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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2015

A N A C T

RELATING TO INSURANCE - MEANINGFUL ACCESS TO ACCURATE PROVIDER DIRECTORIES

Introduced By: Senators Satchell, Goldin, Ottiano, Sosnowski, and Nesselbush

Date Introduced: February 26, 2015

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 81

MEANINGFUL ACCESS TO ACCURATE PROVIDER DIRECTORIES

27-81-1. Title. – This act shall be known and may be cited as the "Meaningful Access to Accurate Provider Directories Act."

27-81-2. Purpose. – The general assembly hereby finds and declares that:

(1) A critical attribute of health care coverage is the network of contracted physicians and other health care providers, commonly referred to as the "provider network". The provider network is comprised of physicians and other individual or institutional health care providers who have contracted to "participate" by agreeing to abide by the network's rules and accept a specified discount off their retail charges. Physicians and other health care providers generally offer substantial discounts to participate in provider networks because they may receive significant benefits in return such as: (i) A promise of prompt payments; (ii) Increased patient volume by virtue of inclusion in provider directories and benefit plans that give patients a substantial financial incentive to go to in-network providers; and (iii) Maintenance of patient loyalty by meeting their patients' request that they be "in-network".

(2) 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;

(3) 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;

(4) 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;

(5) 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; and

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

27-81-3. Definitions. – (a) "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.

(b) "Health care facility" means all persons or institutions, including mobile facilities which offer diagnosis, treatment, inpatient or ambulatory care to two (2) 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.

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

(d) "Health insurer" means an entity or person that offers or administers a health insurance plan, coverage or policy in this state; or contracts with physicians and other health care providers to furnish specified health care services to enrollees covered under a health insurance

plan or policy. "Health insurer" includes, but is not limited to, a nonprofit service corporation, a health maintenance organization, or an entity offering a policy of accident and sickness insurance.

(e) "Health insurance plan" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract or any other health care plan, policy, coverage or arrangement that pays for or furnishes medical or healthcare services, whether by insurance or otherwise, offered in this state.

(f) "Health maintenance organization" means a health maintenance organization as defined in chapter 41 of this title.

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

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

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

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

(k) "Network" or "provider network" means the physicians, healthcare professionals, health care facilities, and ancillary health care providers with whom a health insurer is contracted to provide health care services to a specified group of enrollees under a health insurance plan offered in this state.

(l) "Nonprofit service corporation" means a nonprofit hospital service corporation as defined in chapter 19 of this title or a nonprofit medical services corporation as defined in chapter 20 of this title.

(m) "Policy of accident and sickness insurance" means a policy of accident and sickness insurance as defined in chapter 18 of this title.

27-81-4. Approval required. – A health insurer that provides or seeks to market a health insurance plan shall first submit its provider directory to the office of the health insurance

commissioner (OHIC) for review and approval. Once OHIC's initial approval has been obtained, approval of the updated provider directory must be obtained annually.

27-81-5. Provider directory requirements. – The department shall promulgate regulations to create a process to review each provider directory submitted pursuant to §27-81-4. These regulations shall require that provider directories used by all health insurers offering health insurance in the state of Rhode Island comply with all of the following:

(1) Physician information. The provider directory must list all the following information concerning each participating physician:

(i) Physician specific demographic information as follows:

(A) Physician name, practice address, office telephone number, and website address or other link to more detailed individual physician information, if available;

(B) Specialty and/or subspecialty information;

(C) Indication of whether the physician may be selected as a primary care physician;

(D) The physician's license number;

(E) The hours that the physician is available to treat patients;

(F) The names and locations of the hospital(s) where the physician has medical staff privileges and whether those hospitals are part of the provider network;

(G) Whether the physician is accepting new patients;

(H) If applicable to the plan, 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

(I) If the provider network includes providers who have not contracted directly with the health insurer but through a contracting agent, the provider directory must indicate the name, website 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 twelve (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, twelve (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, twelve (12) point type, which states: "This physician is not an in-network physician with respect to this plan."

(2) Other health care professionals. For each participating non-physician health care professional who bills independently for healthcare services, the provider directory must list that professional's licensure type and all of the information set forth above in subsection (1) of this section, to the extent that information is relevant to or available for that professional.

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

(i) Hospital/health care facility contact information as follows:

(A) 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 website address, if available;

(B) Availability of emergency department services; and

(C) 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.

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

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

(i) Participating pharmacies and pharmacy benefit managers;

(ii) Participating durable medical equipment providers;

(iii) Participating clinical laboratories; and

(iv) Participating ancillary service providers,

(5) Online graphic interactive map capability requirement. The health insurer must offer an online, graphic interactive map that will provide current and prospective enrollees the means to input a reference address and locate physicians, other health care providers, hospitals, and all other providers within the provider directory by name, type specialty, subspecialty and distance.

All of the following shall be displayed for each provider identified by each search:

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

(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.

(6) 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 plan;

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

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

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

(B) An ongoing provider survey mechanism to confirm the continued accuracy of the directory;

(C) An easy mechanism enabling enrollees to report directory errors; and

(D) Updating the online provider directory at least every thirty (30) days on the health insurer's public website.

27-81-6. Enforcement provisions. – A violation of this chapter constitutes an unfair and deceptive act or practice, in the business of insurance under this chapter. Where OHIC has found or it is otherwise determined that the health insurer has failed to meet any of the standards set forth by this law, OHIC shall do the following:

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

(2) Where the violations results in an enrollee's use of an out-of-network provider despite the enrollee's reasonable efforts to remain in network, require the health insurer to pay the non-contracted provider's usual, customary and reasonable charge as state on the claim form.

27-81-7. 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 chapter. The prevailing party in such an action will be entitled to any remedies contained in this chapter and any other remedies available at common law, as well as reasonable attorneys' fees and costs.

27-81-8. Severability. – If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO INSURANCE - MEANINGFUL ACCESS TO ACCURATE PROVIDER DIRECTORIES

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This act would require health insurers to maintain accurate and up-to-date directories of all in-network providers, and to provide that information to plan enrollees.

This act would take effect upon passage.

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