HJR 20 Study: *NAIC Model Legislation on Surprise Medical Bills*

for review and consideration by the HJR 20 Subcommittee
March 21, 2018

Background
The National Association of Insurance Commissioners has developed model legislation on network adequacy for insurance plans that includes language designed to prevent consumers from receiving unexpected bills from out-of-network providers when they receive services from an in-network provider. This document contains the sections of that model legislation, known as the Health Benefit Network Access and Adequacy Model Act, related to surprise bills.

Section 7: Requirements for Participating Facilities with Non-Participating Facility-Based Providers

A. Definition

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.

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.

(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 balance. Such statement also shall inform the 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].

(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; OR 2) 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 plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process; 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.

(4) 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 they are 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.

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;

d. The American Bar Association Dispute Resolution Section; or

e. The state of Montana's [state dispute resolution, mediation, or arbitration section].

(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.

(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.

H. Rights and Remedies

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 deparment] 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, vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by rule, 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 supplemental 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 when a covered person obtains a covered benefit at an in-network level of cost-sharing from a non-participating provider when the health carrier has an insufficient number or type of participating providers available to provide a covered benefit to the person without unreasonable travel or delay.

(3) 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.

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] 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 8. Disclosure and Notice Requirements

(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 the information on what the covered persons' 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.

(3) 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 out-patient 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.

NAIC Definitions of Terms Used in Sections 7 and 8

Sections 7 and 8 of the model legislation use several terms that are defined elsewhere in the NAIC model. The terms and their NAIC definitions are as follows:

- **Authorized agent**: a person to whom a covered person has given express written consent to represent the covered person; a person authorized by law to provide substituted consent for a covered person; or 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.

- **Balance billing**: the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.

- **Emergency medical condition**: a physical, mental or behavioral health condition that mainfests 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: 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; serious impairment to a bodily function; serious impairment of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer to another hospital may pose a threat to the health or safety of the woman or [fetus][unborn child].

- **Emergency services**: with respect to an emergency condition, as defined above, a medical or mental health screening examination that is within the capability fo the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition and any further medical or mental health examination and treatment to the extent that they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- **Facility**: 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.

- **Health benefit plan**: 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.

- **Health care professional**: 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 fo practice under state law.

- **Health carrier**: 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.

- **Participating provider**: A provider who, under a contract with the health carrier or its contractor of subcontractor, has agreed to provide healthcare services to covered persons with an expectation of receiving payment other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.