

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Proposed Healthcare Balance Billing Disclosure Model Act
(February 22, 2010)
[American Medical Association Recommendations March 1, 2010](#)

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

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. Definitions

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 health care provider's charge to the patient is typically limited to deductible, co-payment, and/or co-insurance amounts. Where the health care provider is not 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.

"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.

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

Comment [e1]: The AMA recommends additional definitions be added and changed if AMA network adequacy and transparency amendment is included. See recommended definitions in amendment, Section 1.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

"Emergency" medical care includes any healthcare services provided in a hospital emergency 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.**

C. "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.

~~"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. "Hospital" means a health care facility which is licensed by the (State Department of Health Services.)

~~"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 all of the providers contracted to provide services to a specified group of enrollees, 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. Applicability

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;

Comment [e2]: The AMA recommends that applicability language be changed if AMA network adequacy and transparency amendment is included.

- (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.

REPS. KEISER/CURTISS

#. **This Act applies to all facility-based providers and facilities that are providing medical care to patients, with the exception of emergency services, as defined under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).**

Comment [e3]: The AMA recommends that Reps. Keiser and Curtiss' amendment be removed to reflect that this model bill does not regulate physicians and hospitals. The AMA recommends that the model bill only apply to those who are regulated by the State Insurance Commissioner and allows physicians, non-physician health care providers and hospitals to be regulated by their respective state regulatory authorities.

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]*;
- 3. the state child health plan operated under *[Insert Applicable State Statute]*; or
- 4. Medicare.

Comment [e4]: The AMA recommends that a new section be added here, entitled, "Network Adequacy Requirements." See amendment, Section 2.

Note: Recommend adding AMA Network Adequacy model bill section [here](#).

Section 5. Facility Disclosure

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

Comment [e5]: The AMA recommends that Section 5 be removed from this model bill. The AMA recommends that this model bill only apply to health insurers and allow physicians, non-physician health care providers and hospitals to be regulated by their respective state regulatory authorities.

admitted to the facility or first receives services at the facility that:

REPS. KEISER/CURTISS

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 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 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;

REP. KEISER

- (b) informs consumers that ~~the a~~ facility-based physician who ~~will may~~ provide services to the consumer while the consumer is in the facility ~~is or is may not be~~ a participating provider with the same third-party payors as the facility; **and**
- (c) informs consumers that **are treated by a non-participating provider that** the consumer ~~may receive a bill~~ **will be billed** for medical services from ~~the 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;~~

STAFF NOTE: *Approval of these changes would require a thorough review of other disclosures to determine appropriateness.*

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.

REPS. KEISER/CURTISS

B. In the case of an emergency, Subsection 5(A) disclosures shall be made to the consumer [Insert appropriate period of time] after emergency, post-stabilization care has been provided.

COUNCIL FOR AFFORDABLE HEALTH INSURANCE (CAHI)

C. Each in-network healthcare facility shall require an out-of-network, facility-based healthcare practitioner to provide an enrollee, at least five (5) business days prior to a scheduled, non-emergency healthcare procedure(s):

1. a written good-faith estimate of the healthcare practitioner's reasonably anticipated charges for the enrollee's scheduled, non-emergency healthcare procedure(s);

2. a written statement of the healthcare practitioner's billing policies and practices, including whether the practitioner has a policy of balance billing enrollees for substantially similar healthcare services; and

3. if applicable, whether the healthcare practitioner charges interest on unpaid balance billing balances, including the annual percentage rate charged.

D. The disclosures required by Subsection 5(C) above shall be provided to the enrollee no later than five (5) business days prior to the delivery of the enrollee's scheduled, non-emergency healthcare procedure(s).

E. Each in-network healthcare facility shall obtain the enrollee's signature, acknowledging receipt of the disclosures required by Subsection 5(C), prior to the delivery of the healthcare practitioner's scheduled, non-emergency healthcare procedure(s).

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

Comment [e6]: The AMA recommends that Section 6 be removed from this model bill. The AMA recommends that this model bill only apply to those who are regulated by the State Insurance Commissioner and allow physicians, non-physician health care providers and hospitals to be regulated by their respective state regulatory authorities. The AMA is continuing to work with the hospital based specialty societies and its members to develop language that will address this issue more specifically, but does not have related and approved language that can be considered. See amendment, Section 3.

Section 6. Facility-Based Physician Disclosure

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, 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, 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 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 with the agreement 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 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 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 Disclosure

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

Comment [e7]: The AMA recommends adding AMA model bill language requiring online graphic interactive map capability to this section. See amendment, Section 4.

1. a ~~facility~~hospital-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;
3. ~~the health benefit plan provider network does not include all hospitals, health care providers or hospital-based physicians and a hospital, health care provider or hospital-based physician who is not contracted with the health benefit plan may bill the enrollee for the services that they provide, which amount will likely be greater than the amount covered by the health benefit plan's out-of-network benefit.~~

- 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~~HOSPITAL~~-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.

CE. Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician or other health care provider has been paid at the health benefit plan's allowable or usual and customary amount covered pursuant to the insured's out-of-network benefit, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

DF. An health benefit plan shall provide to an insured on request all the following information on: ¹⁰

LOUISIANA & TEXAS DEPTS. OF INSURANCE

F. An health benefit plan shall provide to an insured prior to a request for a healthcare service or supply but no later than 48 hours after pre-certification, on request information on:

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~~
4. if applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services; and ~~or the insurer's usual and customary reimbursement rate for out-of-network services.~~
5. the out-of-network benefit expressed in a way that allows a reasonable insured to calculate the insured's personal financial responsibility for any out-of-network service as a percentage of the amount the health benefit plan will pay.

EG. A health benefit plan that offers benefits for which the patient's financial responsibility varies depending on what the health benefit plan pays under Section 4 or 5 above, 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.

F. [Health plan disclosure requirements with prior authorization. When the health insurer approves a request for prior authorization for non-emergency health care services, it shall provide its response to the requesting health care provider and patient accompanied by the following notice:](#)

[NOTICE: "ALTHOUGH YOUR REQUEST FOR HEALTH CARE SERVICES FROM \(INSERT HOSPITAL AND PHYSICIAN NAMES\) HAS BEEN AUTHORIZED AND WILL BE TREATED AS IN-NETWORK, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THIS HOSPITAL BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF YOUR HEALTH PLAN'S PROVIDER 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. TO CHECK WHETHER THE HOSPITAL BASED PHYSICIANS AT THIS HOSPITAL ARE MEMBERS OF YOUR PROVIDER NETWORK, GO TO OUR ONLINE PROVIDER DIRECTORY AT \(INSERT WEBSITE ADDRESS\) AND SEARCH TO LOCATE THE HOSPITAL-BASED SPECIALISTS IN YOUR PROVIDER NETWORK. TO FIND OUT WHAT YOUR OUT-OF-NETWORK BENEFIT IS, GO TO \(INSERT WEBSITE ADDRESS.\)"](#)

Section 8. Penalties ¹¹

- 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 grounds for disciplinary action and imposition of an administrative penalty 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 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.

Comment [e8]: As noted above, the AMA believes that this bill should be limited to matters under the jurisdiction of the State Insurance Commissioner.

Section 10. Effective Date

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

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

**American Medical Association Proposed Amendment to
Require Provider Network Adequacy and Transparency**

**NCOIL “Proposed Healthcare Balance Billing Disclosure Model Act”
February 26, 2010**

Section 1. Definitions

Background

The AMA recommends including the following definitions to the model bill if the language from Section 2 of this amendment, “Network Adequacy Requirements” is added. These definitions were taken from AMA model bills.

Recommended Language

- A. “Contracting entity” means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.
- B. “Health care services” means services for the diagnosis, prevention, treatment or cure of a health condition, illness, injury or disease.
- C. “Health insurance plan” means any hospital and medical expense incurred policy, non-profit health care services plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
- D. “Health insurer” means any person that offers or administers a health insurance plan.
- E. “Provider directory” means a listing of each and every participating provider within a provider network.
- F. “Physician profiling” means a system that compares, ranks, rates, measures, tiers or classifies a physician group’s performance, quality, or cost of care against objective standards, subjective standards, or the practice of other physicians, and shall include quality improvement programs, pay for performance programs, public reporting on public performance or ratings and the use of tiered or narrowed networks.

Section 2. Network Adequacy Requirements

Background

The AMA urges NCOIL to include a provision mandating network adequacy. This is the only solution to ensure that patients have the access to the health care services on an in-network basis that they reasonably expected when they purchased health insurance.

A critical attribute of health care coverage is the network of contracted physicians and other health care providers, the “provider network.” Network adequacy is essential to solve the real problem of unanticipated bills for health care services, by ensuring that there are enough hospitals, physicians

(including hospital-based physicians) and other health care providers within the provider network to meet enrollee needs. If this were the case, enrollees would rarely receive an unanticipated bill from a non-contracted physician or other health care provider.

The provider network is comprised of physicians and other health care providers who have contracted to “participate” by agreeing to abide by the network’s rules and accept a specified discount off their retail charges. Physicians and other health care providers generally offer substantial discounts to participate in provider networks because they may receive significant benefits in return: (1) a promise of prompt payment; (2) increased patient volume by virtue of inclusion in provider directories and benefit plans that give patients a substantial financial incentive to go to in-network providers; and (3) maintenance of patient loyalty by meeting their patients’ requests that they be “in-network.”

Because, for financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access, a provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives consumers of the benefit of the money they have paid for health care coverage. Inadequate provider networks also undermine the public health and welfare by forcing consumers to reduce utilization of appropriate preventive services and fail to obtain necessary medical care, which in turn leads to reduced productivity and increased work absenteeism, unnecessary illness and increased emergency department utilization.

This language was taken from the AMA model bill, “Meaningful Access to Physicians and Other Health Care Providers Network Standards Act.”

Recommended Language

- A. Meaningful network standards, report, approval and certification requirements. No health insurer that provides or seeks to market a health plan product in this state may do so without first obtaining a provider network certification from the Insurance Department (“the Department”). The Department’s provider network certification shall set forth the geographic and population capacity of the provider network. The provider network certification shall be awarded only to the extent that the provider network offers the access to physicians and other health care providers reasonably necessary to ensure that all enrollees of a health plan product using the provider network will have timely access to all the medical care that they need on an in-network basis, including but not limited to access to emergency services twenty-four hours a day, seven days per week. The health insurer must meet the following requirements in order to obtain certification:
1. The health insurer must provide a certified network report to the Department once a year documenting all the information as required by Section __ of this Act. The report must be prepared by the actuary who calculated the health insurer’s premium, provided to the Department, and be made available publicly on the health insurer’s website within seven days of the Department certification.
 2. A health insurer shall provide a certified network report that is specific to each health plan product it offers in the state. The health insurer shall not change its provider network for any of its health plan products until after the Department has approved the certified network report applicable to the proposed new network.

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- B. Health insurer network adequacy disclosure requirements. The Department shall evaluate certified network reports based on the following information, by county:
1. Number of enrollees, by health plan product, including the number of males, females, elders (enrollees equivalent to or over age 65); and children (enrollees under, or equal to, age 18);
 2. Number and FTE equivalent number of physicians contracted to participate in the network in each of the following areas, and as a percentage of the total number of physicians of this relevant specialty practicing in the county, by health plan product, including: primary care physicians to enrollee population; geriatric medicine physicians to geriatric population; pediatricians to pediatric population; and women's health physicians to women; and
 3. Number and FTE equivalent number of physicians contracted to participate in the network in each of the specialties as defined by the American Medical Association (AMA) Graduate Medical Education Directory, and as a percentage of the total number of physicians of that relevant specialty practicing in the county, by health plan product.
- C. Health insurer compliance requirements. The health insurer shall also comply with the following requirements to ensure network adequacy is achieved:
1. If the network is tiered in a way that impacts an enrollee's financial obligations, the health insurer shall provide separate totals for both all contracted physicians and for the subset of contracted physicians that enrollees are permitted to access with the least financial obligation;
 2. With respect to hospital-based physicians, the report must indicate how many physicians of each hospital-based specialty are contracting at each participating hospital; and
 3. To the extent that the provider network includes providers that have not contracted directly with the health insurer but through a contracting agent, the report must indicate the name, website address, mailing address and telephone number of each contracting entity with whom any health provider has a direct contract as well as the percentage of each reported physician specialty with which the health insurer contracts directly.
- D. Utilization Data. The following enrollee utilization data must be reported, compared against the prior year's utilization, and assessed against regional and national benchmarks for each health plan product:
1. Number of hospital admissions per thousand enrollees in the last year for outpatient, manageable, preventable conditions, including but not limited to Community Acquired Bacterial Pneumonia, Asthma and Diabetes;
 2. Number of emergency department visits per thousand enrollees in the last year;
 3. Number of preventive services, such as immunizations, which reduce the need for later, costlier interventions per thousand enrollees in the last year;
 4. Percent of out-of-pocket costs incurred by enrollees for emergency department visits as a percentage of total enrollee out-of-pocket costs in the last year;

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5. Number of visits to out-of-network providers per thousand enrollees in the last year;
 6. Percent of services received from in-network providers as a percentage of total services received by enrollees in the last year; and
 7. Percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer.

E. Compliance Monitoring Data. The following compliance monitoring data must be reported:

1. The results of the most recent annual enrollee and provider surveys, and a comparison of those results with the results of the prior year's survey, including a discussion of any change in satisfaction levels;
2. An analysis of the health insurer's contracting practices, including the number of new and terminated providers by specialty and geographic area, an analysis of the reasons for any contract terminations and steps the health insurer took in response, and the number of enrollees affected by each contract termination. The health insurer shall also report any significant reduction to the provider network as soon as feasible and in every case within two business days; and
3. An analysis of all enrollee and provider grievances and complaints alleging a lack of accessibility to health care services in the prior year, including, for each complaint, the county in which it arose; the provider type, including physician specialty for all complaints involving lack of access to a physician; the reason for the complaint; and the resolution, including whether the health insurer referred the enrollee to an out-of-network provider and whether the out-of-network provider provided services to the enrollee.

Section 3: Network Transparency Requirements – Online Interactive Map

Background

Not only must the provider network be adequate to meet enrollees' needs as discussed above, it must also be easy for enrollees, to determine which hospitals, physicians and other health care providers are in the network, both before they purchase a health plan and when they are seeking particular services. To assess the appropriateness of a provider network before selecting a particular health insurance plan, consumers must have all the information relevant to the medical needs of themselves and their families. This includes understanding whether their physicians and preferred hospitals are in or out-of-network, and whether these physicians and hospitals are still accepting new patients.

Consumers need access to a robust, up-to-date provider directory to enable them to determine which physicians, other health care professionals and health facilities remain in the network as their medical needs change. Physicians and other health care providers need the same information. A robust, up-to-date provider directory informs physicians and other health care providers whether their network participation status is accurately reflected.

This language was taken from the AMA model bill, "Meaningful Access to Physicians and Other Health Care Providers: Accurate Provider Directories."

Recommend Language

- A. Online graphic interactive map capability requirement. The health insurance plan must offer an online graphic interactive map that will provide current and prospective enrollees the means to input a reference address and locate providers within the provider directory by name, type, specialty, subspecialty and distance. All of the following shall be displayed for each provider identified by each search:
1. Whether the provider is participating, accepting new patients and if the network is tiered, which tier the provider is in and how that impacts enrollees' financial or other obligations;
 2. Distance from input location;
 3. Provider type, specialty and/or subspecialty;
 4. Provider contact information;
 5. With respect to hospital-based physicians, the physician specialty, the name(s) of the hospital(s) where each hospital-based physician is contracted and whether each of those hospitals is participating in the network; and
 6. With respect to hospitals, the names and contact information for each individual or group of hospital based physicians who provide services at that facility.
- B. The online graphic interactive map must be kept current and accurate as required by the regulations adopted by the Department, including at a minimum: maintenance of an easy mechanism enabling providers to update their own information in the directory; an ongoing provider survey mechanism to confirm the continued accuracy of the directory; an easy mechanism enabling enrollees to report directory errors; and updating the online provider directory at least every thirty days.
- C. In addition to any other remedies, where a violation of these network adequacy or transparency requirements results in an enrollee's use of an out-of-network provider despite the enrollee's reasonable efforts to remain in-network, the health insurer shall fully indemnify the enrollee and pay the non-contracted provider's usual, customary and reasonable charge as stated on the claim form.

Section 4. Physician Fee Schedule Disclosure Standard

Background

The AMA understands the need for enrollees to understand the potential estimate of costs for patient billing. The AMA believes that only the State Medical Board has jurisdiction over physicians, however. This language was taken from the AMA model bill, "Truth in Out-of-Network Health Benefits Act."

Recommended Language

- A. Before providing elective services, a physician practice that is not contracted with an enrollee's health insurer must provide the enrollee with a copy of the physician practice's most current fee schedule as it applies to the elective services that the physician expects to provide to the enrollee.

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- B. The physician practice must also disclose to any patient or prospective patient a copy of the physician practice's retail fee schedule applicable to at least its 100 most commonly provided services by CPT code.
 - C. The practice may make the required disclosure publicly available via hard copy, electronically or via website.

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