



IN THE GENERAL ASSEMBLY STATE OF _____

Meaningful Access to Accurate Provider Directories

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

3 **Section 1. Title.** This Act shall be known and may be cited as the “Meaningful Access to
4 Accurate Provider Directories Act.”

5 **Section 2. Purpose.** The Legislature hereby finds and declares that:

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

- (b) Because, for financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access, a provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives consumers of the benefit of the money they have paid for health care coverage;
- (c) Inadequate provider networks also undermine the public health and welfare by forcing consumers to reduce utilization of appropriate preventive services and fail to obtain necessary medical care, which in turn leads to reduced productivity and increased work absenteeism, unnecessary illness and increased emergency department utilization;
- (d) To assess the appropriateness of a provider network before selecting a particular health insurance plan, consumers must have all the information relevant to the medical needs of themselves and their families, including whether their physicians and preferred hospitals are in- or out-of-network, whether these physicians and hospitals are still accepting new patients, and what the likely wait-time is for an appointment;
- (e) Consumers also 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.

Section 3. Definitions.

Enrollee means a qualified individual or qualified employee enrolled in a health insurance plan.

1 **Essential Health Benefits** means a set of health care service categories that must be covered
2 by certain health insurance plans. These include items and services within at least the
3 following 10 categories: ambulatory patient services; emergency services; hospitalization;
4 maternity and newborn care; mental health and substance use disorder services, including
5 behavioral health treatment; prescription drugs; rehabilitative and habilitative services and
6 devices; laboratory services; preventive and wellness services and chronic disease
7 management; and pediatric services, including oral and vision care. See §1302, Public Law
8 111-148.

9 **Contracting entity** means any person or entity that enters into direct contracts with
10 providers for the delivery of health care services in the ordinary course of business.

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

19 **Health care services** means services for the diagnosis, prevention, treatment or cure of a
20 health condition, illness, injury or disease.

21 **Health Insurer** means an entity or person that offers or administers a health insurance plan,
22 coverage or policy in this state; or contracts with physicians and other health care providers

1 to furnish specified health care services to enrollees covered under a health insurance plan or
2 policy.

3 **Health Insurance Plan** means any hospital and medical expense incurred policy, non-profit
4 health care service plan contract, health maintenance organization subscriber contract or any
5 other health care plan, policy, coverage or arrangement that pays for or furnishes medical or
6 health care services, whether by insurance or otherwise, offered in this State.

7 **Hospital-Based Physician** means any physician, excluding interns and residents, who, as
8 either a hospital employee or an independent contractor, provides services to patients in a
9 hospital rather than at a separate physician practice, and typically includes anesthesiologists,
10 radiologists, pathologists and emergency physicians, but may also include other physicians
11 and non-physician health care professionals.

12 **Tiering** means a system that compares, rates, ranks, measures, tiers or classifies a provider,
13 or a provider group's performance, quality or cost of care against objective standards,
14 subjective standards or the practice of other providers, and shall include quality improvement
15 programs, pay-for-performance programs, public reporting on physician performance or
16 ratings and the use of tiered or narrowed networks.

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

20 **Provider Directory** means a listing of every participating provider within a provider
21 network.

1 **Network** or **Provider Network** means the physicians, health care professionals, health care
2 facilities, and ancillary health care providers with whom a health insurer contracted with to
3 provide health care services to a specified group of enrollees under a health insurance plan
4 offered in this state.

5 **Section 4. Approval required.** A health insurer that provides or seeks to market a health
6 insurance plan in the state shall first submit its provider directory to the Insurance
7 Department (“the Department”) for review and approval. Once the Department’s initial
8 approval has been obtained, approval of the updated provider directory must be obtained
9 annually.

10 **Section 5. Provider directory requirements.** The Department shall promulgate regulations
11 to create a process to review each provider directory submitted pursuant to Section 4 of this
12 Act. These regulations shall require that provider directories used by all managed care
13 organizations offering health insurance in the state comply with all of the following:

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

16 (i) Physician specific demographic information as follows:

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

20 (2) Specialty and/or subspecialty information;

21 (3) Indication of whether the physician may be selected as a primary care
22 physician;

- 1 (4) The physician's license number;
- 2 (5) The hours that the physician is available to treat patients;
- 3 (6) The names and locations of the hospital(s) where the physician has medical
- 4 staff privileges and whether those hospitals are part of the provider network;
- 5 (7) Whether the physician is accepting new patients;
- 6 (8) If applicable to the plan, information about the method used to compensate
- 7 the physician, e.g. by indicating whether the physician is reimbursed on a
- 8 fee-for-service or capitated basis; and
- 9 (9) If the provider network includes providers who have not contracted directly
- 10 with the health insurer but through a contracting agent, the provider
- 11 directory must indicate the name, Web site address, mailing address, and
- 12 telephone number of any contracting agent with whom the provider has a
- 13 direct contract.
- 14 (ii) A notice regarding the availability of the listed physicians. The notice must be in
- 15 12-point type or greater and be placed in a prominent place in the directory. The
- 16 notice shall state: "This directory does not guarantee services by a particular
- 17 provider on this list. If you wish to receive care from any of the specific
- 18 providers listed, you should contact those providers to be sure that they are
- 19 accepting additional patients:"
- 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;

(iv) If the network uses tiering 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

(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 directory 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 or available for 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:

(ii) 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;

(iii) Availability of emergency department services; and

(iv) If the network uses tiering in a way that impacts enrollee obligations, enrollees shall be provided clear information indicating which hospital or health facility is

1 in which tier, and how that tier impacts the enrollee's financial or other
2 obligations.

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

7 (d) Other services information. A provider directory must list the following information,
8 including relevant contact information and online links to the entities, if available:

9 (i) Participating pharmacies and pharmacy benefit managers;

10 (ii) Participating durable medical equipment providers;

11 (iii) Participating clinical laboratories; and

12 (iv) Participating ancillary service providers.

13 (e) Online graphic interactive map capability requirement. The health insurance plan
14 must offer an online, graphic interactive map that will provide current and
15 prospective enrollees the means to input a reference address and locate physicians,
16 other health care providers, hospitals, and all other providers within the provider
17 directory by name, type, specialty, subspecialty and distance. All of the following
18 shall be displayed for each provider identified by each search:

19 (i) Whether the provider is participating in the network, accepting new patients,
20 and if the network uses tiering, the tier to which the provider is assigned and
21 how that impacts enrollees' financial or other obligations;

22 (ii) Distance from input location;

- (iii) Provider type, specialty and/or subspecialty;
- (iv) Provider contact information; and
- (v) With respect to hospital-based physicians, the physician specialty, the name(s) of the hospital(s) where each hospital-based physician is contracted and whether each of those hospitals is participating in the network.

(f) Publication and updating of provider directory. The provider directory shall be:

(i) Provided to the enrollee at the time of enrollment in a downloadable or hard copy format, depending on the method by which the enrollee enrolled in the health insurance plan;

(ii) Posted on the health insurer's public Web site;

(iii) Kept current and accurate as required by the regulations adopted by the Department, including at a minimum:

(1) maintenance of an easy mechanism enabling providers to update their own information in the directory;

(2) an ongoing provider survey mechanism to confirm the continued accuracy of the directory;

(3) an easy mechanism enabling enrollees to report directory errors; and

(4) updating the online provider directory at least every thirty days on the insurer's public Web site.

Section 6. Enforcement provisions. A violation of this Act constitutes an unfair and deceptive act or practice in the business of insurance under this Act. Where the Department

1 has found or it is otherwise determined that the health insurer has failed to meet any of the
2 standards set forth by this law, the Department shall do the following:

3 (a) Institute all appropriate corrective action and use any of its other enforcement powers
4 to obtain the health insurer's compliance with this section, including the imposition of
5 administrative fines and other penalties; and

6 (b) Where the violation results in an enrollee's use of an out-of-network provider despite
7 the enrollee's reasonable efforts to remain in network, require the health insurer to:

8 (i) pay the non-contracted provider's usual, customary and reasonable charge as
9 stated on the claim form;

10 (ii) ensure that the enrollee's financial obligations are no greater than if the service
11 had provided by an in-network provider; and

12 (iii) apply the enrollee's out-of-pocket expenses to any out-of-pocket maximums
13 under their health insurance plan.

14 **Section 7. Private right of action.** Any provider or enrollee may bring an action in a court
15 of appropriate jurisdiction against any individual or entity for any violation of this Act. The
16 prevailing party in such an action will be entitled to any remedies contained in this Act and
17 any other remedies available at common law, as well as reasonable attorneys' fees and costs.

18 **Section 8. Severability.** If any provision of this Act or the application thereof to any person
19 or circumstance is held invalid, such invalidity shall not affect other provisions or
20 applications of the Act which can be given effect without the invalid provision or application,
21 and to this end the provisions of this Act are declared to be severable.