September 6, 2017

To: Mr. William Melofchik
National Conference of Insurance Legislators (NCOIL)
(Via email wmelofchik@ncoil.org)

From: American Academy of Orthopedic Surgeons (AAOS)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American College of Emergency Physicians (ACEP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)
American Society of Plastic Surgeons (ASPS)
College of American Pathologists (CAP)
Physicians for Fair Coverage (PFC)

Re: Proposed Amendments (Attached) to Draft NCOIL Out-of-Network Balance Billing Transparency Act

The following are comments that delineate our concerns with the above-entitled Proposed Model Act and explain our proposed amendments. We appreciate the opportunity to provide constructive input into the development of this Model Legislation by the National Conference of Insurance Legislators (NCOIL).

As a preface to the explanation of our specific amendments (see: Redlined Amendments, Coalition of Medical Specialties), we believe the current NCOIL proposal on network adequacy is ***flawed*** and should be amended in order to ensure that patients are able to purchase and avail health insurance products that can provide the full continuum of health care many may need and that should be covered under the terms and conditions of their particular health plan.

Many medical specialty societies, in coordination with the American Medical Association (AMA), participated in development of the prior version of the NCOIL Model Act (Healthcare Balance Billing Disclosure Model Act- 2011) on out-of-network billing and were pleased with the result. We look forward to again working with NCOIL on updates to the prior version to include requirements for health plan network adequacy that are clearly needed in light of the current health insurance plan market environment.

Section 4 – Definitions:

A definition of "usual and customary rate" (UCR) should be established in the bill in the definition section in order to standardize its use for purposes of the act. In our proposed amendments, we transpose the definition from Section 5 to Section 4 (New definition "N".) In addition, the terminology should be "rate" and not "cost" in accordance with the traditional and widely understood use of the term by the insurance industry in order to reflect the general market value for the service.

Moreover, the UCR should be calculated by entities that have no legal or financial affiliation with health insurance carriers. Such independence in UCR calculation is critical in light of past improper business practices by the health insurance industry brought to light in New York State. A recent study by National Opinion Research Center (NORC) at the University of Chicago evaluated and confirmed the importance and reliability of calculating UCR data based upon independent sources such as Fair Health Inc.[1]

Section 5- Determinations of Network Adequacy

The current draft does not address network adequacy as it relates to in-network physicians at in-network facilities and hospitals. At present, there is a systemic failure by state regulators to ensure network adequacy for facility- and hospital-based physicians at in-network hospitals.

In November 2014, Health Management Associates published a survey of insurance regulators and found that only 14% of state insurance regulators assessed whether insurance plans with in-network hospitals actually include in-network facility- and hospital-based providers. (See: *Ensuring Consumer Access to Care: Network Adequacy Survey, Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market,* Health Management Associates, *November 2014, P.25)* Similarly, in 2015 public testimony, one state insurance regulator acknowledged certifying insurance plans as "adequate" when in fact the regulator ***acknowledged*** the plan was in fact "inadequate" for at least one essential facility- and hospital-based physician specialty.

Current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: "Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including facility- and hospital-based physician specialties, (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible."

In order to remedy the problem of inadequate insurance networks, state regulators should be statutorily compelled to assess whether health plan networks with in-network hospitals have actually contracted with facility- and hospital-based physician specialties at that hospital. Health plans should not be legally allowed to claim compliance with State network adequacy standards when the plan represents to regulators that it has an in-network hospital, but does not undertake the obligation to contract with the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and other hospitalists at such facility.

[1] "Quantitate Assessment of Databases for Out-of-Network Physician Reimbursement," Final Report, NORC at the University of Chicago, May 24, 2017

Furthermore, insurance regulators should be statutorily mandated to conduct a comprehensive network adequacy review to include "provider-to-enrollee ratios for primary care and specialty care providers." Such standards for evaluation should include "geographic accessibility" and maximum distance and wait time standards for patient access.

In sum, state determinations of health plan network adequacy should be sufficiently comprehensive and stringent enough to ensure that all enrollees can have "reasonable and timely access" to in-network health care services at in-network hospitals, facilities and in the community where the enrollee resides. State responsibility in this matter for both the state-based insurance exchanges and the private market is paramount and clearly contemplated by the federal government (Centers for Medicare and Medicaid Services (CMS)) in its most recent rulemaking. (See: 82 FR 18346-18347)

> We are also finalizing policies intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The modified approach we are finalizing for network adequacy, which includes deferring to States with sufficient network adequacy review (or relying on accreditation or an access plan), will not only lessen the regulatory burden on issuers, but also **will recognize the primary role of States in regulating this area.**

Absent such state regulatory oversight, health plans have already demonstrated a widely observed and documented business practice proclivity to *shrink and narrow* their insurance networks in order to shift the cost of health care on to their enrollees. As a broad physician coalition, we strongly denounce these deceptive and manipulative business practices by the health insurance industry. We strongly urge that NCOIL's network adequacy model be a policy basis for protecting patients from these exploitative business practices by the industry.

Section 6 – Coverage Option Mandate

It is important to note at present, many health insurance plans (e.g. United healthcare and Aetna), in fact, do avail the UCR formula for determining payment for out-of-network services. We agree with the proposed draft that the UCR should be established at the 80th percentile benchmark for charges, in the same or similar specialty, based on geography of the service, as determined by an independent database. Use of the UCR is an important public policy incentive for health plans to contract with physicians and to maintain marketplace equilibrium between payers and providers.

In December 2015, the non-partisan National Association of Insurance Commissioners (NAIC) in their annotations on this issue (MDL 74-22) noted that

States should consider a payment formula such as: "a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation."

Furthermore, the NAIC noted the imperative need for states to recognize the need for payment equilibrium in the market: "In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility- and hospital-based providers and heath carriers to agree on a contract."

We believe that mandated UCR payment, as is used in New York State for example, should be an economic inducement for both providers and health insurance carriers to undertake contractual arrangements that greatly maximize the ability of the health insurance networks to provide the enrollee or patient with the full continuum of in-network health care.

Section 7- Emergency Services Provided by Out-of-Network Providers

The health insurance industry should be required to pay the UCR, or the physician's charge, whichever is lesser, for the out-of-network physician service at in-network hospitals and facilities. This standard should include all physicians who provide emergency care. **Emergency physicians, and others who provide emergency care, are performing screening and stabilization for life- or limb-threatening conditions to every patient, as mandated by the federal Emergency Medical Treatment and Labor Act of 1986 (EMTALA).** Accordingly, the provision of their services cannot be contingent upon considerations regarding the patient's insurance status or their participation in the health plan network. Thus, their services should be subject to UCR payment requirements on health insurance carriers.

Moreover, out-of-network payment to physicians should always be made directly to the provider of the service, and not to the enrollee. The diversion of payment to the enrollee is a frequent business practice of health insurance plans to impede and encumber the collection of payment by the out-of-network physician, thereby driving up the administrative cost of care.

Section 9- Provider Notice to Enrollees

Under the proposed NCOIL requirement for providing notice "prior to providing services," patient care is substantially impeded and jeopardized by requiring a potential delay in the performance of physician services for a patient. Quite simply, ethical and legal standards of care do not allow for the performance of certain facility- and hospital-based physician services to be delayed by insurance considerations, as such could be detrimental to quality and to the actual performance of the service. Thus, the provision requiring notice to

enrollees should only be applicable to facilities and to providers who have a scheduled appointment with a patient.

Application of the contemplated "notice" requirement to out-of-network physicians, who have both ethical and legal obligations to ensure the well-being of the patient and the expediency of a diagnosis, is a potentially deleterious impediment to the delivery of health care. For some medical specialties, a delay in providing services can be **directly deleterious to the health of the patient, who may be under anesthesia or otherwise incapable of receiving notice, or to the timely accuracy of a diagnosis (e.g. patient specimen degradation for pathological analysis).**

It is for these aforementioned reasons that this requirement was considered and in broad consensus ***rejected*** by both the National Association of Insurance Commissioners (NAIC) in 2015 and, **notably, in 2010 by the National Conference of Insurance Legislators (NCOIL) in consideration of model legislation being developed on this issue at that time.** Accordingly, we urge NCOIL to maintain its well-deliberated, ***prior position*** on this issue and amend the proposed bill to delete this requirement.

In addition, the referring health care provider cannot infer the determination of another health care provider's insurance status. Thus, enrollees are best positioned to inquire with their own health plans, or to inquire with the actual provider of the service as to what health insurance plans are served as participating providers.

Section 11 – Balance Billing

The proposed NCOIL legislation contravenes conventional medical billing practices by establishing extraordinary, politically improvised additional requirements, exclusively applicable to out-of-network balance bills and that do not provide meaningful or actionable information for the patient.

The proposed requirement for ***itemized bills*** is administratively onerous and illogical since providers, and the health insurance industry, rely upon a largely automated and standardized medical billing and coding system that denotes services for which the health insurance payer or patient are billed and under which claims are processed by the carrier. This delineation of services also appears on an "explanation of benefits (EOB)" the patient receives from the health insurance payer, whether subject to balance billing or billed under deductibles, co-payments or co-insurance.

The requirement for an "itemized listing of non-emergency medical care provided along with the services and supplies provided" is impractical and an unnecessary administrative onus on the health care system. The itemization is not meaningful or actionable when coming from an out-of-network provider. (Such itemization

requirements may have practical purposes if emanating from the hospital or facility for its miscellaneous service and supply charges, but certainly not from physicians to whom such costs are integral to the provision of the service.) It is also unclear to us what policy concern the itemization requirement is intended to remedy.

Equally important, the contemplated disclosure statement ***fails*** to inform enrollees of options to have charges waived based upon economic necessity, which is a common practice voluntarily undertaken by physicians. The voluntary waiver or adjustment of charges by physicians, based upon patient economic necessity, should be communicated and legally safe harbored under our proposal in order to ensure that it is not legally assailed by the health insurance carrier.

Furthermore, the legislation fails to standardize a payment rate for the provider's charge based upon the lesser of the provider's charge or the "usual and customary rate" (UCR). We think this omission is a disservice to patients. We recommend a clear citation of UCR in the out-of-network physician communication, including an affirmation that provider is billing in accordance with the UCR applicable to the service and the location where the service is provided. This provision will also help to curb any truly egregious physician billing outliers who charges do not conform to UCR.

Accordingly, as a practical and equitable measure, our proposed language helps to ensure that out-of-network physicians bill in accordance with the UCR and health insurance carriers commensurately pay in accordance with the UCR, thereby largely remedying policy concerns over inordinate balance billing of patients who are not financially held harmless by their insurance carriers.

We also recommend that the legislation place clear obligations on health insurance plans. The current draft largely elides over health insurance carriers responsibilities both to their enrollees and to the health care system. Specifically, health insurance plans should be clearly obligated to:

> 1) provide the out-of-network facility- and hospital-based physician with an explanation of benefits;
> 2) make payment directly to the out-of-network provider (not payment to the enrollee) at the usual and customary rate, or the pay the provider's charge, whichever is lower; and
> 3) apply any amount paid by the enrollee that exceeds applicable deductibles, co-payments or co-insurance towards the enrollees annual limitation on cost-sharing.

With respect to our proposed new subdivision 3), under federal rules to take effect on January 1, 2018, a health insurance carrier that fails to provide an

enrollee with written notice on higher costs associated with scheduled facility- and hospital-based out-of-network care must "count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing." (See: 45 CFR 156.230 (e) (1)).

We think it is both logical and proper to have states extend this federal patient cost-mitigation measure to situations wherein enrollees cannot access in-network providers at in-network facilities. These situations wherein enrollees have no in-network options at in-network hospitals and facilities should be rare if the Model NCOIL legislation adopts our proposed revisions to ensure specialty physician network adequacy at hospitals and other facilities, including other measures to induce robust health plan network adequacy and health insurance carrier payment for the out-of-network provider in accordance with UCR.

Section 14 – Provider Directories

When health plan enrollees purchase health insurance products that list in-network hospitals and facilities, but such plans have failed to contract with certain essential facility- and hospital-based physician specialties at these locations, the health plan has deceived the enrollee into purchasing an insurance product that is fundamentally deficient. Such deceptive trade practices by health insurance plans should be expressly prohibited and subject to state sanction under this Model legislation.

In addition, the health insurance carrier should be legally responsible for maintaining an accurate and current provider directory so that enrollees can make responsible decisions for accessing in-network health care services. Accordingly, carriers should be required to, at a minimum, conduct a monthly review of each plans network directory for accuracy.

In order to promote accurate directories on an ongoing basis, carriers should be statutorily compelled to contact facilities and providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the facility or provider intends to remain in the carrier's provider network. Carriers should update information within 15 working days after receiving notice from the participating facility or provider of a change. These requirements will enable enrollees and patients to make informed choices in non-emergency situations. Out-of-network care is likely to be more expensive for the patient as the result of higher co-payments, co-insurance and different deductibles; however, in some cases patients may want to elect such providers for their services. In any case, the patient should be fully enabled to make an informed choice in a non-emergency, elective health care situation.

Furthermore, patients who rely upon inaccurate provider directory information should not be responsible for out-of-network health care costs that would

otherwise exceed in-network care. The health carrier should be financially responsible for any difference in the amount.

New: Section 15- Waiver of Out-of-Network Charges

Some health insurance plan payers construe any physician waiver of co-payments, co-insurance, or deductibles whether occurring up front at the time of medical services or after receipt of payment by the plan, on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. It has been noted in the legal community, "...the practice of out-of-network providers waiving co-payments and deductibles has continued and is occurring with such frequency in the market that one national insurer in particular has resolved to commence a major legal campaign to curtail the billing practice."[2]

A provider may receive significant legal protection similarly by including a statement on its insurance claim that it will waive the co-payment or deductible, or that it reserves the right to not pursue the patient for these amounts. This disclosure, however, could result in the insurer's denial of the claim, and if the insurer does not agree to the statement, a provider risks displaying the requisite intent for being accused of insurance fraud.[3]

Nevertheless, according to a recent national survey, approximately 22% of individuals who used out-of-network providers negotiated an out-of-network bill with the insurer or provider, and 58% were successful in reducing their costs for at least one of the bills.[4]

Health insurance plan efforts to legally assail physician authority to waive charges, on a case-by-case basis, based upon a patient's economic condition, creates a hostile legal atmosphere that is designed to deter such benevolent financial actions by physicians for their patients. Accordingly, physicians should have an explicit legal safe harbor in state law to conduct such waivers on out-of-network charges on a case-by-case basis so as to financially benefit economically distressed patients.

Summary

In total, we believe that our proposed amendments to the proposed NCOIL model create a framework for cost efficient health care that minimizes patient cost and that ensures that health insurance carriers cannot circumvent or shirk their legal and financial responsibilities in providing coverage that provides reasonable and timely in-network access to all health care services.

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[2] "Out of Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies," The Health Lawyer, Charles C Dunham, Esq. O"Connell & Assoc. Albany, NY., Volume 25, Number 5, June 2013.

[3] Ibid.

[4] "Patient's Success in Negotiating Out-of-Network Bills," The American Journal of Managed Care, Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

Thank you for your consideration of these proposed amendments.

Respectfully submitted,

American Academy of Orthopedic Surgeons (AAOS)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American College of Emergency Physicians (ACEP)
American College of Radiology (ACR)
American Society of Anesthesiologists (ASA)
American Society of Plastic Surgeons (ASPS)
College of American Pathologists (CAP)
Physicians for Fair Coverage (PFC)

cc: Emily Carroll, Senior Legislative Attorney,
American Medical Association

Attached: Proposed Amendments of the Coalition

PROPOSED REDLINE AMENDMENTS OF THE COALITION OF MEDICAL SPECIALTIES (AAOS, AAOMS, ACEP, ACR, ASA, ASPS, CAP, PFC)

DRAFT NCOIL OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

Section 1. Title
This Act shall be known as the Out-of-Network Balance Billing Transparency Act.

Section 2. Purpose
The purpose of this Act is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network physicians. Improved disclosures by health benefit plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance processes and reduce the incidence of costly, surprise bills.

Section 3. Applicability
A. Except as provided in subsection B, this Act applies to any health benefit plan, provider, and health care facility as defined in Section 4.

B. This Act does not apply to:

1. Medicaid managed care programs operated under [Insert Applicable State Statute];
2. Medicaid programs operated under [Insert Applicable State Statute];
3. the state child health plan operated under [Insert Applicable State Statute];
4. Medicare;
5. or
6. "excepted benefit" products as defined under 42 U.S.C. 300gg-91(c).

Section 4. Definitions
A. "Balance billing" means the practice by a provider, who does not participate in an enrollee's health benefit plan network, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts required by the health benefit plan.

B. "Carrier" or "health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Carriers include a health insurance company, HMO, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

C. "Emergency services" includes any health care service provided in a health care facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

D. "Enrollee" means an individual who is eligible to receive medical care through a health benefit plan.

E. "Facility-based provider" means an individual or group of health care providers:

1. to whom the health care facility has granted clinical privileges; and
2. who provides services to patients treated at the health care facility under those clinical privileges.

F. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of [physical, mental, and/or behavioral] health care services.

G. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing medical care, and which is licensed by [Insert appropriate state agency].

H. "Network" means the providers and health care facilities who have contracted to provide health care services to the enrollees of a health benefit plan. This includes a network operated by or that contracts with a health maintenance organization, a preferred provider organization, or another entity (including an insurance company) that issues a health benefit plan.

I. "Network plan" means a health benefit plan that uses a network to provide services to enrollees.

J. "Out-of-network facility" means a health care facility that has not contracted with a carrier to provide services to enrollees of a health benefit plan.

K. "Out-of-network provider" means a health care provider who has not contracted with a carrier to provide services to enrollees of a health benefit plan.

L. "Out-of-network referral denial" means a denial by a health benefit plan of a request for an authorization or referral to an out-of-network provider on the basis that the health benefit plan has an in-network provider with appropriate training and experience to

meet the particular health care needs of the enrollee and who is able to provide the requested health service.

M. "Provider" means an individual who is licensed to provide and provides medical care.

N. "Usual and customary rate" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be financially affiliated with, or otherwise supported by an insurance carrier

Section 5. Determination of Network Adequacy

A. A health benefit plan that contracts with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered by the health benefit plan.

- **a. The Commissioner shall in consultation with interested stakeholders adopt regulations to establish quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefits plans subject to this act**
- **b. In adopting the regulations, the Commissioner shall take into consideration:**
  - **i. Geographic accessibility of primary care and specialty care providers, with consideration for geographic variation and population dispersion, to establish maximum distance standards**
  - **ii. Waiting times for an appointment with participating primary and specialty care providers to establish maximum wait time standards**
  - **iii. Provider-to-enrollee ratios for primary and specialty care providers to establish provider-to-enrollee ratio standards**
  - **iv. Hours of operation**
  - **v. The ability of the network to meet the needs of enrollees**

B. A carrier shall annually submit a network access plan to the Commissioner with information necessary to document compliance with this provision, including:

- **a. a report for each network hospital that provides the percentage of physicians in each of the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and hospitalists practicing in the hospital who are in the insurer's network(s) so as to ensure enrollees with reasonable and timely access to these in-network physicians**

b. a report on the percentage of primary care and specialty care physicians who are in the insurer's network(s) as to ensure enrollees with reasonable and timely access to necessary medical care

C. The commissioner of [insert applicable state agency] shall review the network of health care providers for adequacy at the time of the commissioner's initial approval of a health insurance policy or contract; at least every ~~three~~ **two** years thereafter; and upon application for expansion of any service area associated with the policy or contract.

D. When determining the adequacy of a proposed provider network, the commissioner must consider whether the carrier's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the proposed network to reasonably ensure enrollees have in-network access for covered benefits delivered at that in-network facility

~~C~~**. E.** To the extent that the network has been determined by the commissioner to meet the standards set forth in [insert applicable section law], such network shall be deemed adequate by the commissioner.

~~D~~**. F.** Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.

Section 6 Coverage Option Mandate

A. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers shall make available and, if requested by the policyholder or contract holder, provide ~~at least one option for~~ coverage **at** ~~at least eighty percent of~~ the usual and customary **rate** ~~cost of~~ **for** each service provided by an out-of-network provider after imposition of **any applicable** deductible, co-payment or co-insurance. ~~or any permissible benefit maximum.~~

B. If there is no coverage available pursuant to subparagraph (A) of this section in a rating region, then the commissioner may require a carrier issuing a comprehensive group health benefit plan in the rating region, to make available ~~and, if requested by the policyholder or contract holder, provide at least one option for~~ coverage ~~of eighty percent of~~ at the usual and customary **rate** ~~cost~~ of each service provided by an out-of-network provider after imposition of any permissible deductible or benefit maximum. The commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this paragraph on behalf of another carrier, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of services provided by

out-of-network providers to be made available pursuant to this subsection if the commissioner determines that it would pose an undue hardship upon a carrier.

~~C. For the purposes of this subsection, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with a carrier.~~

~~D. This section shall not apply to emergency care services in health care facilities or pre-hospital emergency medical services as defined by [insert applicable section of state law].~~

~~E.~~ C. Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and subscriber contracts, to require additional coverage options for services provided by out-of-network providers, or to provide for standardization and simplification of coverage.

Section 7. Emergency Services Provided by Out-of-Network Provider

A. When an enrollee in a health benefit plan that covers emergency services receives the services from an out-of-network provider, the health benefit plan shall ensure that the enrollee shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider.

1. Upon receipt of an out-of-network provider or facility's bill for emergency health care services, the carrier must make payment at the usual and customary rate, or the provider's charge, whichever is lower, directly to the provider or facility, rather than the covered person.

Section 8. Health Benefit Plan Notice to Enrollees

A. Where applicable, and through its website, a health benefit plan must give to an enrollee:

1. notice

a. that the enrollee may obtain a referral or preauthorization for services from an out-of-network provider when the health benefit plan does not have in its network a provider who is geographically accessible to the enrollee and has the appropriate training and experience to meet the particular health care needs of the enrollee; and

b. the procedure for requesting and obtaining such referral or preauthorization;

2. notice

a. that the enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and

b. the procedure for requesting and obtaining such a standing referral;

3.notice

a. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care; and

b. the procedure for requesting and obtaining such a specialist;

4. notice

a. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center; and

b. the procedure for requesting and obtaining such access may be obtained;

5. notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy.

6. a listing of providers in the health plan network, pursuant to Section 14.

7. with respect to out-of-network coverage:

a. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services;

b. a description of the amount that the carrier will reimburse under the methodology for out-of-network health care services set forth as a percentage of **t**he usual and customary **rate** ~~cost~~ for out-of-network health care services; and

c. examples of anticipated out-of-pocket costs for frequently billed out-of- network health care services; and

d. information that reasonably permits an enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health benefit plan will reimburse for out-of-network health care services and the usual and customary ~~cost~~ rate for out-of-network health care services

B. Upon request of an enrollee and no later than 48 hours after the enrollee has been pre-certified to receive non-emergency services at a facility, a health benefit plan shall provide by electronic or written correspondence, information on:

1. whether the enrollee's provider is a participating provider in the health benefit plan network;
2. whether proposed non-emergency medical care is covered by the health benefit plan;
3. what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and
4. if applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary payment rate for out-of-network services.

Section 9. Provider Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. Verbally at the time an appointment is scheduled and in writing or through a website prior to providing services, a health care provider, **who has a scheduled appointment with the enrollee,** or the provider's representative shall **ascertain the enrollee's insurance information and** disclose to the enrollee in writing or through an internet website, the health benefit plans in which the provider participates and the hospitals with which the provider is affiliated.

~~C. If a provider does not participate in the enrollee's health benefit plan network, the provider shall:~~

~~1. prior to providing services, inform the enrollee that the amount or estimated amount the provider will bill the enrollee for health care services is available upon request; and 2. Upon request, provide the enrollee with a written amount or estimated amount the provider anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided~~.

~~D.~~ **C.** When services rendered in a provider's office require referral to, or coordination with, an anesthesiologist, laboratory, pathologist, radiologist, and/or assistant surgeon, the provider or provider's representative initiating the referral or coordination shall give to the enrollee, the following information in writing about the aforementioned who will be providing services to the enrollee: ~~(1)~~ name, practice name, mailing address, telephone number, ~~and (2) how~~ **in order for the enrollee** to determine in which health benefit plan networks each participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

~~E.~~ **D**. At the time a provider or the provider's representative is scheduling an enrollee to receive services at a health care facility, that provider or provider's representative shall give to the enrollee, the following information in writing about any

anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services to the enrollee: ~~(1)~~ name, practice name, mailing address, telephone number, ~~and (2) how~~ **for the enrollee** to to determine in which health benefit plan networks each participates.

Section 10. Health Care Facility Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. A health care facility shall establish, update and make public through posting on its website, to the extent required by federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the federal Social Security Act.

C. A health care facility shall post on its website:

1. the networks in which the health care facility is a participating provider;

2. a statement that:

a. physician services provided in the health care facility are not included in the facility's charges;

b. physicians who provide services in the facility may or may not participate with the same health benefit plans as the facility;

c. if an enrollee in a health benefit plan receives services in the facility that is in that health benefit plan's network, but receives those services from a provider who is not in that network, the enrollee may be billed for the amount between what the provider charges and what the enrollee's health benefit plan pays that provider, including any co-pays, co-insurance, and/or deductibles that are the enrollee's responsibility; and

d. the enrollee should check with the provider arranging for the enrollee to receive services in the facility to determine whether that provider participates in the enrollee's health benefit plans network.

3. as applicable, the name, mailing address and telephone number of the facility-based providers and facility-based provider groups that the facility has employed or contracted with to provide services including anesthesiology, pathology, and/or radiology, and instructions about how to determine in which health benefit plan networks each participates.

D. In registration or admission materials provided in advance of non-emergency services, a health care facility shall:

1. advise the enrollee to check with the physician arranging for the services to determine the name, practice name, mailing address and telephone number of any

other physician who is reasonably anticipated to be providing services to the enrollee while in the health care facility, including but not limited to physicians employed by or contracting with the health care facility; and

2. inform the enrollee about how to timely determine in which health benefit plan networks the providers referenced in Section 10 C 3 participate.

E. Upon request, a facility shall provide the enrollee with a written amount or estimated amount that the facility anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

Section 11. ~~Balance~~ Out-of-Network Billing and Payment

A. ~~If an~~ Out-of-network provider bills sent to an enrollee for non-emergency medical care, requesting payment ~~the balance~~ of the provider's charge ~~that is not related to co-pays, coinsurance payments, or deductible payments and~~ ~~is not covered by the health benefits plan, the billing statement from that provider~~ must contain:

1. ~~an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;~~
2. ~~1.~~ a conspicuous, plain-language explanation that the provider is not within the health plan network; and ~~b.~~ the health benefit plan has paid **a usual and customary** rate, as determined by the health benefit plan, ~~which is below the facility-based provider's billed amount;~~
3. ~~2.~~ a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;
4. ~~3.~~ a statement that the enrollee may call to discuss ~~alternative~~ payment arrangements **for those amounts that the enrollees is financially responsible for under their plan of insurance or for any other amounts not paid by their health plan;**
5. ~~4.~~ **a statement affirming that the out-of-network provider has billed in an amount no greater than the usual and customary rate for the out-of-network service and that if the health plan pays the the provider's charge in full or at that rate in full the enrollee will only be financially responsible for applicable deductibles, co-insurance and co-payments .**

~~5. a notice that the enrollee may file complaints with the [Insert State Medical Board] and includes the [Insert State Medical Board] mailing address and complaint telephone number; and~~

5. a notice that if an enrollee owes more than $200 to the provider (over any applicable co-payments, co-insurance, or deductibles and insurance payments) and the enrollee agrees to a payment plan

a. the provider will not furnish adverse information to a consumer reporting agency if the enrollee substantially complies with the terms of

the payment plan (1) within six months of having received the medical services or (2) within 30 days of receiving the first billing statement that reflects all insurance payments and the final amount owed by the enrollee; and

b. a patient may be considered by the provider to be out of substantial compliance with the payment plan agreement if payments in compliance with the agreement have not been made for a period of 45 days.

B. A health insurance carrier for an out-of-network non-emergency bill from a physician shall:

1. provide the physician with an explanation of benefits as to any payment determination thereof; and

2. Upon receipt of an out-of-network provider or facility's bill for health care services, make payment at the usual and customary rate, or the provider's charge, whichever is lower, directly to the provider or facility, rather than the covered person.

3. Count any amount paid by the enrollee that exceeds applicable deductibles, co-insurance or co-payments towards the enrollees annual limitation on cost sharing.

Section 12. Out-of-Network Referral Denials

A. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. The notice of an out-of-network referral denial provided to an enrollee shall include information regarding how the enrollee can appeal the denial, including but not limited to what information must be submitted with the appeal.

C. Appeals

1. An enrollee or enrollee's designee may appeal an out-of-network referral denial by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty appropriate to treat the enrollee for the health service sought, provided that:

a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service; and

b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

2. If an out-of-network referral denial has been upheld by the health benefit plan's internal appeals process and the enrollee wishes to pursue an external appeal, the external appeal agent shall

a. review the utilization review agent's health benefit plan's final adverse determination; and

b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall:

i. be conducted only by one or a greater odd number of clinical peer reviewers;
ii. based upon review of the (1) training and experience of the in-network health care provider or providers proposed by the plan, (2) the training and experience of the requested out-of-network provider, (3) the clinical standards of the plan, (4) the information provided concerning the insured, (5) the attending physician's recommendation, (6) the insured's medical record, and (7) any other pertinent information; and
iii. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;
iv. be binding on the plan and the insured; and
v. be admissible in any court proceeding.

c. Upon reaching its decision, the external appeals agent shall submit to the enrollee and the health benefit plan, a written statement that:

i. the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines that (1) the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and (2) that the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service and is likely to produce a more clinically beneficial outcome.

or

ii. the external appeal agent is upholding the health plan's denial of coverage.

Section 13. Prior Authorization

A. A health benefit plan shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a that determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the information necessary to make the determination. To the extent practicable, such written notification to the enrollee and the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify:

1. whether the services are considered in-network or out-of-network;

2. whether the enrollee will be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

3. as applicable, the dollar amount the health benefit plan will pay if the service is out-of-network; and

4. ~~as applicable~~, information explaining how an enrollee can determine the anticipated out-of-pocket cost for out-of-network health care services**, based upon applicable co-payments, deductibles and co-insurance and the usual and customary payment rate for such services.** ~~**in a geographical** area or zip code based upon the difference between what the health benefit plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services~~

Section 14. Provider Directories

A. A carrier shall provide a provider directory on both the carrier's website and in print format.

1. The carrier shall **conduct a monthly review of each plan's network directory for accuracy** ~~periodically audit at least a reasonable sample size of its provider directories for accuracy~~ and retain documentation of such an audit to be made available to the insurance commissioner upon request.

2. The directory on the carrier's website and in print format shall contain the following general information in plain language for each network plan:

a. a description of the criteria the carrier has used to build its network;
b. if applicable, a description of the criteria the carrier has used to tier providers;
c. if applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier;
d. if applicable, a statement that authorization or referral may be required to access some providers;

e. what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state;
f. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the directory posted online, the carrier shall

1. update the provider directory at least monthly;

2. ensure that the public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

3. make available in a searchable format the following information for each network plan:

a. For health care professionals: name; gender; participating office location(s); specialty, if applicable; medical group affiliations, if applicable; facility affiliations; if applicable; participating facility affiliations, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients.
b. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; provided however,; and
c. For facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).
d. **A carrier with a provider network shall not state nor imply in communications with or directed toward enrollees or potential enrollees that a hospital, licensed under xxx , is an in-network health care facility if the health care providers who provide the following specialty services at such hospital do not also participate in the health benefit plan's network: Anesthesiology, emergency medicine, radiology and pathology. A violation of this provision shall be considered a deceptive or unfair trade practice subject to sanction under [ ]**

4. make available the following information in addition to the information available under Subsection B 3:

a. for health care professionals: contact information; board certification(s); and languages spoken other than English by clinical staff, if applicable;
b. for hospitals: telephone number; and
c. for facilities other than hospitals: telephone number.

C. A carrier shall:

b. Contact the facilities and providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the facility or provider intends to remain in the carrier's provider network

c. Update the information within 15 working days after receiving notice from the participating facility or provider of a change

D. Regarding the provider directory in print format, the carrier shall include a disclosure that the directory is accurate as of the date of printing and that enrollees and prospective enrollees should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service phone number] to obtain current provider directory information.

E. If a patient receives care from a provider listed in the directory as participating, but unintentionally receives out-of-network care due to an inaccurate carrier directory, the carrier is required to compensate the provider at the provider's full rate at no expense to the patient

D. Upon request of an enrollee or a prospective enrollee, the carrier shall make available in print format, the following provider directory information for the applicable network plan:

a. for health care professionals: name; contact information; participating office location(s); specialty, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;
b. for hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and
c. for facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s) and telephone number.

Section 15 Waiver of Out-of-Network Charges

Any out-of-network provider who, on a case by case basis, determines to waive any cost for an enrollee in a health benefit plan based upon economic circumstances of the enrollee, including any balance billed amount, co-payment, coinsurance or copayment, shall not be subject to: 1) any civil cause of action by a health plan; (2) subject to prosecution for any violation in any court of jurisdiction, or (3) any sanction before any state oversight board (4) any approval requirement of a health benefit plan.

Section ~~15~~.16 Effective Date

This Act shall take effect on [insert months] following enactment.

6-13-17, 5 p.m. (Edits to correct punctuation, alphabetizing, numbering, inconsistent language.)