

From: Elizabeth Schumacher
Sent: Thursday, January 28, 2010 12:37 PM
To: Jordan Estey
Subject: AMA Comments Re: Proposed Draft Model- Healthcare Balance Billing Disclosure

Dear Jordan,

The AMA has reviewed the proposed draft model, "Health Care Balance Billing Disclosure." As mentioned in my earlier email and phone conversation, we will need to discuss the model language with our Council on Legislation prior to taking any position. The council is meeting on February 27, where I will discuss the model and NCOIL activity.

While the language does promote transparency, we would recommend that the language go further to ensure that adequate networks are implemented and that provider directories be held to stronger standards to ensure that patients have adequate access and transparent information to meet their medical needs.

The AMA has drafted many model bills to address the issues surrounding out-of-network transparency in health care benefits. I have attached two of the model bills from this campaign for your review that address improved networks and provider directories. We would recommend that the language from these bills be considered and/or included in the model bill. I am glad to answer questions about these bills with you.

As promised, I will provide additional feedback after our Council on Legislation reviews the model language later next month.

I look forward to our next conference call.

Liz

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IN THE GENERAL ASSEMBLY STATE OF _____

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

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

3

4 **Section I. Title.** This Act shall be known and may be cited as the “Meaningful Access to
5 Physicians and other Health Care Providers: Accurate Provider Directories Act.”

6

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

8

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

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

1 **Section III. Definitions.**

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

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

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

3
4 **Section V. Provider directory requirements.** The Department shall promulgate
5 regulations to create a process to review each provider directory submitted pursuant to
6 Section IV of this Act. These regulations shall require that provider directories comply with
7 all of the following:

8
9 (a) **Physician information.** The provider directory must list all the following information
10 concerning each participating physician:

11
12 i) Physician specific demographic information as follows:

- 13
14 1. Physician name, practice address, county, office telephone number, and
15 Web site address or other link to more detailed individual physician
16 information, if available;
- 17
18 2. Specialty and/or subspecialty information;
- 19
20 3. Indication of whether the physician may be selected as a primary care
21 physician;
- 22
23 4. The physician's license number;
- 24
25 5. The hours that the physician is available to treat patients;
- 26
27 6. The names and locations of the hospitals where the physician has medical
28 staff privileges;

1 7. Whether the physician is accepting new patients;

2
3 8. Information about the method used to compensate the physician, e.g. by
4 indicating whether the physician is reimbursed on a fee-for-service or
5 capitated basis; and

6
7 9. If the provider network includes providers that have not contracted directly
8 with the health insurer but through a contracting agent, the provider
9 directory must indicate the name, Web site address, mailing address, and
10 telephone number of any contracting agent with whom the provider has a
11 direct contract.

12
13 ii) A notice regarding the availability of the listed physicians. The notice must be in
14 12 point type or greater and be placed in a prominent place in the directory. The
15 notice shall state: “This directory does not guarantee services by a particular
16 provider on this list. If you wish to receive care from any of the specific
17 providers listed, you should contact those providers to be sure that they are
18 accepting additional patients”;

19
20 iii) Information about how to select a primary care physician, change a primary care
21 physician and how to use the primary care physician for access to other care;

22
23 iv) If the network is tiered in a way that impacts enrollee obligations, enrollees shall
24 be provided a conspicuous disclaimer in bold, 12 point type, indicating which
25 physicians are in which tier and how that physician tier impacts the enrollee’s
26 financial or other obligations; and

1 v) If the provider directory includes the name of any physician to which the
2 enrollee has no right to access on an in-network basis, the directory must contain a
3 conspicuous disclaimer in bold, 12 point type, which states: “This physician is
4 not an in-network physician with respect to this health insurance plan.”
5

6 (b) Other health care professionals. For each participating non-physician health care
7 professional who bills independently for health care services, the provider directory
8 must list that professional’s licensure type and all of the information set forth above
9 in subsection (a), to the extent that information is relevant to that professional.
10

11 (c) Hospital/health care facility information. A provider directory must list all the
12 following information about each participating hospital and other health facility:
13

14 i) Hospital/health facility contact information as follows:
15

- 16 1. Information concerning all contracted hospital and/or health care facility
17 services, including but not limited to name and health facility type; address
18 and telephone number; and Web site address, if available;
19
- 20 2. Availability of emergency department services; and
21
- 22 3. If the network is tiered in a way that impacts enrollee obligations, enrollees
23 shall be provided clear information indicating which hospital or health
24 facility is in which tier, and how that tier impacts the enrollee’s financial or
25 other obligations.
26

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

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.

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 enrollees 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.

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.



IN THE GENERAL ASSEMBLY STATE OF _____

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

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

3

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

6

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

8

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

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

1 **Section III. Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 i) Males;

11

12 ii) Females;

13

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

15

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

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

23 i) Primary care physicians to enrollee population;

24

25 ii) Geriatric medicine physicians to geriatric population;

26

27 iii) Pediatricians to pediatric population; and

28

29 iv) Women's health physicians to women.

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

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

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

- 1 54. Podiatry;
- 2 55. Psychiatry;
- 3 56. Pulmonary Disease;
- 4 57. Radiation Oncology;
- 5 58. Radiology;
- 6 59. Reconstructive Surgery;
- 7 60. Reproductive Endocrinology;
- 8 61. Rheumatology;
- 9 62. Sleep Medicine;
- 10 63. Spine Surgery;
- 11 64. Sports Medicine;
- 12 65. Surgery;
- 13 66. Surgical Critical Care;
- 14 67. Thoracic Surgery;
- 15 68. Vascular Surgery; and
- 16 69. Urology.

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(d) The insurer shall comply with the following:

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

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

7
8 (e) Utilization Data. The following enrollee utilization data must be reported,
9 compared against the prior year's utilization, and assessed against regional and
10 national benchmarks for each health plan product:

11
12 i) Number of hospital admissions per thousand enrollees in the last year for
13 outpatient, manageable, preventable conditions, including but not limited to
14 Community Acquired Bacterial Pneumonia, Asthma and Diabetes;

15
16 ii) Number of emergency department visits per thousand enrollees in the last
17 year;

18
19 iii) Number of preventive services, such as immunizations, which reduce the
20 need for later, costlier interventions;

21
22 iv) Percent of out-of-pocket costs incurred by enrollees for emergency
23 department visits as a percentage of total enrollee out-of-pocket costs;

24
25 v) Number of visits to out-of-network providers per thousand enrollees in the
26 last year;

27
28 vi) Percent of services received from in-network providers as a percentage of
29 total services received by enrollees; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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