AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-15)

Introduced by: Texas

Subject: Insurance Regulators Must Regulate Insurers, Not Physicians

Referred to: Reference Committee B
(Clarence P. Chou, MD, Chair)
PASSED

Whereas, Each year since 2013, the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) has issued "Letter to Issuers in the Federally-facilitated Marketplaces" describing the federal government's regulatory approach to overseeing insurers that offer health plans on the Marketplaces; and

Whereas, In the 2014 letter CCIIO indicated it would assess the adequacy of health plan networks using a reasonable access standard; and

Whereas, Subsequent to that letter, the National Association of Insurance Commissioners (NAIC) expressed their continued concern over CCIIO's expressed desire to increase federal scrutiny of plans' provider networks, which the NAIC stated would add an additional layer of review of health insurance company operations; and

Whereas, The NAIC requested that CCIIO allow the NAIC time to thoughtfully analyze network adequacy issues because the NAIC contends a one-size-fits-all national standard "would not benefit consumers or the insurance companies;" and

Whereas, The current draft NAIC Network Adequacy Model Act departs from regulating health insurance networks and inappropriately regulates physician billing by prohibiting out-of-network billing in certain circumstances; and

Whereas, The current NAIC proposal to regulate physicians rather than focus upon the health insurers they are charged with regulating is not in the best interest of patients and physicians; and

Whereas, The current NAIC proposal lacks quantitative standards delineating what constitutes an adequate network; and

Whereas, The Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, when adopting regulations on insurer payments in emergencies, stated the Affordable Care Act "does not prohibit balance billing, even where the protections in the statute apply, patients may be subject to balance billing;" therefore be it

RESOLVED, That our American Medical Association call upon the Center for Consumer Information & Insurance Oversight within the Centers for Medicare & Medicaid Services to move forward to develop and adopt strong network adequacy standards for health benefit plans offered on the Federally-facilitated Marketplaces while permitting more stringent state standards to remain in force. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.
Received: 10/02/15

Out of Network Billing and the NAIC Model Draft Bill

Background: The mission of the National Association of Insurance Commissioners is to assist state insurance regulators in regulating the conduct of insurance companies and their agents. In 2015, NAIC created a work group on creating a network adequacy model. On November 23rd, NAIC released its final draft of model regulation titled Health Benefit Plan Network Access and Adequacy Model Act (HBPNAA). The 17 section model act will be brought up in the 2016 legislative session and many forms of the legislation were considered in 2015.

Sections Concerning Members: Section 7 of the HBPNAA potentially concerning members.

Section 7: Requirements for Participating Facilities with non-participating (out of network), facility based providers

This section creates rules for out of network providers giving care at in-network facilities. There are two main requirements of this section of the rule, for emergency situations and non-emergency situations.

In emergency situations, under this rule, patients would only pay what they would pay for care from in-network providers. Patients would forward any balance bills to the insurer who can address the bill under a newly created mediation process. The patient would be guaranteed payment from the insurer to the provider for the full balance bill.

Staff Recommendation: Concerns.

In non-emergency situations, under this rule, patients who receive bills of more than $500 have the option to either pay the entire balance bill or opt into mediation. The patient would pay the traditional in-network portion then send the rest of the balance bill to the insurer requesting mediation. Provision F of Section 7 allows for a provider to receive payment outside of the mediation process determined by the state legislature as an "XX percentage of Medicare payment rates." Health plans must establish, under this rule, a mediation process for payment of out-of-network providers at in-network facilities. The provider and health plan will split the cost of mediation evenly.

Staff Recommendation: Major Concerns.

Staff Recommendations and Insights:

The model legislation, at its core, is a prohibition on the ability of out-of-network physicians to bill for their services. To be clear: The model legislation mandates that there be regulation on physician billing. In most cases, if the patient who receives a balance bill does not agree to pay the physician for the services rendered in a non-emergency situation, the provider will not be paid for their services unless they go through a mediation process with the carrier or they opt to receive "XX percentage of Medicare payments." The provider must pay for half of the mediation process. Both the cost and time for a mediation process creates an undue burden that some physicians may not participate in.

Furthermore, section 7 creates an incentive system that rewards carriers with the poorest network by creating, what staff internally considers, “networks-in-law.” One of the last remaining bargaining points physicians have is not contracting in order to compel plans to set fair and reasonable terms for in-network services. Only allowing physicians to pay a percentage of Medicare on OON charges or requesting mediation is rate regulation by health plans.

Legislation is being brought in New Jersey, Florida and Nevada but almost every legislature will bring this issue up in the next 5 years as they modernize their network adequacy laws. The New York Times, Wall Street Journal and many local “newspapers of record” have written about this issue. Some, like the New York Times, have targeted members.

Finally, insurance commissioners exist to regulate insurance licensees (health plans). The NAIC, in section 7, is creating model legislation that regulates providers and the rates that they set. The NAIC should address balance billing issues by creating model legislation that further regulates insurance companies – the entities their members regulate.

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

October 31, 2015

Commissioner Roger A. Sevigny
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301

Commissioner Mike Kreidler
Office of the Commissioner of Insurance
Insurance Building, Capitol Campus
Olympia, Washington 98504

Attention: Jolie H. Matthews, Esq.

Re: NAIC Network Adequacy Model Bill

Dear Commissioners Sevigny, Kreidler, and Members of the Health Insurance and Managed Care (B) Committee:

The Texas Medical Association ("TMA") is a private, voluntary, nonprofit association of almost 49,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: "Physicians Caring for Texans." TMA's diverse physician members practice in all fields of medical specialization.

TMA appreciates this opportunity to once again comment upon the proposed NAIC Network Adequacy Model Law. Consistent with its mission, TMA has a keen interest in advocating for laws and regulations promoting patient well-being and access to medical care, efficiency in the delivery of healthcare and economic viability of physician practices. TMA offers the following comments.

Section 7 of the draft Model Act, at its heart, is a prohibition on the ability of out-of-network physicians to bill a patient for his or her services. TMA, under any circumstance, cannot support such a prohibition outside government programs and current existing in-network "hold harmless" requirements that result from voluntary agreement to contract terms. As described below, Section 7 serves to reward insurance companies for their poor marketplace conduct and signals other insurers to reduce investment in network adequacy, especially in emergencies. TMA respectfully urges the Committee to strike Section 7 from the Model Act.

As stated in our letters submitted in July of last year and January and September of this year, the discussions upon the Network Adequacy Model Act (model act) have offered many opportunities for the NAIC workgroup to set quantitative standards delineating what constitutes an adequate network. The Model Act before you lacks meaningful standards (and the American Medical Association and Consumer Groups agree as provided in their comment letter). Perhaps now is the time for the Centers for Medicare and Medicaid Services and the Center for Consumer Information and Insurance Oversight to move forward and impose time and distance requirements upon insurers

as they had proposed while leaving more stringent state standards in place. To that end, we have courtesy copied Secretary Burwell, Acting Administrator Slavitt, and Deputy Administrator Counihan on this correspondence for consideration as they may determine is appropriate.

TMA collected network information upon network hospitals and the facility-based physicians who practice on those campuses in December of last year (which was provided via comment letter to the workgroup). TMA could not locate this information for certain large insurers – so the information provided here is not likely to offer a complete catalogue of all possible network inadequacies.

TMA would bring members' attention to the following conditions:

Humana Health Plan, according to their own documents published on their website at the time, does not have contracts with emergency room physicians in approximately fifty-four percent (54%) of their in-network hospitals. They do not have network physicians offering radiological services in 31% of their network hospitals. Additionally, the company does not contract with anesthesiologists in 36% of their network hospitals.

United Healthcare, the health insurer of choice of the State of Texas Employee Retirement System had better numbers, though not much better in regards to emergency physicians in network hospitals. Approximately 40% of the hospitals they contract with do not have a contracted emergency physician or physician group.

For illustration purposes you will find below a chart/grid created from the insurer information that is made available on the internet to the public as of December 1, 2014. All of the hospitals on the left side of the grid are network facilities for each of the three plans for which the information was available (TMA staff, after a diligent search, could not locate chart/grid information for any other carriers). The chart is for network Austin hospital services and the emergency services provided at those network facilities. Hospitals that were not contracted with all three insurers were omitted from the chart.

Austin

Three Carriers – Common Network Hospitals

Emergency

	Blue Cross Blue Shield	United Healthcare	Humana
Dell Childrens Medical Center	Emergency Medical	Dell Childrens Med Ctr/Central Tx	[redacted]
Heart Hospital of Austin	ACS Primary Care Physicians	ACS Primary Care Physicians SW	[redacted]
North Austin Medical Center	Capitol Emergency	Capitol Emergency Assoc	Capital Emergency Associates [Sic]
NW Hills Surgical	Emergency Staffing Solutions	[redacted]	N/A
Seton Medical Center	Emergency Services Partners - Austin	Capitol Emergency Assoc [NOTE - May be inaccurate]	[redacted]
Seton Northwest Hospital	Emergency Services Partners - Austin	Capitol Emergency Assoc [NOTE - May be inaccurate]	[redacted]
Seton Southwest Hospital	Emergency Services Partners	[redacted]	[redacted]
St Davids Hospital	Capitol Emergency	Capitol Emergency Assoc	Capital Emergency Associates [Sic]
St. David's South Austin Medical	Capitol Emergency	Capitol Emergency Assoc	Capital Emergency Associates [Sic]
University Medical Center At Brackenridge	Daughters of Charity Health Services	Capitol Emer Staff PA	[redacted]

This chart, for a single city served by the three carriers for which we have information, provides examples of each and every deficiency that plagues network coverage and directories.

(1) **Physicians are willing to contract – Some Insurers are UNwilling to contract.** Interestingly, Blue Cross/Blue Shield has network agreements with the groups Humana has kept out-of-network. In other words, physicians are willing to contract in each network hospital. Humana is unwilling to offer a reasonable arrangement similar to arrangements these physicians have agreed to with other insurers. The question in Austin is then **"Why can't Humana come to an agreement with physicians where Blue Cross and United Healthcare have managed to contract with physicians?"** The problems in Austin are created by some of the insurers, but it is certainly not caused by the physicians.

(2) **Inadequate Networks.** Consumers covered by Humana in Austin had only three network hospitals (of the hospitals in-network with the three carriers) where in-network emergency services are available – is this the coverage their insured persons expect? No, it is not. Of the hospitals that are in-network with all three carriers, two-thirds of Humana's network hospitals have out-of-network emergency services. Yet Humana is permitted to sell a network product to Texans in Austin.

(3) **Directories are Inaccurate.** The information provided by the insurers is inaccurate. As a simple demonstration, Humana has misspelled the name of "Capitol Emergency Associates." Even worse, United Healthcare, as of December 2014, indicates that Capitol Emergency Associates is the emergency physician group for two hospitals where the group providing the service is actually Emergency Services Partners (as confirmed by accessing the Emergency Services Partners website). So, if a United Healthcare insured person goes to Seton Medical Center or Seton Northwest in Austin believing the emergency services are in-network – that insured person will discover the insurer has misdirected them to an out-of-network physician group. The insured person would be misled by the directory entry.

Yet, Section 7, from the perspective of Texas physicians, would **reward** the carrier with the poorest network and sends a message to the other insurance marketplace participants that they have **wrongly invested in network development**. Section 7, by prohibiting collection and billing (as the section clearly states in emergencies that a bill is not legally enforceable against a person who has received services left unpaid) **serves to cram-down a "network-in-law" complete with mandated dispute resolution that is typically only utilized when parties agree to waive their rights.** Insurers need not concern themselves with network development for emergency care. It is no wonder AHIP and the Blue Cross Blue Shield Association can embrace the model act in a two page letter.

As stated in previous correspondence with the workgroup, insurance policies are created to provide consumers protections for the perils covered by the contract. Health insurance offers protection against the risk of losses resulting from medical expenses (illness, disease, and injury, etc.). Proposed Section 7 of the draft model act, offers to eliminate, through a proposed statute, much of the covered loss for which the policy was issued in the first place. TMA continues to be confounded as to why a model ostensibly revisited to address insurance company network adequacy attempts to regulate medical practitioners where the inadequacy of insurers is manifested. If committee members are concerned with the outcome of the insurance company claim settlement and insurers' shortcomings in the protect consumers, TMA suggests the NAIC require the benefits of the policy be modified to address those shortcomings. A balance is left to be paid by a consumer **only** because an insurer has capped its liability under the policy.

Finally, TMA would bring to the attention of the Committee Members that the prohibition proposed in Section 7 of the model act is a limitation on the authorization to practice medicine. The statutory definition of practicing medicine[1] in Texas is as follows:

> (13) "Practicing medicine" means the **diagnosis, treatment, or offer to treat** a mental or physical disease or disorder or a physical deformity or injury by any system or method, or **the attempt to effect cures** of those conditions, by a person who:
> (A) publicly professes to be a physician or surgeon; or
> (B) directly or indirectly **charges** money or other compensation **for those services.**[2]

A license to practice medicine in Texas, therefore, **expressly includes authority to charge money or other compensation** for offering to treat or diagnosing diseases and disorders. The term "charge" in the definition of practicing medicine is not confined to any particular method of payment or any particular type of fee. TMA urges the workgroup to refrain from offering statutory language that modifies the very fundamental definition of "practicing medicine." Therefore, the NAIC model act should not contain a section dedicated to regulating the conduct of professionals **engaged in lawful private enterprise**.

Once again, TMA thanks you for the opportunity to provide these comments and requests that Section 7 of the Model Act be removed.

Respectfully Submitted,

Lee A. Spangler, JD
Vice President, Medical Economics
Texas Medical Association

cc:
Honorable Sylvia Mathews Burwell
Secretary, U.S. Department of Health & Human Services

Honorable Andrew Slavitt
Acting Administrator, Centers for Medicare and Medicaid Services

Honorable Kevin Counihan
Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight

[1] A license issued by the Texas Medical Board conveys the authority to practice medicine. *See* Subchapter A, Chapter 155, Tex. Occ. Code and Texas Constitution Article 16, Section 31.
[2] Tex. Occ. Code Section §151.002(13) (emphasis added).

National Association of Insurance Commissioners Model Network Adequacy Act

Background

In November 2015, the National Association of Insurance Commissioners (NAIC) approved the Health Benefit Plan Network Access and Adequacy Model Act (model act). The AMA, several state medical and specialty societies, and many more stakeholders were engaged throughout the 18-month process and the resulting model act is a mixed bag. Many of the changes to the model bill are positive, but there also are areas of concern. To assist medical societies in states where the NAIC model has been introduced or where the medical society would like to propose network adequacy legislation, the AMA offers the attached revised version of the NAIC's model bill.

The AMA-revised model act

There are many positive provisions in the NAIC model act that the AMA version promotes:

- Applicability expanded to all networks, not just HMOs.
- Access to specialty care recognized as a component of network adequacy.
- Accreditation is not to be used in place of active regulator oversight.
- Greater transparency than previous version in terms of provider selection standards.
- Strong requirements on provider directories.
- Stronger requirements of what should be included in an access plan.
- Provisions to prevent discrimination in network design against certain patients and physicians.

There are also many areas where the AMA suggests the NAIC did not go far enough to ensure adequate networks. The AMA version makes the following changes:

- Regulators would be required to review and approve networks before they go to market.
- State regulators would measure adequacy using multiple, measurable, objective standards.
- The adequacy of tiered networks would be determined based on the lowest cost-sharing tier.
- Telemedicine would not be used as a way to meet network adequacy requirements.
- Provisions preventing nonparticipating hospital-based providers from receiving fair payments have been removed.
- Insurers would be required to recognize patient assignment of benefits to nonparticipating providers.

How to use this document

The attached redline version of the NAIC model act represents the AMA's recommended changes. With these changes, the model act is strong legislation to ensure patients have timely access to appropriate providers, as well as the transparency needed to make informed decisions about their health care.

For questions about the model act or the revisions recommended by the AMA, please contact ARC Senior Legislative Attorney Emily Carroll, JD, at emily.carroll@ama-assn.org or 312-464-4968 or Daniel Blaney-Koen, JD, at daniel.blaney-koen@ama-assn.org or 312-464-4954.

AMA suggested edits to the NAIC's
HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to:

A. Establish standards for the creation and maintenance of networks by health carriers; and

B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered services to covered persons; and

(2) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with Section 5 of this Act, including any requirements in Section 5E of this Act related to its availability to the public.

Drafting Note: In states that regulate prepaid health services, this Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons.

Section 3. Definitions

For purposes of this Act:

A. "Assignment of benefits" means any written instrument executed by the covered person or authorized representative that assigns to the treating provider the covered person's right to receive reimbursement for medical services or items rendered to the covered person.

B. "Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

C. "Balance billing" means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.

D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

E. "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

F. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

G. "Economic credentialing" means the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing participation in a network.

~~G.~~H. "Emergency medical condition" means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual's physical, mental or behavioral health or, with respect to a pregnant woman, the woman's or her ~~[~~fetus'~~]~~ ~~[unborn child's]~~ health in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or

(4) With respect to a pregnant woman who is having contractions:

(a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) That transfer to another hospital may pose a threat to the health or safety of the woman or ~~[~~fetus~~]~~ ~~[unborn child]~~; or~~.~~

(5) A threat to the individual's safety or the safety of others.

~~H.~~I. "Emergency services" means, with respect to an emergency condition, as defined in Subsection F:

(1) A ~~medical or mental~~physical, mental or behavioral health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(2) Any further ~~medical or mental~~physical, mental or behavioral health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Drafting Note: States should be aware that the definition of "emergency services" above is derived from the federal definition for the term. Some states have developed a broader definition of "emergency services." For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state. States should be aware that if they use this definition of "emergency services," it could mean that emergency transportation is excluded from the special out-of-network cost-sharing protections applied to emergency services.

~~I.~~J. "Essential community provider" or "ECP" means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Pub.L.111-8.

Drafting Note: States should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers (ECPs) in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

~~J.~~K. "Facility" means an institution providing ~~[~~physical, mental or behavioral~~]~~ health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Drafting Note: States ~~that regulate Medicaid managed care plans~~ may wish to broaden this definition.

~~K.~~L. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of ~~[~~physical, mental or behavioral~~]~~ health care services, including substance use disorder.

~~L.~~M. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified ~~[~~physical, mental or behavioral~~]~~ health care services consistent with their scope of practice under state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

~~M.~~N. "Health care provider" or "provider" means a primary or specialty health care professional, a pharmacy or a facility.

Drafting Note: A pharmacy is an entity where prescription drugs are prepared, compounded, preserved or dispensed. Many types of pharmacies provide a broad range of access for prescription drug benefits in the health care services delivered to a covered person. Any determination of network sufficiency should consider the broad range of pharmacy access points available to covered persons and that certain provisions of this Act may not apply to pharmacy. States should take note of the federal rules implementing the federal Affordable Care Act (ACA) that go into effect Jan. 1, 2017, which will require carriers providing essential health benefits (EHBs) in the individual and small group markets to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies (see Title 45 CFR – Subpart B – Essential Health Benefits Section 156.122(e)).

~~N.~~O. "Health care services" means primary or specialty services and devices for the diagnosis, prevention, treatment, cure or relief of a ~~physical, mental or behavioral~~ health condition, illness, injury or disease, including physical, mental or behavior health conditions, illnesses, injuries or diseases, or ~~including~~

~~mental health and~~ substance use disorders.

~~O.~~P. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the PHSA defines the term "health insurance issuer" instead of "health carrier." The definition of "health carrier" above is consistent with the definition of "health insurance issuer" in Section 2791(b)(2) of the PHSA.

Q. "Facility-based professionals" mean those health care professionals that typically provide their services in a hospital or other similar facility setting .

~~P.~~R. "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

~~Q.~~S. "Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

~~**Drafting Note:** In some cases, dental benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope dental plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.~~

~~R.~~T. "Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

~~**Drafting Note:** In some cases, vision benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of "limited scope vision plan" to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.~~

~~S.~~U. "Network" means the group or groups of participating providers providing services under a network plan.

~~T.~~V. "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

Drafting Note: The definition of "network plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other ~~innovative~~ delivery system models.

~~U.~~W. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

~~V.~~X. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

~~W.~~Y. "Primary care" means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

Drafting Note: Many states may have an existing definition of "primary care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "primary care" needs to be defined for purposes of this Act using the definition above for "primary care" or the state's existing definition of "primary care."

~~X.~~Z. "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

~~Y.~~AA. (1) "Specialist" means a physician or non-physician health care professional who:

(a) Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

(b) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

~~Z.~~BB. "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

Drafting Note: Some states may have an existing definition of "specialty care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "specialty care" needs to be defined for purposes of this Act using the definition above for "specialty care" or the state's existing definition of "specialty care."

~~AA.~~CC. "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

Drafting Note: States should review the definition of "telemedicine" or "telehealth" for consistency with any state laws or regulations related to telemedicine or telehealth.

~~AA~~DD. "Tier~~ed network~~" means to structure a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Drafting Note: Health carriers may use different terms other than the term "tier" to refer to the type of network described in the definition above. State insurance regulators should be aware of this for purposes of the definition above and any changes a state may want to make to the definition above as a result, such as using another term or terms in place of or in addition to the term "tier."

~~BB~~EE.. "To stabilize" means with respect to an emergency medical condition, as defined in Subsection H~~F~~, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

Drafting Note: States should be aware that if they decide not to include the definition of "emergency services" using the language provided in Subsection H~~G~~, it may not be necessary to include this definition.

~~CC~~FF. "Transfer" means, for purposes of Subsection ~~BB~~ EE the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(1) Has been declared dead; or

(2) Leaves the facility without the permission of any such person.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act applies to all health carriers that offer network plans.

B. The following provisions of this Act shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 5A(2) of this Act;

(2) Section 5F(7)(e), (8)(b) and (11) of this Act;

(3) Section 6L(2)(a)(i)(I) and (III) and (c)(iii)(III) of this Act;

(4) Section 8 of this Act;

(5) Section 9B(2) and (3) of this Act; and

(6) Section 9C(1)(a) and (b), (2) and (3) of this Act.

Drafting Note: In addition to Subsection B, states will need to consider what other types of health benefit plans subject to the insurance laws and regulations of this state that use networks should be subject to the requirements of this Act.

~~**Drafting Note:** States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act's requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity or health carrier should provide the state with documentation that the health carrier and its networks have been accredited by the entity and make the underlying accreditation files available to the state upon request.~~

Section 5. Network Adequacy

A. (1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and ~~appropriate~~ types of appropriate providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) For purposes of networks that are tiered, network adequacy shall be determined through evaluation of the lowest cost-sharing tier.

(3) Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

(4) States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, when determining if a networks meets some or all of this Act's requirements; however, accreditation shall not be used as a delegation of state regulatory authority in determining network adequacy and may not be used as a substitute for state regulatory oversight.

(a) Should a state use accreditation as an additional regulatory tool in determining compliance with the standards required under this Act, the accrediting entity shall provide to the state and make available to the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements; and

(b) The private accrediting entity or health carrier shall provide the state with documentation

that the health carrier and its networks have been accredited by the entity and make the underlying accreditation files available to the state upon request.

Drafting Note: Particular attention should be given to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider. State insurance regulators should carefully review filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and ~~may~~ shall establish sufficiency by reference to any reasonable criteria, which ~~may~~ shall include but ~~shall~~ not be limited to:

(1) Full-time equivalent p~~P~~rovider-covered person ratios by specialty, including facility-based professionals;

(2) Full-time equivalent p~~P~~rimary care professional-covered person ratios;

(3) Geographic accessibility of providers, including primary care professionals, specialties, hospitals and facility-based professionals;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency; and

~~(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and~~

~~(9)~~(8) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

Drafting Note: When determining criteria for evaluating network sufficiency provided in Subsection B, state insurance regulators also may want to consider a number of additional factors, such as the extent to which participating providers are accepting new patients, the degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care. State insurance regulators also may conduct or review available periodic surveys of covered persons and providers to help inform their monitoring of network adequacy and may choose to make the results publicly available.

Drafting Note: State insurance regulators should consider establishing network sufficiency and accessibility standards that are specific to limited scope dental and/or vision plans. Certain network sufficiency and accessibility requirements for comprehensive health benefit plans may not be appropriate for these type benefit plans. For example, hours of operation for dental offices are traditionally standard business hours and are not utilized to illustrate network sufficiency, nor is telehealth widely utilized in the dental and vision industry.

Drafting Note: Some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), limits on travel distance to providers, limits on travel time to providers and limits on waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

C. The Commissioner shall conduct periodic surveys of covered person and providers to help inform the monitoring of network adequacy and shall make the result publicly available.

~~C.~~D. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but does not have an appropriate ~~type of~~ participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of appropriate participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access at in-network cost-sharing rates to obtain a covered benefit from a non-participating provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

Drafting Note: For purposes of this paragraph, "specialized health care services or medical services" include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(b) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (2) as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

Drafting Note: In order to determine what may be considered "in a timely fashion," state insurance regulators may want to review the timeframes and notification requirements provided in its utilization review law or regulation.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Act nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies

available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Drafting Note: It is presumed that the health carrier shall make its process under this subsection available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify.

~~D.~~E. (1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

Drafting Note: If the commissioner determines that there is a deficiency in access to care for a limited scope dental and /or vision plan, the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

~~E.~~F. (1) Beginning [insert effective date], a health carrier shall file with the commissioner ~~[for review] [~~for approval~~]~~ prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act.

~~**Drafting Note:** States will establish different requirements for the access plan. Paragraph (1) provides for this by giving states the option to require a health carrier to file the access plan with the commissioner for approval before use. Paragraph (1) also gives states the option to require a health carrier to file the access plan with the commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In states that require a health carrier to file access plans with the commissioner for review, the commissioner may want to consider, for example, whether access to specific types of providers or health care services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.~~

~~(2)~~(1) (a) The health carrier may request the commissioner to deem sections of the access plan as ~~[~~proprietary~~, competitive or trade secret]~~ information that shall not be made public. The health carrier shall make the access plans, absent ~~[~~proprietary~~, competitive or trade secret]~~ information, as determined by the Commissioner, available online, at its business premises, and to any person upon request.

(b) For the purposes of this subsection, information is ~~[~~proprietary ~~or competitive or a trade secret]~~ if revealing the information would cause the health carrier's competitors to obtain valuable business information.

Drafting Note: State insurance regulators should be aware that the intent of Paragraph (1~~2~~) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is ~~[~~proprietary, ~~competitive or trade information]~~ and, as such, no provision of the plan may be made public. State insurance regulators should review their open records laws in determining whether a particular provision, if any, of an access plan is ~~[~~proprietary, ~~competitive or trade secret]~~ information and should not be made public based on information received from the health carrier supporting its request. ~~. For purposes of this paragraph, state insurance regulators also should review their laws or regulations to determine which term "proprietary," "competitive" or "trade secret" is appropriate to use or if some other term is more appropriate. State insurance regulators should rely on the state law or regulation that defines "trade secret" or "proprietary."~~

(2) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval ~~or file with the commissioner, as appropriate,~~ an update to an existing access plan.

(3) For the purposes of this Section, material changes means any change to the network or plan population that impacts the ability of network to satisfy requirements of this Act.

~~**Drafting Note:** State insurance regulators may want to consider defining "material change" for purposes of Paragraph (3)~~

~~above. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network non-compliant with one or more network adequacy standards. Types of changes that could be considered material could include: 1) a significant reduction in the number of primary or specialty care physicians available in a network; 2) a reduction in a specific type of provider such that a specific covered service is no longer available; 3) a change to the tiered, multi-tiered, layered or multi-level network plan structure; or 4) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.~~

Drafting Note: State insurance regulators should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

~~F.~~G. The access plan shall describe or contain at least the following:

~~(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;~~

(1) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select and tier providers.

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

~~(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;~~

~~(5)~~(4) The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

~~(6)~~(5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

~~(7)~~(6) The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:

(a) The plan's grievance and appeals procedures;

(b) Its process for choosing and changing providers;

(c) Its process for updating its provider directories for each of its network plans;

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(e) Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

Drafting Note: State insurance regulators should ensure that limited scope dental plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.

Drafting Note: Some states may have an existing definition of "urgent care" in their state laws or regulations. Those states that have an existing definition of "urgent care" may want to consider including that definition in this Act.

~~(8)~~(7) The health carrier's system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians; and

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

~~(9)~~(8) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

~~(10)~~(9) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

~~(11)~~(10) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

~~(12)~~(11) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called "access plan" for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term "access plan."

Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a network plan shall satisfy all the requirements contained in this section.

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at

the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

Drafting Note: The reference to termination of coverage in Paragraph (1) above is meant to encompass all the ways a covered person's coverage can be terminated. The grounds, conditions and effective date of termination are dictated by other provisions of law, which are outside the scope of this Act, such as for nonpayment of premium or the performance of an act or practice that constitutes fraud or an intentional misrepresentation of material fact in connection with the coverage. State insurance regulators should keep this in mind in implementing Paragraph (1).

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

Drafting Note: Subsection D above provides that the obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under Subsection L.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F. (1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection ~~[~~and tiering~~]~~ of participating providers by the health carrier and its intermediaries with which it contracts.

(b) The standards shall meet the requirements of [insert reference to approprate state ~~provisions~~ law ~~equivalent to the Health Care Professional Credentialing Verification Model Act~~regarding credentialing].

(3) (a) Selection ~~[~~and tiering~~]~~ criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding ~~[~~and tiering~~]~~ providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization, or

~~(ii)~~(iii) That would allow a health carrier to economically credential a provider. ~~.~~

(b) (i) Selection and tiering criteria must include a quality component that carries equal or greater weight than other components of the selection and tiering criteria.

(~~c~~b) (i) In addition to Subparagraph (a) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (~~c~~b)(i) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

Drafting Note: States should be aware that the provisions of Subparagraph (b) above are based in large part on the provisions of Section 2706(a) of the Public Health Service Act (PHSA). The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, issued on May 26, 2015, sub-regulatory guidance in the form of frequently asked questions (FAQs), which provides an enforcement safe harbor for health insurance issuers subject to Section 2706(a) of the PHSA. Specifically, in the Affordable Care Act Implementation FAQs Part XXVII, Q4 and Q5 issued May 26, 2015, the Departments restated their current enforcement approach to Section 2706(a) of the PHSA which is to not take any enforcement action against a health insurance issuer offering group or individual coverage, with respect to implementing the requirements of Section 2706(a) of the PHSA as long as the issuer is using a good faith, reasonable interpretation of the statutory provision.

(4) Paragraph(3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for ~~review [and~~ approval~~]~~ by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

Drafting Note: State insurance regulators should review how a health carrier markets or represents its network plans to consumers particularly for those network plans that carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

~~**Drafting Note:** The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law.~~

H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the

health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

I. A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

Drafting Note: States should be aware that the term "participating provider" is meant to include a health care professional acting within the scope of their authority who may not be in the typical physician office setting or hospital setting, and may include licensed, accredited or certified staff, such as patient care coordinators, operating under the supervision of a participating provider.

K. Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their of medical and health records.

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause or a health carrier moves the provider to another tier in the same network..

Drafting Note: In addition to when a provider is removed or leaves the network without cause, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a provider's removal, ~~or~~ leaving the network, or movement to another tier within the network within thirty (30) days of receipt or issuance of a notice provided in accordance with Subparagraph (a) of this paragraph to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(c) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. ~~When the provider either gives or receives the notice in accordance with Subparagraph (a) of this paragraph, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.~~

(2) (a) For purposes of this paragraph, the following terms have the meanings indicated:

(i) "Active course of treatment" means:

(I) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;

(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or

interfere with anticipated outcomes.

(ii) "Life-threatening health condition" means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) "Serious acute or chronic condition" means a disease or condition requiring complex on- going care which the covered person is currently receiving, ~~such~~ including but not limited ~~as~~to chemotherapy, post-operative visits or radiation therapy.

(b) For purposes of Subparagraph (a)(i) of this paragraph, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an "active course of treatment."

(c) (i) When a covered person's provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under Paragraph (1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and specialty, and information about how the covered person may request continuity of care as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier's Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered person or the treating provider;

b. [Ninety (90) days] unless the Medical Director determines that a longer period is necessary;

c. The date that care is successfully transitioned to a participating provider;

d. Benefit limitations under the plan are met or exceeded; or

e. Care is not medically necessary~~.~~, as determined by the treating provider.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When determining the length of time for the continuity of care period, states should consider the number of providers, especially specialty providers who are available to treat serious health conditions in their states. States that have relatively few specialists or where consumers face significant wait times for appointments may want to adjust the continuity of care time frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

(I) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract or new payment and terms agreed to by the provider and health carrier; and

(II) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision plan participating provider, the commissioner may work with the plan's health carrier for approval of in-network benefits provided to the covered person until the episode of care is concluded.

Drafting Note: States may want to review other state laws and regulations and consider adding special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to have been a participating provider at the time of enrollment or when a participating provider was listed as accepting new patients, but was not accepting new patients at the time of enrollment.

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

O. A health carrier shall notify the participating providers at the time care is being provided of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non- covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish a mechanism by which participating providers may determine ~~in a timely manner~~ at the time services are being provided whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium. Information provided to the provider regarding a grace periods is binding on the health carrier for purposes of payment to providers.

~~**Drafting Note:** There are situations that may arise when using the mechanism established in accordance with Subsection Q above when a participating provider has verified an individual's eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation that may arise due to enrollment timing issues and other issues under the federal Affordable Care Act (ACA). Providers in this situation are permitted to bill the individual for payment of services provided. States may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility~~.

R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

T. (1) (a) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(b) While the contract is in force, the carrier shall ~~timely~~ notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract 90 days prior to the implementation of the changes and allow a provider to reject those changes without terminating the existing contract.~~.~~

~~(c) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.~~

Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section, Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider at least 90 days before placing the provider in the network.

~~**Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers**~~

~~A. For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility based provider as part of the facility's general business operations, and a covered person or the covered person's health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.~~

~~**Drafting Note:** States should carefully review the definition of "facility-based provider" above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.~~

~~B. Non-emergency out-of-network services.~~

~~(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:~~

~~(a) That certain facility based providers may be called upon to render care to the covered person during the course of treatment;~~

~~(b) That those facility based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;~~

~~(c) That the service(s) therefore will be provided on an out-of-network basis;~~

~~(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;~~

(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and

(f) A statement indicating that the covered person may obtain a list of facility based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility based providers.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B of this Act.

(2) At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in Paragraph (1), and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

C. Out-of-network emergency services.

(1) For out-of-network emergency services, the non-participating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balancethe covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan's allowable amount is more than [$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a non-participating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act* (#73) and revise them accordingly.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where a non-participating facility based provider sends a billing notice directly to a covered person for the non-participating facility based provider's service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2)

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation – copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR2) if the difference in the billed charge and the plan's allowable amount is more than [$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility based provider billing process or the provider mediation process required by [this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in Paragraph (2), may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made in Paragraph (2) may elect the Provider Mediation Process described in Subsection G.

This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to non-participating facility-based providers shall be presumed to be reasonable if it is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in Subsection F.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

(3) Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the non-

participating facility based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non participating facility based provider's charges for the out of network service(s).

(5) A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.

Drafting Note: In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long term care insurance, as defined by [insert the reference to state law that defines long term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

The requirements of this section do not apply to facilities that have made arrangements with facility based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non participating facility based provider.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 7~~8~~. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number or type of participating primary care and specialty care providers available to provide adequate and reasonable access for covered persons to covered benefits related to facility-based health care professionals who are not in the same network as the facility. States may want to consider developing appropriate laws and regulations to apply notice and disclosure standards to facilities to advise covered persons of the potential for balance billing by non-participating providers performing covered services at those facilities.

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act's requirements pertaining to hospitals and/or other type of facility.

Section 8~~9~~. Provider Directories

A. (1) (a) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in Subsection C.

(b) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) (a) The health carrier shall update each network plan provider directory at least monthly.

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as participating providers who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; and 2) closely monitoring consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating that the provider is a participating provider, state insurance regulators should consider an appropriate remedy, including referral of the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

(b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(a) In plain language, a description of the criteria the carrier has used to build its provider network;

(b) If applicable, in plain language, a description of the criteria the carrier has used to tier providers, and in which tier each provider is placed for the network;

(c) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(d) If applicable, note that authorization or referral may be required to access some providers.

~~(d)~~(e) Identification to be determined by the Commissioner regarding the breadth of each network.

(5) (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to Subsections B, C and D in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Participating office location(s);

(d) Specialty, if applicable;

(e) Medical group affiliations, if applicable;

(f) Facility affiliations, if applicable;

(g) Participating facility affiliations, if applicable;

(h) Languages spoken other than English, if applicable; and

(i) Whether accepting new patients.

(2) For hospitals:

(a) Hospital name;

(b) Hospital type (*i.e.* acute, rehabilitation, children's, cancer);

(c) Participating hospital location; and

(d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(a) Facility name;

(b) Facility type;

(c) Types of services performed; and

(d) Participating facility location(s).

C. For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Subsection B:

(1) For health care professionals:

(a) Contact information;

(b) Board certification(s); and

(c) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

D. (1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(a) For health care professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(b) For hospitals:

(i) Hospital name;

(ii) Hospital type (*i.e.* acute, rehabilitation, children's, cancer); and

(iii) Participating hospital location and telephone number; and

(c) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in Paragraph (1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain current provider directory information.

Drafting Note: In addition to the information provided in Subsections B, C and D health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination and diagnostic equipment and availability of programmatic accessibility.

Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision plans.

Section 9~~10~~. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine

compliance with this Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

I. Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

Section 10~~1~~. Filing Requirements and State Administration

A. At the time a health carrier files its access plan, the health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

Drafting Note: States may want to review their open records laws to determine whether the sample contract forms filed under Subsection A are considered public information.

B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner [for approval] at least [cite period of time in the form approval statute] days prior to use.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file contracts and material changes for prior approval. A state should choose which option is appropriate for the state.

Drafting Note: States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person's access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

[C. If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, the contract or change is deemed approved.]

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 11~~2~~. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 12~~3~~. Enforcement

A. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

Drafting Note: The reference to requiring the health carrier to modify the access plan instead of instituting a corrective action is to reflect the idea that sometimes the network changes through no fault of the health carrier and in those instances, the commissioner may require the health carrier to modify the access plan to bring the health carrier into compliance with the network adequacy requirements of this Act.

Drafting Note: State insurance regulators may use a variety of tools and/or methods to determine a health carrier's ongoing compliance with the provisions of this Act and whether the health carrier's provider network is sufficient and provides covered persons with reasonable access to covered benefits. Such tools and/or methods include consumer surveys, reviewing and tracking consumer complaints and data collection on the use of out-of-network benefits.

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

Section 1~~3~~4. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 1~~4~~5. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 1~~5~~6. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 1~~6~~7. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

D. Transition period for compliance with amended Section 5 of this Act.

Option 1.

For states with access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.

Option 2.

For states without access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of Act or effective date of amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.