtaining a provider network certification from the
4 Insurance Department ("the Department"). The Department's provider network
5 certification shall set forth the geographic and population capacity of the provider
6 network. The provider network certification shall be awarded only to the extent that the
7 provider network offers the access to physicians and other health care providers
8 reasonably necessary to ensure that all enrollees of a health plan product using the
9 provider network will have timely access to all the medical care that they need on an in-
10 network basis, including but not limited to access to emergency services twenty-four
11 hours a day, seven days per week. The health insurer must meet the following
12 requirements in order to obtain certification:
13
14 (a) The health insurer must provide a certified network report to the Department once
15 a year documenting all the information contained in Section V of this Act as
16 follows:
17
18 i) The report must be prepared by the actuary who calculated the health
19 insurer's premium; and
20
21 ii) The report must be provided to the Department, and made available publicly
22 on the health insurer's website, within seven days of the Department
23 certification.
24
25 (b) A health insurer shall provide a certified network report that is specific to each
26 health plan product it offers in the state; and

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

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

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

i) Males;

ii) Females;

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

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

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

i) Primary care physicians to enrollee population;

ii) Geriatric medicine physicians to geriatric population;

iii) Pediatricians to pediatric population; and

iv) Women's health physicians to women.

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(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;

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

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

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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

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

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

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

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

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

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

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

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

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

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

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(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;

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1 vi) Reviewing and evaluating, on not less than a quarterly basis, the information
2 available to the health insurer regarding accessibility, availability and
3 continuity of care, including but not limited to information obtained through
4 enrollee and provider surveys, contract terminations, utilization of services,
5 enrollee complaints and grievances and their resolution; and
6
7 vii) Verifying the accuracy of its own provider directory;
8
9 iv) A health insurer shall undertake a prompt investigation and implement
10 timely corrective action when compliance monitoring discloses that a health
11 plan product's provider network is not sufficient to ensure timely access as
12 required by this Act, including but not limited to taking all necessary and
13 appropriate action to identify the cause(s) underlying identified, timely
14 access deficiencies and to bring its network into compliance. Health
15 insurers shall make all necessary modifications to their contracting practices
16 to ensure compliance; and
17
18 v) Health insurers shall give advance written notice to all contracted providers
19 affected by a corrective action ordered by the Department to rectify an
20 access problem. The notice shall include: a description of the identified
21 deficiencies; the rationale for the corrective action; and the name and
22 telephone number of the person authorized to respond to provider concerns
23 regarding the health insurer's corrective action.
24
25 **<u>Section VIII</u>. <u>Enforcement</u>.** The Department shall oversee compliance with this law.
26
27 (a) <u>Investigation</u>. Where the Department has reason to believe that the requisite
28 standards are not met or other indicators of lack of access exist, then the
29 Department shall do the following:

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

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

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

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

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

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

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IN THE GENERAL ASSEMBLY STATE OF _____________

"Truth in Out of Network Healthcare Benefits Act"

1 Be it enacted by the People of the State of _____________, represented in the General
2 Assembly:
3
4 **Section I. Title.** This Act shall be known and may be cited as the "Truth in Out of
5 Network Healthcare Benefits."
6
7 **Section II. Purpose.** The Legislature hereby finds and declares that:
8
9 (a) 70 percent of privately insured Americans choose more expensive health insurance
10 coverage that offers access to both in-network and out-of-network physicians.[1]
11 Consumers typically pay more for the right to have the health insurer cover a portion
12 of the cost of accessing an out-of network physician because the choice of physician
13 is such a critical decision. Unfortunately, consumers have not always received the
14 benefit of higher premiums that they have been charged for insurance products
15 offering out-of-network coverage;
16
17 (b) Health insurers have traditionally defined the out-of-network benefit as a stated
18 percentage of the "usual, customary and reasonable (UCR) charge" for health care
19 services provided by an out-of-network physician or other health care provider.
20 While health insurers have in recent years used various iterations of this language,

[1] 2008 Kaiser/HRET Employer Health Benefits Survey

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1 the words "usual charge," "customary charge," and "reasonable charge" commonly
2 have the meanings given to them under Section II of this Act. Because physicians
3 generally bill at a rate which is typical for their specialty, consumers purchasing
4 health insurance coverage with an out-of-network benefit have reasonably expected
5 their health insurance to cover the percentage of the out-of-network bill promised in
6 the health insurance policy;
7
8 (c) Recent events have shown that the health insurance industry has manipulated UCR
9 criteria to underpay amounts due out-of-network physicians and unlawfully shift
10 financial responsibility from health insurers to consumers. Numerous health
11 insurers utilize defective databases to pay out-of-network physicians substantially
12 less than the amount physicians would be entitled to receive under properly applied,
13 accurate UCR data;
14
15 (d) As a result of private litigation and investigations by the New York Attorney
16 General Andrew Cuomo, a significant number of health insurers entered into
17 settlements under which they agreed to discontinue utilizing a flawed database to
18 determine UCR, and to pay more than 90 million dollars to finance the creation of a
19 new and accurate database to determine the UCR charges for medical care provided
20 by out-of-network physicians;
21
22 (e) Many health insurers are now replacing "UCR charges" as the basis for calculating
23 out-of-network physician payments with language referencing the Medicare fee
24 schedule or other terminology. These emerging, "non-UCR charge" methods of
25 determining out-of-network physician payment typically give consumers no clear
26 idea of how much of the out-of-network physician's bill the health insurer will pay,
27 and how much of that bill will remain the subscriber's financial responsibility; and

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1 (f) Consumers must be armed with full knowledge of the facts to make informed
2 decisions concerning the health insurance coverage they purchase and where, and
3 from which providers, they seek health care services. Central to making an
4 informed decision is understanding the amount that an out-of-network physician will
5 charge for providing a medical service. Physicians should, therefore, volunteer fee
6 information to patients and to discuss their out-of-network fees in advance of
7 services. Additionally, only when health insurers clearly disclose the scope and
8 limitations of any out-of-network benefit they purport to provide, in language that is
9 meaningful to the average consumer, will consumers (1) be able to shop intelligently
10 for health insurance, and (2) be assured that the higher premiums they pay to make
11 affordable access to out-of-network physicians reasonably reflect the actuarial value
12 of the out-of-network benefit actually provided.
13
14 **Section III. Definitions.**
15
16 (a) "Customary charge" means a charge that is within a range of usual fees currently
17 charged by physicians of similar training and experience, for the same service
18 within the same specific and limited geographic area.
19
20 (b) "Health Insurer" means any person that offers or administers a health insurance
21 plan.
22
23 (c) "Out-of-network physician charge" means the usual, customary and reasonable
24 charge (UCR charge) a non-contracted physician bills a patient for medical
25 services, as "usual charge," "customary charge," and "reasonable charge" are
26 defined in this Section II.
27

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1 (d) "Reasonable charge" means a charge that is usual and customary, and is justifiable
2 considering the special circumstances of the particular case in question, without
3 regard to payments that have been discounted under governmental or non-
4 governmental health insurance plans or policies.
5
6 (e) "Retail charge" means the charge that the physician bills on those claims where the
7 physician is not billing a charge that reflects a payment discounted under
8 governmental or non-governmental health insurance plans or policies.
9
10 (f) "Usual charge" means a charge for a given service that the physician usually
11 charges to his or her private patients.
12
13 **Section IV. Standardized definition of "out-of-network physician charge."** Any
14 insurer offering health insurance coverage with an out-of-network benefit that calculates
15 payment amounts for services provided by out-of-network physicians using a physician
16 charge-based methodology must do so based on the out-of-network physician charge as
17 "out-of-network physician charge" and "usual charge," "customary charge," and
18 "reasonable charge" are defined in Section II of this Act, and may not add or subtract
19 language from those definitions.
20
21 **Section V. Requirements concerning the data on which charge-based methodologies**
22 **to determine payments to out-of-network physicians can be based.**
23
24 (a) Conflict of interest. A health insurer shall not use any person or entity as the
25 source of the database from which payments to out-of-network physicians are
26 calculated if that person or entity owns or controls, or is owned or controlled by, or
27 is an affiliate of, any person or entity with a pecuniary interest in the development
28 or use of the database. The person or entity who is the source of the database must

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1 also be granted tax-exempt status by the Internal Revenue Service under 26 U.S.C.
2 § 501(c)(3) of the United States Internal Revenue Code. An insurer, health
3 maintenance organization, medical association, or health care provider shall not be
4 prohibited from nominating an individual to serve on the board of the tax-exempt
5 person or entity, although no such individual may receive compensation from the
6 tax-exempt person or entity beyond reimbursement for reasonable expenses
7 associated with that service.
8
9 (b) **Data integrity**.
10
11 i) Data analytics. Any health insurer using a charge-based methodology for
12 determining payments to out-of-network physicians must ensure that the
13 database from upon which payments to out-of-network physicians are
14 calculated satisfies the following criteria:
15
16 1. The health insurer must calculate an out-of-network physician's charge
17 based on either: (a) 100% of the available retail charge data from all
18 legally separate and distinct physician practices in the relevant
19 geographic area and specialty or subspecialty (if applicable); or (b) data
20 from a random sample of no less than (10) legally separate and distinct
21 physician practices in the relevant geographic area and specialty or
22 subspecialty (if applicable). "Random sample" means that every separate
23 and distinct physician practice within the relevant geographic area and
24 specialty or subspecialty (if applicable) has an equal opportunity to be
25 included in the sample upon which the out-of-network physician's usual,
26 customary, and reasonable charge is calculated;
27

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2. In determining an out-of-network physician's charge, the data in the database must consistently account for factors reflecting the physician's experience and expertise, including but not limited to, the date of the physician's graduation from medical school, any board certifications held by the physician, any of the physician's academic appointments, and the site where the physician provides the service;

3. The data in the database cannot include physician charges that reflect payments discounted under governmental or non-governmental health insurance plans; and

4. The data in the database cannot:

    (1) Exclude valid high charges;

    (2) Exclude charges accompanied by modifiers that indicate procedures with complications; and

    (3) Pool data from physicians and nonphysician providers.

ii) Data sources. The health insurer must ensure that the data upon which a charge-based methodology is based is both drawn from a sufficient number and diversity of health insurers and health care providers, and supported by independent research by the person or entity that is the source of the data, to ensure compliance with the requirements of Section V(b)(i) of this Act.

iii) Single database. Regardless of the charge-based methodology used to calculate out-of-network physician payment amounts, all such calculations

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1 must be based on a single database that complies with the requirements of this
2 Section V.
3
4 iv) Updating. The health insurer is obligated to ensure that the data in the database
5 from which payments to out-of-network physicians are calculated is updated
6 regularly to reflect accurately current physician retail charges. This obligation
7 to update includes, but is not limited to, an obligation to remove data from the
8 database that contains charge information satisfying the earlier of the
9 following: when the charge data is older than three years from the current
10 year, or when the medical expense index applicable to prior charge data is 15
11 percent less than the current year's medical expense index.
12
13 v) Audits and certifications. Annually, the health insurer will obtain a
14 certification from an independent auditor certifying that:
15
16 1. The data in the database, and the charge-based methodology used to
17 calculate out-of-network physician payments satisfy the requirements of
18 this Act; and
19
20 2. The sources of the data used to create and update the data in the single
21 database from which payments to out-of-network physicians are
22 calculated comply with Section V(b) 1 (b), (d), (e) and (f).
23
24 vi) Approval and statistical analyses by the department.
25
26 1. A health insurer shall not utilize a database or methodology for
27 determining an out-of-network physician's charge unless the Department
28 determines that the health insurer, database and methodology from which

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payment to out-of-network physicians are calculated satisfy the requirements of Section V of this Act.

2. The Department shall annually perform a statistical analysis to ensure that the sample error of the sample size specified in Section V (b) 1 (b) is not greater than 5.5 percent. The Department will perform other appropriate statistical analyses to determine the validity of the methodology described in Section V (b) 1 (b) and to ascertain whether adjustments need to be made to that methodology to ensure that calculations based on that methodology accurately reflect the usual, customary, and reasonable charge of out-of-network physicians.

Section VI. Restrictions concerning non-charge-based methodologies. A health insurer shall not utilize a non-charge based methodology for determining the amount of payments due out-of-network physicians unless the Department annually approves the use of that methodology. The Department must on an annual basis approve the use of the non-charge-based methodology.

Section VII. Disclosure concerning how payment amounts to out-of-network physicians are calculated.

(a) Disclosures concerning charge-based methodologies to subscribers and prospective purchasers. A health insurer utilizing a charge-based methodology to calculate payment amounts for services provided by out-of-network physicians must disclose in the summary plan description and to a prospective purchaser of out-of-network coverage the following information:

i) The definition of "usual," "customary," and "reasonable," as defined under Section II of this Act;

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ii) The source of the database from which payment amounts due out-of-network physicians are calculated;

iii) The name of the entity, if any, from which payments due out-of-network physicians are calculated;

iv) The Web site address at which a subscriber or prospective purchaser may access the database from which payments due out-of-network physicians are calculated;

v) A description of how the charge-based methodology is used to calculate amounts due out-of-network physicians, including but not limited to the percentile of UCR-charges that the health insurer will be obligated to pay under the out-of-network benefit; and

vi) That the payment due pursuant to the out-of-network benefit may be lower than the out-of-network physician's retail charges, and that the subscriber may be responsible to pay the physician the difference between the physician's retail charges and the amount that the health insurer is obligated to pay the physician, in addition to any other cost sharing imposed under the subscriber's benefit plan.

(b) Disclosures concerning non-charge-based methodologies to subscribers and prospective purchasers. A health insurer utilizing a non-charge based methodology to calculate payment amounts for services provided by out-of-network physicians must disclose in the summary plan description and to a prospective purchaser of out-of-network coverage the following information:

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1
2 i) The health insurer's description of the data source upon which the payment
3 amounts for services provided by out-of-network physicians are calculated;
4
5 ii) The Web site address at which a subscriber or prospective purchaser may
6 access that data source;
7
8 iii) The name of the entity, if any, that the health insurer relies on to calculate the
9 non-charge-based payments due out-of-network physicians;
10
11 iv) The methodology the health insurer uses to calculate payment amounts for
12 services provided by out-of-network physicians using the data source
13 described above, including instructions on how to calculate the amount of the
14 out-of network benefit which will be paid for any physician service using that
15 Web site;
16
17 v) A description of the average percentage of an out-of-network physician's
18 usual, customary, and reasonable charge the consumer will likely still owe
19 even after the physician receives the out-of-network benefit payment, so that
20 the consumer will understand what his or her payment obligation will likely
21 be as a percentage of usual, customary, and reasonable charges, in addition to
22 any non-charge based description provided to the consumer. The usual,
23 customary, and reasonable charges must be calculated as provided in this
24 Section VII for charge-based methodologies; and
25
26 vi) That the payment due the out-of-network provider by the health insurer may
27 be lower than the out-of-network physician's retail charges, and that the
28 subscriber may be responsible to pay the physician the difference between

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the physician's retail charges and the amount that the health insurer is obligated to pay the physician, in addition to any other cost sharing imposed under the subscriber's policy.

(c) Disclosure of estimated payment. A health insurer must make the following information available to the general public in order to ensure that the subscriber or physician with an objective good faith estimate of: (1) the amount of the out-of-network benefit the health insurer would expect to pay for a particular elective medical service or services provided by the out-of-network physician to the subscriber, and (2) the amount for which the subscriber would still be financially responsible, assuming the health insurer paid the expected benefit amount. The health insurer must permit subscribers and physicians to request these estimates by e-mail or other electronic means. This disclosure must be provided in writing not later than one (1) business day after the health insurer receives the subscriber's or physician's request.

(d) Required Web site disclosure**.** A health insurer utilizing either a charge-based or non-charge based methodology to determine payment due an out-of-network physician must establish a Web site that can perform the following functions:

i) Allow subscribers, prospective purchasers, and physicians to select medical services by CPT Code, physician specialty, and the zip codes for the areas where the services are sought;

ii) The search result must clearly indicate the UCR charge amount at least the 50th, 80th, and 90th percentile in a given geographic area for a physician specialty;

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1 iii) The Web site must advise users of the Web site to refer to applicable benefit
2 plan documents or the respective plan administrator for further information
3 concerning the applicable benefit plan, including, with respect to charge-based
4 out-of-network methodologies the percentile of the UCR that will be applied to
5 determine the applicable out-of-network benefit amount;
6
7 iv) The search result must also remind users of the Web site that they may be
8 financially responsible for the balance of the out-of-network physician's retail
9 charges that exceed the amount paid by the health insurer;
10
11 v) The Web site must describe in a transparent manner the purpose of the website,
12 and its search function; and
13
14 vi) A description of the average percentage of an out-of-network physician's
15 charge the user of the Web site will likely still owe even after the physician
16 receives the out-of-network benefit payment, so that the user will understand
17 what the user's payment obligation will likely be as a percentage of usual,
18 customary, and reasonable charges. The usual, customary, and reasonable
19 charges must be calculated as provided in this Section VII for charge-based
20 methodologies.
21
22 (e) Manner of disclosures**.** The disclosure obligations required under A through D of
23 Section VII of this Act must be:
24
25 i) Made in easily understood language by subscribers and prospective
26 purchasers;
27
28 ii) Made in a uniform, clearly organized manner;

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1
2 iii) Of sufficient detail and comprehensiveness as to provide for full and fair
3 disclosure; and
4
5 iv) Updated as necessary to ensure that all disclosures required by this Act remain
6 accurate.
7
8 (f) Required annual disclosures to the Department. Health insurers must annually
9 disclose to the Department the information described in Section VII, (a) (1) through
10 (5) and Section VII, (b) (1) through (5).
11
12 **Section VIII. Physician fee schedule disclosure.**
13
14 (a) A physician practice must maintain a current schedule of retail fees for the medical
15 services that it typically provides;
16
17 (b) Prior to providing elective services to a subscriber, a physician practice that is not
18 contracted with the subscriber's health insurer must provide the subscriber with a
19 copy of the physician practice's most current fee schedule as it applies to the elective
20 services that the physician practice expects to furnish to the subscriber; and
21
22 (c) A physician practice must disclose to any patient or prospective patient a copy of the
23 practice's retail fee schedule applicable to at least its one hundred (100) most
24 commonly provided services by CPT code. The practice may make the required
25 disclosure publicly available via hard copy, electronically or via a Web site.

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1 **<u>Section IX</u>. <u>Subscriber and physician appeal rights</u>.**
2
3 (a) Any subscriber or physician who disagrees with the information disclosed pursuant
4 to Section VII, (a) through (d) of this Act may appeal the health insurer's
5 determination.
6
7 (b) Any subscriber or physician that submits an appeal to the health insurer as provided
8 under this Section IX may request in writing from the health insurer any and all
9 information that was used to determine the information required to be disclosed
10 under Section VII (a) through (d)of this Act. The health insurer is responsible under
11 this Act for ensuring that the subscriber or physician receives the requested
12 information within 2 (two) business days of receiving the written request.
13
14 (c) A health insurer may not prohibit or in any way interfere with a physician's or
15 subscriber's ability to assist one another in making an appeal described in this
16 Section IX.
17
18 **<u>Section X</u>. <u>Actuarial certification</u>.**
19
20 (a) Any health insurer that offers a health insurance product purporting to provide in-
21 network and out-of-network coverage must disclose to the Insurance Commissioner
22 a written certification by an independent, professional actuary stating:
23
24 i) The difference in value for the purchaser between (a) the in-network coverage
25 without the out-of-network coverage, and (b) the in-network and out-of-
26 network coverage combined; and
27

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1 ii) That the difference between (a) the premium that the purchaser will be
2 charged for in-network coverage without the out-of-network coverage, and (b)
3 the premium that the purchaser will be charged for in-network and out-of-
4 network coverage combined, reasonably reflects the difference in value
5 certified pursuant to Section X (a) (1).
6
7 (b) The certifications required by Section X (a) must be made in easily understood
8 language, in a uniform, clearly organized manner, and be of sufficient detail and
9 comprehensiveness as to provide for full and fair disclosure to an average
10 consumer. The difference between the value of the in-network benefit coverage
11 and the combined in-network/out-of-network coverage must be expressed terms of
12 a percentage, although use of a percentage alone will not be sufficient to satisfy the
13 obligations required by this Section X.
14
15 (c) The certifications required by this Section X must be made by a professional
16 actuary currently licensed in [*the state in which the insurance product is being*
17 *offered*] and currently certified [*by a nationally-recognized actuarial certification*
18 *organization*] who is not affiliated with the health insurer or any of its subsidiaries.
19
20 (d) The certifications required by this Section X must be updated annually and made
21 readily available to the general public.
22
23 **Section XI. Enforcement and remedies.**
24
25 (a) Investigation. Where the Department has reason to believe that a health insurer is
26 not compliant with the requirements of this Act, the Department shall:
27

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1 i) Require the health insurer to conduct a statistically valid survey of a sample of
2 physicians approved by the Department, within the same specialty or
3 subspecialty within the same five digit zip code with respect to services
4 identified by the Department using the services' CPT Codes;
5
6 ii) Require the health insurer to conduct a statistically valid survey of a sample of
7 subscribers who have received services within the prior three months from an
8 out-of-network physician;
9
10 iii) Interview the health insurer, subscribers, prospective purchasers, and
11 physicians; and
12
13 iv) Any other requirements that the Department determines is necessary to ensure
14 compliance with the requirements of this Act.
15
16 (b) Remedies. A violation of this Act constitutes an unfair and deceptive act or
17 practice in the business of insurance. Where the Department has found or it is
18 otherwise determined that a health insurer has failed to meet any of the Act's
19 requirements, the Department shall perform the following:
20
21 i) Institute all appropriate corrective action and use any of its other enforcement
22 powers to obtain the health insurer's compliance; and
23
24 ii) Where the violation results in a subscriber's use of an out-of-network
25 physician, the health insurer must pay the out-of network physician's retail
26 charge(s) as indicated on the applicable claim form(s).

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1 (c) Independent jurisdiction of the Attorney General**.** The Attorney General has
2 jurisdiction independent of the Department of Insurance to bring actions to enforce
3 the provisions of this Act.
4
5 **Section XII. Severability.** If any provision of this Act or the application thereof to any
6 person or circumstance is held invalid, such invalidity shall not affect other provisions of
7 applications of the Act which can be given effect without the invalid provision or
8 application, and to this end the provisions of this Act are declared to be severable.
9
10 *[Drafting Note: The Advocacy Resource Center (ARC) strongly advises that this model*
11 *bill be introduced in conjunction with the ARC's model bill requiring covered entities to*
12 *honor valid assignments of benefits].*

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National Health Plan Identifier White Paper

Prepared by the American Medical Association (AMA) Practice Management Center (PMC)

September 22, 2009

As adopted in 1996, the Health Insurance Portability and Accountability Act (HIPAA) included a chapter entitled "Administrative Simplification," designed to encourage transmission of health care transaction data electronically in order to bring efficiency and cost savings to the administrative practices of health care. The HIPAA regulations relevant to administrative simplification include four interlocking components: (1) Privacy; (2) Security; (3) Unique Identifiers; and (4) Uniform Electronic Transactions and Code Sets. This paper focuses on the third component: unique identifiers.[1] HIPAA requires the assignment of unique health identifiers for each individual, employer, health plan and health care provider in the health care system. To date, the unique identifiers for employers and health care providers have been implemented. The development of a unique patient identifier standard for each patient has not occurred due to privacy concerns. The National Health Plan Identifier (NHPI) has not been adopted either. However, the NHPI is needed in the HIPAA standard transactions to achieve the true benefits of automated administrative transactions and to support the emerging trend towards real-time adjudication of claims. **The AMA urges the Department of Health and Human Services' (HHS) immediate action on the NHPI and provides the following recommendation for consideration by all stakeholders in the claims processing and payment process.**

The NHPI is viewed by many as a crucial step toward one-stop, automated billing. To achieve this goal, the NHPI must provide for the clear identification of all the entities involved in the claims payment process, including:

1. the entity with primary financial responsibility for paying the claim;
2. the entity responsible for administering the claim;
3. the entity that has the direct contract with the health care provider;
4. the specific fee schedule that applies to the claim;
5. the specific plan/product type;
6. the location where the claim is to be sent; and
7. any secondary or tertiary payers.

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[1] This white paper expands on the previous Administrative Simplification White Papers which summarize the AMA's recommendations to eliminate significant administrative waste from the health care system by simplifying and standardizing the current health care billing and payment process. Visit www.ama-assn.org/go/simplify to access the "Standardization of the Claims Process" and the "Standardization of CPT codes, guidelines and conventions" white papers.

With payer responsibilities clear at the outset, the burden on patients, physicians, other health care providers and payers for determining the parties with financial responsibility is eliminated, and ambiguity regarding payment is greatly reduced. The Medical Group Management Association has estimated the savings to the industry from this initiative to be approximately $8.8 billion dollars over the next 10 years.

A significant discussion of the NHPI occurred in the late 1990s and is captured in a paper titled, "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper" dated March 11, 1998.[2] This paper provides a good overview of the challenges of the claims billing, payment and claims reconciliation process without the establishment of a NHPI. The AMA, through the National Uniform Claim Committee, supported the NHPI proposal contained in that 1998 white paper. However, changes in the health care environment since the late 1990s and lessons learned from the enumeration and implementation of the National Provider Identifier (NPI) have led the AMA to revisit this issue. We now suggest a new approach which we believe will better provide the information necessary for streamlining the claims payment and reconciliation process, while at the same time building on the existing enumerators for health plans and their agents, thus reducing the potential disruption of NHPI implementation. We also recommend a two-phase approach to adopting a NHPI. Phase I would prioritize the adoption of a unique identifier for private sector health plans and private payers administering public plans. The adoption of a unique identifier for governmental entities would occur in Phase II and requires additional study.

Challenges with the lack of a NHPI

The issues with the lack of a National Health Plan Identifier listed in the 1998 discussion paper mentioned above have only become more complex with the proliferation of different types of health insurance products, benefit plans and delivery vehicles, including high deductible health plans, health savings accounts, discount cards and ever-evolving relationships between payers and their agents, including third-party administrators and rental network preferred provider organizations (PPO). This increased complexity has increased the challenges to automating the claims payment and reconciliation process. It is not only necessary to ensure that transactions are routed correctly and in a timely way, but it is also critical that all the entities associated with the claims billing and payment process and the specific fee schedule applicable to each claim are clearly identified.

To achieve the goal of a fully automated claims payment and reconciliation cycle, all relevant information concerning the payer, the payer's agents and the fee schedule amount must be transmitted on all relevant transactions in unambiguous terms. Today, physicians are unable to clearly identify:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim;

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[2] Visit www.payorid.com/Medicare/HIPAA to access the "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper".

4. The fee schedule that applies to the claim;
5. The specific plan/product type;
6. The location where the claim is to be sent; or
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim.

Without a standard method of identification of these variables, patients, physicians and other health care providers must either contact the plan directly and request the information before patient treatment is delivered, and/or be forced to contact the plan after payment is rendered to ascertain if the contractual agreement was fulfilled. Ambiguity and manual intervention contributes to higher costs for everyone.

Coordination of benefits

The NHPI will also enable the automation of the coordination of benefits (COB) process. COB is the process of coordinating the adjudication of a claim between two or more payers that both have financial responsibility for health services being rendered. The adoption of a NHPI to include provider networks, third-party administrators (TPAs) and other entities involved in a claim transaction would facilitate identification of the various payers. Further, because the process of identifying secondary payers is not automated, physicians and other health care providers must often generate paper claims, further contributing to higher transaction costs and increased risk of error. NHPI will facilitate the generation of claims automatically to secondary payers or a Medicare supplemental plan, reducing the burden on the patient or beneficiary. A robust, standard NHPI will ensure that a physician or other health care provider using a clearinghouse will always have access to all relevant payer IDs, whether they are primary, secondary or tertiary.

This example of cost savings that could be realized is not isolated to the commercial health insurers. Automating a Medicare patient's COB is one example of how the NHPI could simplify the routing of multiple transactions, including coordination of benefit issues, many of them currently routed manually by beneficiaries and physicians. "By law, Medicare is not the primary health plan (1) when certain Medicare beneficiaries are also covered under employer group health plans or (2) when the illness or injury is covered under liability or no-fault insurance or workers' compensation. Currently, it is difficult to identify exactly what other coverage a Medicare beneficiary has, and millions of Medicare dollars are spent for care that is the primary responsibility of another health plan. Use of an NHPI for each health plan would reduce inappropriate expenditure of funds and expensive recovery efforts. A unique NHPI would also assist Medicare in transferring claims for Medicare beneficiaries covered by Medigap policies and in transmitting complementary claims to and from other health plans. The NHPI would supply the correct electronic address when Medicare needs to send a crossover claim electronically to another health plan."[3]

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[3] "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper" visit www.payorid.com/Medicare/HIPAA to access.

For all the forgoing reasons, the increased efficiencies and costs savings that can be realized by all stakeholders through the adoption of a robust NHPI would be significant.

Lessons learned from implementation of previous national identifier standards

In developing this recommendation, the AMA considered the lessons learned from the implementation of both the Employer Identifier and the NPI standards.

The employer identifier standard, published in 2002, adopts the employer's tax ID number or Employer Identification Number (EIN) as the standard for electronic transactions. This was an established number, and no separate sign-up, enumeration or enumerator was required. The transition to the EIN was quite seamless.

On the other hand, the NPI was a newly created unique identification number for HIPAA-covered health care providers. It required every health care provider in the country to apply to receive at least one new identification (ID) number, and many health care professionals had to get at least two—one to identify themselves as individuals and one to identify themselves as a medical practice. It also required the establishment of a new database, the National Plan and Provider Enumeration System (NPPES) to house the identifiers and the data associated with each number as well as a registry, which contains the subset of the overall information available to the public. The transition to the newly created NPI was wrought with challenges for all stakeholders. The implementation of the NPI caused great emotional and financial turmoil for physicians nationwide, and the implementation cost was much greater than ever anticipated for all stakeholders.

This experience strongly suggests that existing identifiers should be used whenever feasible. This eliminates the challenges of: (1) getting entities to apply for a new identifier; (2) getting the entire industry to recognize an entirely unfamiliar number; and (3) maintaining a whole new directory of these new numbers.

Enumeration strategy

Appropriate enumeration of health plans and their products has been a source of ongoing debate. One of the main points of contention is the issue of "sub-parts." (This is similar to the issues faced with adoption of the NPI—the difficulty of enumerating the appropriate sub-parts of a provider organization.) With the NHPI, the challenge is how best to enumerate individual health plans—at the corporate level, at the plan "type" level (e.g. HMO, PPO, indemnity, dental, etc.), product level or other level.

If enumerated at the plan "product" level, for example, the NHPI could encompass tens of thousands of numbers. However, plan products change every year, and new numbers would need to be issued on an ongoing basis.

A simpler solution is to enumerate health plans and their agents at the entity level, and use other fields in the X12 5010 271 eligibility benefit response and 835 electronic remittance advice

electronic standards to correctly identify the applicable product and contract. For example, the "Claim Filing Indicator Code" field can be used to indicate the product type. If there is more than one fee schedule that could apply for the same "Claim Filing Indicator Code," then the "Class of Contract" field can be completed using a text string description that ties to the applicable fee schedule, such as a Medicare Advantage Gold or specific rental network PPO.

Given the plethora of potential claims billing and payment scenarios—including the added complexity of rental network PPOs—payment transparency and accuracy can only occur if the following information is clearly identified on the X12 271 eligibility and 835 electronic remittance advice:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim;
4. The fee schedule that applies to the claim;
5. The specific plan/product type;
6. The location where the claim is to be sent; and
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim.

Clear identification of each entity, plan/product type and the specific fee schedule involved in the determination of the ultimate patient benefit and claim payment will result in transparency gains that will benefit patients, payers, and physicians and other health care providers, as well as contribute to a decrease in health care costs for the entire industry. The following recommendation is aimed at simplifying the identification of the above information.

Simplified approach for determining an NHPI for commercial payers

The AMA recommends the consideration of the following NHPI approach:

- Use the IRS health plan identifier (Employer Identification Number [EIN] followed by three-digit plan type), or other applicable IRS identifier, similar to the employer identifier standard, for each of the entities set forth above;

- Use a Global Unique Identifier (GUID), generated by the entity with the direct contract with the health care provider or a consistent industry standard unique identifier, following that entity's IRS identifier, to specify the applicable fee schedule; and

- Use the Claim Filing Indicator Code, coupled with the Class of Contract Code as necessary, to identify the product type.

After reviewing the pending 5010 X12 835 electronic remittance advice, the AMA determined that the IRS identifier could be used as an enumerator for several of the transaction fields, specifically, elements 1, 2, 3 and 7 listed above:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim; and
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim;

With respect to item 4, identification of the fee schedule that applies to the claim, we believe the best solution would be for each entity that contracts with health care providers to generate a GUID or a consistent industry standard unique identifier for each contracted fee schedule. As we understand it, health plans typically generate a fee schedule identifier now, so moving to a uniform fee schedule identifier should not be too burdensome, particularly given the dramatic efficiency to be gained in automated claims reconciliation and first-pass pay accuracy. Not only would such an identifier virtually eliminate disputes between payers and health care providers over which fee schedule should apply to the claim, but it would also provide an easy way for providers to verify the accuracy of their contracts and upload their fee schedules into their practice management systems. Item 5, identification of the specific plan type, would require completion of the Claim Filing Indicator Code, as well as a response in the Class of Contract field when a disclosed fee schedule pertains to more than one product.

Finally, the best way to address item 6, the location where the claim is to be sent, remains open. One option would be to establish a plan registry similar to the NPI registry that contains both a physical mailing address and an electronic address for the IRS identifier of each entity with the potential to be included in the field indicating the entity responsible for the administration of the claim. Where such entities have more than one location where claims are to be sent, these entities could ensure the correct addresses are listed by place of service zip code, Claim Filing Indicator Code or even Class of Contract Code to the extent these might be relevant.

Currently, clearinghouses and practice management systems have their own unique health plan identifiers that could easily be replaced with the IRS identifiers. In fact, the newest version of the HIPAA standard transactions being implemented now, Version 5010, has already provided specific guidance for using the EIN in certain fields of the transactions. After reviewing the Technical Report 3s (TR3) for each HIPAA transaction, our recommendations for the NHPI are as follows:

NHPI recommendation			
NHPI recommended information	**Field content**	**5010 segment**	**5010 field**
Entity that is financially responsible for payment	Use EIN plus 3 digits for plan type	BPR-FINANCIAL INFORMATION	Originating Company Identifier
Entity that is responsible for administering the claim	Use EIN	N1-PAYER IDENTIFICATION	Identification Code
Entity that has the direct contract with the provider	Use EIN	REF-OTHER CLAIM IDENTIFICATION RELATED	Reference Identification
Fee schedule that applies to the claim	Create a "Fee Schedule ID" GUID or a consistent industry standard unique identifier; can be reported in the Claim Filing Indicator Code field in the 835 (Electronic Remittance Advice) following the EIN of the entity that has the direct contract with the provider		
Plan/product type "description," not to be confused with the Claim Filing Indicator which is the Plan/Product code. The 271 Plan/Product list should be "synched" with the 835.	Text string description reported in the Class of Contract field in the 835 (Electronic Remittance Advice) should be required when the Claim Filing Indicator Code is associated with more than one product/fee schedule.		
Secondary or tertiary entities that may be financially responsible for payment	Use EIN plus 3 digits for plan type	REF-ADDITIONAL PAYER IDENTIFICATION	Reference Identification
Location of where the claim is sent	Use Uniform Resource Locator to identify where the claim should be sent for processing.	PER-PAYER TECHNICAL CONTACT INFORMATION	Communication Number

Implementation considerations

Implementation timeframes

HIPAA mandates a 24-month implementation period for providers, clearinghouses and most health plans after the effective date of a new standard is established. We believe that the process of developing and publishing a Notice of Proposed Rulemaking and a final rule should be expedited in order for the industry to begin taking advantage of the NHPI administrative simplification benefits. The simultaneous implementation of the HIPAA 5010 (October 1, 2012

implementation date) electronic transactions and the NHPI should be seriously considered as this could reduce the number of practice management system software upgrade requirements. We would strongly encourage all health plans to enumerate and disseminate their NHPIs prior to the compliance date of the NHPI final rule. **The AMA encourages the HHS Secretary to publish a final rule to create an implementation date of October 1, 2012.**

Transition phase

It will be important to carefully consider how best to handle running systems using any health plan, clearinghouse or practice management system existing legacy numbers with the NHPI, as running dual identification numbers became quite cumbersome during the transition to the NPI despite the fact that it allowed for interim steps to implementation. The Centers for Medicare and Medicaid Services (CMS) is strongly encouraged to work closely with all the key stakeholders to ensure feedback is sought at key junctures along the way to NHPI implementation. Key stakeholders should also be encouraged to assist CMS with the critical outreach that will be required to ensure sufficient awareness that will lead to the successful implementation of NHPIs.

Infrastructure and required modifications

Because the NPPES was developed specifically for assigning and housing identifiers, CMS should not have to build another database to house the NHPIs and electronic claim submission addresses and mailing addresses, if CMS wishes to serve as a clearinghouse for the IRS health plan identifiers set forth above. However, the EIN and IRS health plan identifiers are currently public, and the GUIDs associated with specific fee schedules would be relevant only to the contracting health care providers who would receive these directly from the contracting agent, so it is possible that only the identifiers associated with claims' submission addresses would need to be included. In addition, even if a NHPI was established tomorrow, there are fields in the existing HIPAA standard transactions where these could be used, so the standards do not need modification prior to implementation.

Despite this existing infrastructure, a number of lessons were learned during the NPI enumeration process that should be taken into consideration as plans for NHPI implementation continue:

- Every effort must be made to ensure physician and other health care provider payment interruptions are averted. Specifically, clear and flexible guidance must be created and shared widely for advance payments (i.e., to date, despite numerous repeated requests of Medicare, only a handful of contractors have any information on their Web sites, and many customer service agents continue to remain unaware of this option despite an untold number of physicians who experienced cash flow problems that lasted months during the NPI transition).

- Ample time and clear messaging from CMS is needed in order to ensure a smooth transition.

- CMS should work closely with all HIPAA-covered entities and the vendor community to ensure feedback is sought at key junctures of the implementation process and on critical outreach.
- Interim steps to implementation will be helpful.
- Running dual identification numbers, NHPI and legacy numbers, could be cumbersome and inefficient for physicians and other health care providers, yet they may become necessary to facilitate a smooth transition.
- Standardization/normalization across all payers/clearinghouses is critical during the transition period.
- Industry access to the NHPI database will be critical to implementation.

Conclusion

The Secretary of HHS should expedite the adoption of a NHPI. Clear identification of each health plan, each health plan contractor involved in the claims process and the specific fee schedule applicable to each claim will benefit patients, payers and health care providers. With the informed experience gained from the implementation of the HIPAA employer and provider unique identifiers, including the use of existing identifiers to the extent feasible, the disruption from this initiative can be minimized.