

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Proposed Healthcare Balance Billing Disclosure Model Act
(July 19, 2010)

Proposed Consumer Healthcare Charges Transparency Model Act
~~Proposed Healthcare Balance Billing Disclosure Model Act~~ – (AHIP)

Sponsored for discussion by Sen. Ann Cummings (VT) and Rep. Charles Kleckley (LA)

STAFF NOTE

This document incorporates changes approved by the full Health, Long-Term Care & Health Retirement Issues Committee on March 6 and July 10, 2010, in Sections three, four, five, six, and seven. It also contains interested party comments and proposed markups that have not yet been considered.

KEY

Double-lined boxes contain proposed amendments and comments.

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Section 1. Purpose

Section 2. Summary

Section 3. Definitions¹

A . "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

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Jan. 29 comments

A . "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan, **provided that such charges shall not include applicable**

deductibles, co-payments, coinsurance or other cost-sharing amounts provided for in the health benefit plan.

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Mar. 1 comments

~~A. "Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.~~

A. "Patient billing" means the practice by a health care provider of charging a patient for the health care services that have been provided to the patient, to the extent that the health care provider has not contracted to bill a third party payer for those services instead of the patient. Where the health care provider is contracted with the patient's third party payer, the patient is financially responsible for the services that the patient has received, less the amount the third party payer may have paid the health care provider directly pursuant to the patient's out-of-network benefit.

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

C. "Emergency medical care" includes any healthcare services provided in a healthcare 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. "Facility-based provider" means an individual, or group of, radiologists, anesthesiologists, pathologists, emergency department physicians, or neonatologists:

1. to whom the facility has granted clinical privileges; and
2. who provides services to patients of the facility under those clinical privileges.

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~~D. "Facility-based provider" means an individual, or group of, radiologists, anesthesiologists, pathologists, emergency department physicians, or neonatologists:~~

- ~~1. to whom the facility has granted clinical privileges; and~~
- ~~2. who provides services to patients of the facility under those clinical privileges.~~

D. "Hospital-based physician" means any physician, excluding interns and residents, who, as either a hospital employee or an independent contractor, provide services to patients in the

hospital setting 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.

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Mar. 1 comments

Definition excludes hospitalists/intensivists and other non-physician practitioners. We believe they should be incorporated into this document as "qualified health care providers."

- E. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.

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~~E. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.~~

E. "Hospital" means a health care facility which is licensed by the [Insert State Department of Health Services].

- F. "Health care provider" means an individual who is licensed to provide and provides health care services.
- G. "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

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G. "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that **may** requires those enrollees to use health care providers participating in the plan and procedures covered by the plan. The term includes a network operated by:

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Mar. 1 comments

G. "Provider network" means **all of the providers contracted to provide services to a specified group of enrollees, a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan.** The term includes a network operated by:

1. a health maintenance organization;
2. a preferred provider benefit plan issuer; or
3. another entity that issues a health benefit plan, including an insurance company.

Section 4. Applicability²

A. This Act applies to any health benefit plan that:

1. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
 - (a) an insurance company;
 - (b) a group hospital service corporation operating under *[Insert Applicable State Statute]*;
 - (c) a fraternal benefit society operating under *[Insert Applicable State Statute]*;
 - (d) a stipulated premium company operating under *[Insert Applicable State Statute]*;
 - (e) a health maintenance organization operating under *[Insert Applicable State Statute]*;
 - (f) a multiple employer welfare arrangement that holds a certificate of authority under *[Insert Applicable State Statute]*;
 - (g) an approved nonprofit health corporation that holds a certificate of authority under *[Insert Applicable State Statute]*; or
 - (h) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or
2. provides health and accident coverage through a risk pool created under *[Insert Applicable State Statute]*.

B. This Act applies to a person to whom a health benefit plan contracts to:

1. process or pay claims;
2. obtain the services of physicians or other providers to provide health care services to enrollees; or
3. issue verifications or preauthorizations.

C. The Act applies to all healthcare facilities and facility-based providers that are providing medical care to patients.

D. 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. emergency medical care as defined under Subsection 3(C) of this Act; or
6. care as provided in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Section 5. Facility Disclosure³

- A. Each healthcare facility shall develop, implement, and enforce written policies for the billing of non-emergency, elective facility health care services and supplies. The policies must address:
1. the providing of a conspicuous written disclosure to a consumer at the time the consumer is first admitted on a non-emergency basis to the facility, at pre-admission, or first receives non-emergency or post-stabilization services at the facility that:
 - (a) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided;
 - (b) informs consumers that if a facility-based provider who provides services to the consumer while the consumer is in the facility is not a participating provider with the same third-party payors as the facility, then the consumer may be billed for medical services for the amount unpaid by the consumer's health benefit plan.
 2. the requirement that a facility provide a list, on request, to a consumer to be admitted to, or who is expected to receive services from, the facility, that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility; and
 3. if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility's website of a list that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

Section 6. Facility-Based Provider Disclosure⁴

- A. If a facility-based provider bills a patient who is covered by a health benefit plan described in Section 4 that does not have a contract with the facility-based provider, requesting payment on 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 facility-based provider shall send a billing statement that:
1. contains an itemized listing of the services and supplies provided along with the dates the services and supplies were provided;
 2. contains a conspicuous, plain-language explanation that:
 - (a) the facility-based provider is not within the health plan provider network; and
 - (b) the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider billed amount;

3. contains 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. contains a statement that the patient may call to discuss alternative payment arrangements;
 5. contains a notice that the patient may file complaints with the *[Insert State Medical Board]* and includes the *[Insert State Medical Board]* mailing address and complaint telephone number; and
 6. for billing statements that total an amount greater than \$200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 30 days of receiving the first billing statement that includes all insurance payments and reflects the final amount owed by the enrollee or six months after the receipt of medical treatment, whichever occurs first and substantially complies with the agreement, the facility-based provider may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment.
- B. A patient may be considered by the facility-based 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.

Drafting Note: States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance billing.

Section 7. Health Benefit Plan Disclosure⁵

- A. Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:
1. a facility-based provider or other health care provider may not be included in the health benefit plan's provider network; and
 2. a health care provider described by Section 7A(1) may balance bill the enrollee for amounts not paid by the health benefit plan.
- B. 1. The health benefit plan shall provide the disclosure in writing to each enrollee:
- (a) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;
 - (b) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and
 - (c) conspicuously displayed, on any health benefit plan website that an enrollee is reasonably expected to access.
2. The commissioner by rule may prescribe specific requirements for the disclosure required under B(1). The form of the disclosure must be substantially as follows:⁶

NOTICE: "ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF

THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN."

- C. A health benefit plan must clearly identify healthcare facility-based providers within the provider network who participate in the health benefit plan's provider network. Facility-based providers identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.
- D. Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.
- E. A health benefit plan shall provide to an insured by electronic or written correspondence, upon request for a healthcare service or supply but no later than 48 hours after pre-certification, information on:⁷
 - 1. whether a facility-based provider or other health care provider is a participating provider in the insurer's preferred provider network;
 - 2. whether proposed health care services are covered by the health insurance policy;
 - 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.

~~F. A health benefit plan that must comply with this Act under Section 4 shall, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and shall also specify any deductibles, copayments, coinsurance, or other amounts for which the enrollee is responsible. The estimate must be provided not later than the 10th business day after the date on which the estimate was requested. A health benefit plan must advise the enrollee that:~~

- ~~1. the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and~~
- ~~2. the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.~~

STAFF NOTE: During the July 10 Committee meeting, there was a request to review language that would require estimates under Sections five, six, and seven during future conference calls.

SUPPLEMENTAL LOUISIANA LANGUAGE

Section 8. Website Disclosure⁸

- A. No later than March 31, 2010, or within thirty days of the effective date of a new contract, each hospital or ambulatory surgical center, hereinafter referred to as "facility" or "contracted facility" for

purposes of this Section, shall provide to each health insurance issuer with which it contracts, the National Provider Identifier (NPI) as set forth in 45 CFR §162.402 et. seq., name, business address, and business telephone number of each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that facility. Thereafter, the facility shall notify each health insurance issuer of any changes to the information as soon as possible but not later than thirty days following any change.

- B. No later than *[Insert Date]*, or within thirty days of the effective date of a new contract, each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at a contracted facility shall provide the health insurance issuer with which it is contracted, the NPI, name, business address, and business telephone number of each group or individual so contracted. Thereafter, the group or individual so contracted shall notify each health insurance issuer of any changes to the information as soon as possible but not later than thirty days following any change.

EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOC.

Jan. 29 comments

- B. No later than *[Insert Date]*, or within thirty days of the effective date of a new contract, each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at a contracted facility shall provide the health insurance issuer with which it is contracted, the NPI, name, business mailing address, and business telephone number of each group or individual so contracted. Thereafter, the group or individual so contracted shall notify each health insurance issuer of any changes to the information as soon as possible but not later than thirty days following any change.

- C. 1. Based on information received pursuant to Sections 5(B) and 6(D) of this Act, a health insurance issuer shall report on its website, no later than *[Insert Date]*, in a format that is clear and easy for its enrollees to understand, the following information arranged by contracted facility:
- (a) Facility name, address, and phone number.
 - (b) The names, business addresses, and business telephone numbers of each individual or group of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that facility and who are contracted with the health insurance issuer.
2. For each specialty at each contracted facility, there shall be a clear indication when the health insurance issuer has no contract in place with any of the individuals or groups of anesthesiologists, pathologists, radiologists, emergency medicine physicians, and neonatologists who provide services at that contracted facility.
3. A health insurance issuer shall update its website as soon as possible but not later than thirty days following receipt of any updated information or within thirty days of the effective date of a contract.
- D. No later than *[Insert Date]*, a health insurance issuer shall provide a link to its website containing the information described in Subsection 8(C) of this Act to the Department of Insurance. No later than *[Insert Date]*, the Department of Insurance shall make available on its website, the links received from health insurance issuers.

- E. Except as otherwise provided in Subsection G of this Section, the Department of Insurance may promulgate rules and regulations to provide for civil fines payable by a health insurance issuer not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.

LOUISIANA DEPARTMENT OF INSURANCE

Jan. 29 comments

~~E. Except as otherwise provided in Subsection G of this Section, the Department of Insurance may promulgate rules and regulations to provide for civil fines payable by a health insurance issuer not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.~~

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Mar. 1 comments

We do not believe the financial penalty to the health insurance carrier will be a deterrent.

- F. The Department of Health and Hospitals may promulgate rules and regulations to provide for civil fines payable by a healthcare provider not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.

LOUISIANA DEPARTMENT OF INSURANCE

Jan. 29 comments

~~F. The Department of Health and Hospitals may promulgate rules and regulations to provide for civil fines payable by a healthcare provider not to exceed five hundred dollars for each and every act of violation of the requirements of this Section, not to exceed an aggregate fine of fifty thousand dollars. For purposes of this Subsection, "act of violation" is limited to an intentional act or an act of gross negligence.~~

- G. A health insurance issuer that reports information received from a health care provider shall indemnify and hold the health care provider harmless for the nonintentional erroneous or incomplete information provided by the health care provider to the health insurance issuer under the provisions of this Section. A health care provider that provides information to a health insurance issuer under the provisions of this Section shall indemnify and hold the health insurance issuer harmless for nonintentional erroneous or incomplete information reported by the health insurance issuer under the provisions of this Section. The penalties under this Section shall be the exclusive remedy for any violations and there shall be no independent cause of action by any person based upon such violation or other information reported hereunder.

LOUISIANA DEPARTMENT OF INSURANCE

Jan. 29 comments

G. A health insurance issuer that reports information received from a health care provider shall indemnify and hold the health care provider harmless for the nonintentional erroneous or incomplete information provided by the health care provider to the health insurance issuer under the provisions of this Section. A health care provider that provides information to a health insurance issuer under the provisions of this Section shall indemnify and hold the health insurance issuer harmless for nonintentional erroneous or incomplete information reported by the health insurance issuer under the provisions of this Section. ~~The penalties under this Section shall be the exclusive remedy for any violations and there shall be no independent cause of action by any person based upon such violation or other information reported hereunder.~~

H. The provisions of this Section shall apply to the Office of Group Benefits; however, the commissioner of insurance shall not be authorized to levy a fine against the Office of Group Benefits. If the commissioner of insurance concludes that the Office of Group Benefits has violated this Section, the commissioner of insurance shall notify the commissioner of administration in writing within sixty days of such violation.

COUNCIL FOR AFFORDABLE HEALTH INSURANCE *Jan. 29 comments*
Suggest removing these requirements/entire section.

Section 9. Penalties⁹

A. The commissioner may take disciplinary action against a licensee that violates this Act, in accordance with *[Insert Applicable State Statute]*.

LOUISIANA DEPARTMENT OF INSURANCE *Jan. 29 comments*
A. The commissioner may take disciplinary action against a **licensee health benefit plan** that violates this Act, in accordance with *[Insert Applicable State Statute]*. **The licensee shall, in addition to any regulatory fine imposed, pay damages to the enrollee in an amount equal to the difference between the estimated charges and the actual charges if the estimated charge is greater than fifty percent higher than the estimated charge. Such damages shall not be imposed if the charges could not be reasonably anticipated by the licensee at the time of the estimate.**

B. A violation of this Act by a facility-based provider is grounds for disciplinary action and imposition of an administrative penalty by the *[Insert State Medical Board]*.

LOUISIANA DEPARTMENT OF INSURANCE *Jan. 29 comments*
B. A violation of this Act by a facility-based provider is grounds for disciplinary action and imposition of an administrative penalty by the *[Insert State Medical Board]* **and fine by the State Attorney General.**

EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOC. *Jan. 29 comments*
B. A violation of this Act by a facility-based provider **is after full due process has been exhausted and judgment determined by the applicable state review board may be** grounds for disciplinary action and imposition **in accordance with state law** of an administrative penalty **not to exceed \$ _____ or 10 percent of the amount billed, whichever is less** by the *[Insert State Medical Board]*.

C. The *[Insert State Medical Board]* shall:

1. notify a facility-based provider of a finding by the *[Insert State Medical Board]* that the facility-based provider is violating or has violated this Act or a rule adopted under this Act; and

EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOC. *Jan. 29 comments*
1. notify a facility-based provider of a finding by the *[Insert State Medical Board]* that the facility-based provider **is violating has exhausted due process rights and has been found to be in violation** or has violated this Act or a rule adopted under this Act; and

2. provide the facility-based provider with an opportunity to correct the violation without penalty or reprimand.

LOUISIANA DEPARTMENT OF INSURANCE

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2. ~~provide the facility-based provider with an opportunity to correct the violation without penalty or reprimand.~~

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D. A violation of this Act by a healthcare facility is grounds for disciplinary action and imposition of an administrative penalty by the [insert state healthcare facility regulator].

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Mar. 1 comments

E. A physician will have the opportunity to dispute the alleged violation of this Act.

Section 10. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

Section 11. Effective Date

This Act shall take effect on *[insert months]* following enactment of the bill.

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

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This Act shall take effect ~~on *[insert months]*~~ **12 months** following enactment of the bill.

ADDITIONAL INTERESTED PARTY ISSUES ADDRESS:

- NETWORK ADEQUACY REQUIREMENTS
- ONLINE GRAPHIC INTERACTIVE MAPS
- GOVERNMENTAL WEBSITE AND OTHER DISCLOSURES
- DATA CALLS ON REIMBURSEMENT RATES

¹ Texas Ins. Code Ann., § 1456.001

² Texas Ins. Code Ann., § 1456.002

³ Texas Health and Safety Code, § 324.101(a)(6) through (8)

⁴ Texas Ins. Code Ann., § 1456.004

⁵ Texas Ins. Code Ann., § 1456.003

⁶ Texas Ins. Code Ann., § 1456.006 (*Section 7B(2) only*)

⁷ Texas Ins. Code Ann., §§ 843.201, 1301.158 (*Section 7E only*)

⁸ Louisiana Rev. Stat., § 22: 1879

⁹ Texas Ins. Code Ann., § 1456.005