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January 29, 2010

Sent Via Electronic Mail to SNolan@nolan-associates.com

Ms. Susan Nolan
Executive Director
National Conference of Insurance Legislators
385 Jordan Road
Troy, NY 12180

Re: National Conference of Insurance Legislators Proposed Draft Model—Healthcare Balance Billing Disclosure

Dear Ms. Nolan:

On behalf of the Emergency Department Practice Management Association (EDPMA), I write to you today to offer comments for consideration as NCOIL contemplates model legislation regarding Health Care Balance Billing Disclosure.

The EDPMA is a national organization representing the interests of emergency physician groups and their partners, both in the federal arena and in every state of the country. The EDPMA's mission is to enhance quality patient care through operational excellence and financial stability.

The EDPMA very much appreciates the solicitation of comments from interested parties on the draft model. Attached are our remarks with regards to this first draft of the legislation. EDPMA stands ready to assist NCOIL in any way possible, particularly regarding the unique aspects associated with emergency medicine care.

We sincerely thank you for the opportunity to submit comments for the subcommittee's consideration. We welcome any questions you may have and offer our assistance to both you and the legislative members serving in this endeavor.

Very truly yours,

A handwritten signature in black ink, appearing to read "Randy Pilgrim", is written over a light-colored rectangular stamp or watermark.

Randy Pilgrim, MD, FACEP
Chair, Board of Directors

**NCOIL Proposed Draft Model—Healthcare Balance Billing Disclosure (HBBD)
EDPMA General Comments**

Below please find EDPMA comments on the NCOIL draft legislation issued from the NCOIL office on January 25, 2010.

1. The definitional section does not make clear if the HBBD is intended to cover Third Party Administrator (TPA) arrangements that might include certain Preferred Provider Organization (PPO) activity. We know that TPAs may function as PPOs in certain states and may or may not be regulated by that state's Department of Insurance (DOI) or regulatory agency that typically regulates health plans.
 - a. PPOs are certainly included in Section 3.
 - b. TPAs may be included within the definition of "health benefit plan" in Section 4 (A) (1) (h) where plans that contract directly for health care services "**on a risk sharing basis**" are covered.
 - c. Perhaps that Section regarding plans who take risk should include specifically by name TPAs that may be functioning as PPOs and not simply providing typical TPA functions such as claims editing, adjudication and member services.
2. **Section 5: Facility Disclosure:**
 - a. Section 5 (A) (1) raises significant concerns for ED physicians (EDPs) under the federal Emergency Medical Treatment Active Labor Act (EMTALA) for the following reasons:
 - i. The hospital's written billing policies must be provided when the patient "first receives services at the facility."
 - ii. The DHHS OIG has stated that communications with the patient that may cause unreasonable delay in the EDP's provision of the medical screening exam (MSE) or stabilizing care could be construed as EMTALA violations.

- iii. With the written disclosures mandated by Section 5, it is not difficult to conceive that the patient or their family members would then engage in questions or discussions regarding the facility's in-network or out-of-network providers. To the extent that this comprised the MSE or patient care, then this provision would likely be contrary to federal law and rendered invalid.
- iv. Section 5 (A) (1) (c) suffers a similar flaw. This Section could be improved with preconditions that the ED patient had received his/her MSE and stabilizing care and the notice could be provided to the patient that they may be responsible for the difference between health plan reimbursements and provider charges.
- v. Section 5 (A) (1) (b) **presupposes** that the EDP or other ED professionals would necessarily know who among the other hospital-based specialists might be consulted or provide care to the ED patient. EDPs may not in fact know which of the EMTALA on call specialists will be consulted during the MSE or the provision of stabilizing care for an emergency medical condition. Unless the patient or his/her representatives are provided with a list of all of the other hospital-based physicians who **might** provide ED patient care services, this provision is neither practical or realistic in application for the more severe ED presentations.

3. **Section 6: Facility Based Physician Disclosure:**

- a. What is meant by the term itemized listing in Section 6 (A) (1)?
 - i. EDPMA's preference would be to add examples that would include "standard" CPT-4 and/or ICD-9 descriptors such that the CPT definitions for the Level IV E/M service (CPT 99284) are used, for example.
- b. While the provisions for the notice of a plain language statement (in A. 2.) may be laudable goals, EDPMA's concern is the re-programming costs

that will be imposed on the hospital based physicians and their practice managers.

- i. The requirements that the provider indicate that they are not in network and that the patient may be billed for the balance that is not reimbursed by the health plans (Section 6, A. 2.) are not statements typically found in ED physician patient billing statements.
 - ii. Likewise, practice management software may have limitations on the characters or amount of verbiage that can be included in the patient statements. In fact, since hospital-based physicians go in and out of network with health plans regularly, the patient statement verbiage would have to be tailored at the health plan or the health plan product level. Hospital based physician billing statements are generally not programmed to be driven at the specific health plan or product level and present serious operational and logistical challenges.
 - iii. While re-programming may be able to accommodate these new requirements, the programming will have a direct cost that is likely to be passed on to the hospital base physicians and ultimately to patients.
4. Section 7: In terms of mandating health plan disclosures, EDPMA believes that the LA alternative language is better from a provider standpoint. The disclosures are better than that provided for in Section 7 and the obligation to update which providers are in and are out of network are more clear.

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Proposed Draft Model – Healthcare Balance Billing Disclosure

STAFF NOTE

Alternative and supplemental language in boxes below comes from Louisiana Rev. Stat., § 22:1879. All other language was enacted in Texas under 2007 S.B. 1731.

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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 [non-participating](#) 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 [non participating](#) health care provider that is not fully reimbursed by the enrollee's health benefit plan.
- B. "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan; [regardless if the individual receives services in or out-of-network](#).
- C. "Facility-based physician" means a radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:
 - 1. to whom the facility has granted clinical privileges; and
 - 2. who provides services to patients of the facility under those clinical privileges.
- D. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.
- E. "Health care practitioner" means an individual who is licensed to provide and provides health care services.
- F. "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and ~~that~~ [which may or may not](#) 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 or entity 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. 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]*; or
3. the state child health plan operated under *[Insert Applicable State Statute]*.

Section 5. Facility Disclosure³

A. Each healthcare facility shall develop, implement, and enforce written policies for the billing of 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 to the facility or first receives 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 a facility-based physician who may provide services to the consumer while the consumer is in the facility may not be a participating provider with the same third-party payors as the facility;
 - (c) informs consumers that the consumer may receive a bill for medical services from a facility-based physician for the amount unpaid by the consumer's health benefit plan;
 - (d) informs consumers that the consumer may request a listing of facility-based physicians who have been granted medical staff privileges to provide medical services at the facility; and
 - (e) informs consumers that the consumer may request information from a facility-based physician on whether the physician has a contract with the consumer's health benefit plan and under what circumstances the consumer may be responsible for payment of any amounts not paid 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 physician or facility-based physician 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 physician or facility-based physician 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.

SUPPLEMENTAL LOUISIANA LANGUAGE

B. 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.⁴

Section 6. Facility-Based Physician Disclosure⁵

- A. If a facility-based physician 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 physician or the physician's group, the facility-based physician 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 physician 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 physician 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~~\$1,000, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 45 days of receiving the first billing statement and substantially complies with the agreement, the facility-based physician may pursue only all means available to the provider for collection of the debt; but 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 physician to be out of substantial compliance with the payment plan agreement if payments ~~are not made in compliance~~ in compliance with the agreement have not been made for a period of 90 days.
- C. ~~A facility-based physician who bills a patient covered by a preferred provider benefit plan or a health benefit plan under [Insert Applicable State Law] that does not have a contract with the-~~ A non-participating facility-based physician shall send a billing statement to the patient with information sufficient to notify the patient of the mandatory mediation process available under *[Insert Applicable State Law]* if the amount for which the enrollee is responsible, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than \$1,000.

SUPPLEMENTAL LOUISIANA LANGUAGE

- D. 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.⁶

Section 7. Health Benefit Plan Disclosure⁷

A. Each health benefit plan that provides health care through a provider network shall provide notice to its enrollees that:

1. a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network; and
2. a health care practitioner 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:⁸

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 PRACTITIONERS 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 any health care facilities within the provider network in which facility-based physicians do not participate in the health benefit plan's provider network. Health care facilities identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.

-OR-

ALTERNATIVE LOUISIANA LANGUAGE

C.⁹ 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 7(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. 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 self determined allowable or usual and customary amount;⁹ a health benefit plan must also include the number for the [Insert State's] Department of Consumer Protection Division for complaints regarding how the health plan determined and issued payment.
- F. An health benefit plan shall provide to an insured on request information on:¹⁰
1. whether a physician 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 the health benefits plan's method for calculating its non-participating allowable payment amount; 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 reimbursement rate for out-of-network services.
- G. 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.

Section 8. Penalties¹¹

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

- B. A violation of this Act by a facility-based physician is after full due process has been exhausted and judgement 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% 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 physician of a finding by the *[Insert State Medical Board]* that the facility-based physician 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 physician with an opportunity to correct the violation without penalty or reprimand.

SUPPLEMENTAL LOUISIANA LANGUAGE

- D¹². 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.
- E. The Department of Health and Hospitals may promulgate rules and regulations to provide for civil fines payable by a health care 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.
- F. 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.
- G. 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.

Section 9. 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 10. Effective Date

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

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- 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 Louisiana Rev. Stat., § 22: 1879 A(1)
⁵ Texas Ins. Code Ann., § 1456.004
⁶ Louisiana Rev. Stat., § 22: 1879 A(2)
⁷ Texas Ins. Code Ann., § 1456.003
⁸ Texas Ins. Code Ann., § 1456.006 (*Section 7B(2) only*)
⁹ Louisiana Rev. Stat., § 22: 1879 B and C
¹⁰ Texas Ins. Code Ann., §§ 843.201, 1301.158 (*Section 7E only*)
¹¹ Texas Ins. Code Ann., § 1456.005
¹² Louisiana Rev. Stat., § 22: 1879 D through G