Side-by-Side Comparison of

NCOIL Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers
(or "NCOIL Proposed Network Adequacy Model Act")

NAIC Health Benefit Plan Network Access and Adequacy Model Act
(or "NAIC Network Adequacy Model Act")

NCOIL Healthcare Balance Billing Disclosure Model Act
(or "NCOIL Balance Billing Model Act")

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
TITLE		
Section 1 This Act may be called the Model Act Regarding Network Adequacy and Use of Out-of-Network Providers	Section 1 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.*	

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PURPOSE		
Section 2 The purpose of this Act is to protect consumers from unexpected medical bills as a result of using out-of-network physicians. New network adequacy requirements, improved disclosures from insurers and providers to consumers, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance process and reduce the incidence of costly, surprise bills.	Section 2 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 prepared 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 1 The purpose of this Act is to provide transparency, accountability, and disclosure by healthcare facilities, facility-based providers, and health benefit plans regarding billing practices, notice of network benefits, and financial responsibilities in the delivery of non-emergency medical care.
APPLICABILITY		
Section 3A Applies to insurers that issue a health insurance policy or contract with a network of healthcare providers.	Section 4 Except as provided in Subsection B, this Act applies to all health carriers that offer network plans, except that certain specified sections to not apply to carriers that offer network plans that consist solely of	Section 3 A. This Act applies to any health benefit plan that:

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	limited scope dental plans or limited scope vision plans. **[Editor's Note: The sections noted above are specified in the addendum to this side-by-side document.]** *Drafting note: In addition to [certain exclusions for limited scope dental plans or limited scope vision plans], 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 provider 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 7J Requirements for Participating Facilities with Non-Participating Facility-Based Providers - 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),	1. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by: (a) an insurance company; (b)a group hospital service corporation operating under [Insert Applicable State Statute]; (c) a fraternal benefit society operating under [Insert applicable State Statute]; (d) a stipulated premium company operating under [Insert Applicable State Statute]; (e) a health maintenance organization operating under [Insert Applicable State Statute]; (f) a multiple employer welfare arrangement that holds a certificate of authority under [Insert Applicable State Statute]; (g) an approved nonprofit health corporation that holds a certificate of authority under [Insert Applicable State Statute]; or (h) an entity not authorized under this code or another insurance law of this state that contracts directly for non-emergency medical care on a risk-

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	coverage under a plan through Medicare, Medicaid, or FEHBP, any coverage issued under Title 10 of the U.S. Code with respect to armed forces and any coverage issued as supplement to that coverage, any covered 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 (in-network benefits) (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. *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.*	sharing basis, including a capitation basis; or 2. provides health and accident coverage through a risk pool created under [Insert Applicable State Statute]. B. This Act applies to a person to whom a health benefit plan contracts to: 1. process or pay claims; 2. obtain the services of physicians or other providers to provide non-emergency medical care to enrollees; or 3. issue verifications or pre-authorizations. C. The Act applies to all healthcare facilities and facility-based providers that are providing medical care to patients, except for those providing care in Section 3(D). D. This Act does not apply to: 1. Medicaid managed care programs operated under [Insert Applicable State Statute]; 2. Medicaid programs operated under [Insert Applicable State Statute]; 3. the state child health plan operated under [Insert Applicable State Statute]; 4. Medicare; 5. emergency medical care as defined under Subsection 2(C) of this Act;

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		6. care as provided in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA); or 7. "excepted benefit" products as defined under 42 U.S.C. 300gg-91(c).
DEFINITIONS		
	Section 6 L (2)(a)(i) [For purposes of Section 6] "Active course of treatment" means: (1) An ongoing course of treatment for a life-threatening condition; (2) An ongoing course of treatment for a serious acute condition; (3) The 2nd or 3rd trimester of pregnancy; or (4) An ongoing course of treatment for health condition for which a treating physician or health care provider attests that discontinuing care by the physician or health care provider would worsen the condition or interfere with anticipated outcomes.	
	Section 3A "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.	
	Section 3B "Balance billing" means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.	Section 2A "Balance billing" means the practice by a provider, who is not a participating provider in an

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		enrollee's health plan network, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts as required by the health benefit plan. *Drafting Note: States should review their regulation of billing and payment practices for network and non-network providers.*
	Section 3C "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 HMOs, 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.*	
	Section 3D "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.	
	Section 3E "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.	

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Section 3G For the purpose of this section, "emergency services" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: 1. placing the patient's health in serious jeopardy; 2. serious impairment to bodily functions; or 3. serious dysfunction of any bodily organ or part. *Drafting note: The definition of "emergency services" is identical to the "emergency medical care" definition in the 2011 NCOIL Healthcare Balance Billing Disclosure Model Act*.	Section 3G "Emergency services" means, with respect to an emergency condition, as defined: (1) a medical or mental 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 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 is derived from the federal definition for the term. Some states have developed a broader definition of emergency services. For those state with a broader definition, each state will have to determine with 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.* Section 3F "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].	Section 3C "Emergency medical care" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: 1. placing the patient's health in serious jeopardy; 2. serious impairment to bodily functions; or 3. serious dysfunction of any bodily organ or part.

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		Section 2B "Enrollee" means an individual who is eligible to receive non-emergency medical care through a health benefit plan.
	Section 3H “Essential community provider” or “ECP” means a provider that serves predominantly low-income, medically underserved individuals, including a health care provider defined in sections 340(B)(a)(4) of the PHSA or 197(c)(1)(D)(i)(IV) of the SSA (manufacturers of covered outpatient drugs). *Drafting note: States should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the ACA and implementing regulations.*	
	Section 3I “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.*	Section 2E "Healthcare facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing non-emergency medical care, which is licensed by [Insert State Department of Health Services].
	Section 7A [For purposes of this section] “Facility-based provider” means a provider who provides health care services to patients who are in an	Section 2D "Facility-based provider" means an individual or group of healthcare providers:

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	in-patient or ambulatory facility, including services such a 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 healthcare services provided at the in-patient or ambulatory facility.*	1. to whom the facility has granted clinical privileges; and 2. who provides services to patients treated at the facility under those clinical privileges.
	Section 3J "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.	Section 3A This act applies to any health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage offered by specified entities.
	Section 3K "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."	

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	Section 3L "Health care provider" or "provider" means a 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 ACA that go effect January 1, 2017, which will require carriers providing EHBs to the individual and small group markets to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies.*	Section 2F "Healthcare provider" means an individual who is licensed to provide and provides non-emergency medical care.
	Section 3M "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance abuse disorders.	
	Section 3N "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, HMO, 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 HMOs pursuant to statutes other than the insurance statutes and regulations, such as the public health*	

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	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 "healthcare." The definition of "health carrier" above is inconsistent with the definition of "health insurance issuer" in Section 2791(b)(2) of the PHSA.*	
	Section 3O "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.	
	Section 6L(2)(a)(ii) [For purposes of Section 6] "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.	
	Section 3P "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 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.*	

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	Section 3Q "Limited scope vision plan" means a plan that provides coverage sustainability 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 health benefit plans. *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.*	
	Section 3R "Network" means the group or groups of participating providers providing services under a network plan.	Section 2G "Provider network" means all of the physicians and health care providers who have contracted to provide health care services to the enrollees of a health benefit plan. This includes a network operated by or that contracts with a health maintenance organization; a preferred provider organization; or another entity that issues a health benefit plan, including an insurance company.
	Section 3S "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, PPOs, ACOs and other innovative delivery system models.*	

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	Section 3T "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, co-payments or deductibles, directly or indirectly from the health carrier.	
	Section 3U "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 thereof.	
	Section 3V "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 have an existing definition of "primary care." Such states should compare their existing definition with the above definition to determine whether the state's existing definition or the above definition should be used for purposes of this Act.*	
	Section 3W "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.	

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	Section 6L(2)(a)(iii) [For purposes of Section 6] "Serious acute condition" means a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.	
	Section 3X "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/she practices to provide specialty care. "Specialist" includes a subspecialist who has additional training and recognition above and beyond his/her specialty training.	
	Section 3Y "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 have an existing definition of "specialty care." Such states should compare their existing definition with the above definition to determine whether the state's existing definition or the above definition should be used for purposes of this Act.*	

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	Section 3Z "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.*	
	Section 3AA "Tiered network" means 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 such as using another term or terms in lieu or addition to the term "tier."*	
	Section 3BB "To stabilize" means with respect to an emergency medical condition, as defined in 3F (emergency medical condition), 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 3G, it may not be necessary to include this definition.*	

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	Section 3CC "Transfer" means, for purposes of 3BB (to stabilize), 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.	
WHAT CONSTITUTES AN ADEQUATE NETWORK AND REGULATORY REVIEW OF NETWORK ADEQUACY		
Section 3A An insurer that issues a health insurance policy or contract with a network of healthcare providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The commissioner shall review the network of health care providers for adequacy at the time of the commissioner's initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in *[insert applicable section of public health law]*, such network shall be deemed adequate by the commissioner.	Section 5A A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that service predominantly low income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, to be accessible without unreasonable travel or delay. Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week. *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.*	.

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Section 3F Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of accident and health insurance policies and subscriber contracts, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.	Section 5B The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to: (1) Provider-covered person ratios by specialty; (2) Primary care professional-covered person ratios; (3) Geographic accessibility of providers; (4) Geographic variation and population dispersion; (5) Waiting times for an appointment with participating providers (6) Hours of operations; (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; (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) 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 sufficiency provided, state insurance regulators also may want to consider 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*	

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	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.* Section 5D (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 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 reimbursement to covered persons.*	

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COVERAGE OPTION MANDATE		
Section 3 B An insurer that issues a comprehensive group or group remittance health insurance policy or contract that covers out-of-network health care services shall make available and, if requested by the policyholder or contract holder, provide at least one option for coverage for at least eighty percent of the usual and customary cost of each out-of-network healthcare service after imposition of a deductible or any permissible benefit maximum. Section 3C If there is no coverage available pursuant to subparagraph (B) of this section in a rating region, then the commissioner may require an insurer issuing a comprehensive group or group remittance health insurance policy or contract in the rating region, to make available and, if requested by the policyholder or contract holder, provide at least one option for coverage of eighty percent of the usual and customary cost of each out-of-network health care service after imposition of any permissible deductible or benefit maximum. The commissioner may, after giving consideration to the public interest, permit an insurer to satisfy the requirements of this paragraph on behalf of another insurer, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of out-of-network health care services to be made available pursuant to this subparagraph if the commissioner determines that it would pose an undue hardship upon an insurer.		

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Section 3D For the purposes of this subsection, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with an insurer. Section 3E This subsection shall not apply to emergency care services in hospital facilities or pre-hospital emergency medical services as defined by *[insert applicable section of state law]*. Section 3F Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of accident and health insurance policies and subscriber contracts, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.		
PROCESS TO PROVIDE ENROLLEES WITH ACCESS TO OON PROVIDERS		
[Note: This section is also found in the "Holding the Consumer Harmless" Section.] Section 3G When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider	Section 5C (1) Health carriers 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:	

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network of an insurer, the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network. a. For the purpose of this section, "emergency services" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part *[Drafting note: The definition of "emergency services" is identical to the "emergency medical care" definition in the 2011 NCOIL Healthcare Balance Billing Disclosure Model Act.]*	(a) The health carrier has a sufficient network, but does not have a 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 of type of participating provider available to provide the covered benefit to the covered person without unreasonable delay. (2) A health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided above 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 section, "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) (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 above as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such	

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	services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan. (4) The processes in 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 and shall provide this information to the commissioner upon request. (6) The process established is not intended to be used by health carriers as a substitution 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 section available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify.*	

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HOLDING THE CONSUMER HARMLESS		
[Note: this section is also found above in "Process to Provide Access to OON Providers"] Section 3G When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network of an insurer, the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the health care plan's provider network. a. For the purpose of this section, "emergency services" includes any healthcare services provided in a healthcare facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part *[Drafting note: The definition of "emergency services" is identical to the "emergency medical care" definition in the 2011 NCOIL Healthcare Balance Billing Disclosure Model Act.]*	Section 6B 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 resources 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 co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a FFS 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(s). Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy." Section 6C 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	

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	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 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 regulators should keep this in mind when implementing these provisions.* (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. Section 6D The contract provisions that satisfy the requirements of 6B and 6C 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. *Drafting Note: Subsection D 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 6L.*	

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	Section 6E 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.	
INSURER NOTICE TO CONSUMERS		
Section 4 A. Where applicable, an insurer must give notice to an insured that: a. an insured enrolled in a managed care product or in a comprehensive contract that utilizes a network of providers offered by the corporation may obtain a referral or preauthorization for a health care provider outside of the corporation's network or panel when the corporation does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral or preauthorization; b. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;	Section 8A (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. Section 8B 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 10 days of an appointment for in-patient or outpatient services at the facility or at the time of non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's	Section 6 A Each health benefit plan that reimburses healthcare through a provider network shall provide notice to its enrollees that: 1. a facility-based provider or other healthcare provider may not be included in the health benefit plan's provider network; and 2. a healthcare provider described by Section 6A(1) may balance bill the enrollee for amounts not paid by the health benefit plan. Section 6B 1. The health benefit plan shall provide the disclosure in writing to each enrollee: (a) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage; (b) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and (c) conspicuously displayed on any health benefit plan website that an enrollee is reasonably expected to access.

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c. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (1) a life-threatening condition or disease, or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist; d. an insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with (1) a life-threatening condition or disease, or (2) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained; e. an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy B. Where applicable, an insurer must give to an insured: a. a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and	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 of participating 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.* **[Editor's Note: Portions of Sections 4A and 4B of the NCOIL Proposed Network Adequacy Model Act (left column), and Section 6 C of the NCOIL Balance Billing Model Act (right column) refer either directly or indirectly to the information provided in provider directories. Section 9 of the NAIC Network Adequacy Model Act discusses provider directories in detail. In the interest of keeping this document as to as few pages as possible, the NAIC language related to provider directories is found in the addendum to this document.**	2. The commissioner by rule may prescribe specific requirements for the disclosure required under B (1). The form of the disclosure must be substantially as follows: NOTICE: "IF YOU HAVE RECEIVED NON-EMERGENCY MEDICAL CARE IN A FACILITY THAT IS IN YOUR HEALTH PLAN'S NETWORK, BUT THE CARE IS DELIVERED BY A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO IS NOT INTHAT NETWORK, YOU MAY BE RESPONSIBLE FOR PAYING SOME OR ALL OF THAT PHYSICIAN'S OR PROVIDER'S FEE THAT IS NOT COVERED BY YOUR HEALTH INSURANCE." Section 6C A health benefit plan must clearly identify healthcare facility-based providers who participate in the health benefit plan's provider network. Facility-based providers identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory. *Drafting note: States may wish to consider amending their health plan network adequacy statutes to require that plans contract with an adequate number of facility-based providers at each in-network health care facility to serve their enrollees.*

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telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation; b. with respect to out-of-network coverage: (1) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services; (2) a description of the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and (3) examples of anticipated out-of-pocket costs for frequently billed out-of- network health care services; and C. information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services		Section 6D Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment. Section 6E A health benefit plan shall provide to an insured by electronic or written correspondence, upon request for a healthcare service or supply but no later than 48 hours after pre-certification, information on: 1. whether a facility-based provider or other healthcare provider is a participating provider in the insurer's preferred provider network; 2. whether proposed non-emergency medical care is covered by the health insurance policy; 3. what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and 4. if applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary payment rate for out-of-network services.

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PROVIDER NOTICE TO CONSUMERS		
Section 6 A. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, shall disclose to patients or prospective patients in writing or through an internet website the health care plans in which the health care professional, group practice, diagnostic and treatment center or health center, is a participating provider and the hospitals with which the health care professional is affiliated prior to the provision of non-emergency services and verbally at the time an appointment is scheduled. *[Note: Section 6 B is also referenced in the "Balance Billing Section."]* B. If a health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, does not participate in the network of a patient's or prospective patient's health care plan, the health care professional, group practice, diagnostic and treatment center or health center, shall: a. prior to the provision of non-emergency services, inform a patient or prospective patient that the amount or estimated	Section 7C (1) For OON 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/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/her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described herein, 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 to balance bill the covered person, should be aware that the provisions of Paragraph (1) 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 its laws or regulations that may be equivalent to Section 11C of the NAIC Utilization Review and Benefit Determination Model Act (#73) and revise them accordingly.* (2) Nothing precludes a covered person from agreeing to accept and pay the charges for the OON services and not using the Provider Mediation Process described in Subsection G. Section 7D Limits 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 services, the billing notice shall include the Payment Responsibility Notice as required below.	Section 5 A If a facility-based provider bills a patient treated at the facility for non-emergency medical care who is covered by a health benefit plan described in Section 3 that does not have a contract with the facility-based provider, requesting payment on the balance of the provider's charge that is not related to co-pays, coinsurance payments, or deductible payments and is not covered by the health benefits plan, the facility-based provider shall send a billing statement that: 1. contains an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided; 2. contains a conspicuous, plain-language explanation that: a. the facility-based provider is not within the health plan provider network; and b. the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider billed amount; 3. contains a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues; 4. contains a statement that the patient may call to discuss alternative payment arrangements;

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amount the health care professional will bill the patient for health care services is available upon request; and b. upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, a schedule of fees that the health care professional, group practice, diagnostic and treatment center or health center, will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided. C. A health care professional who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider. D. A health care professional who is a physician shall, for a patient's scheduled hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency	(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 – co-payment, 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], 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 7E (health carrier OON facility-based provider payments). (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.	5. contains a notice that the patient may file complaints with the [Insert State Medical Board] and includes the [Insert State Medical Board] mailing address and complaint telephone number; and 6. for billing statements that total an amount greater than $200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 30 days of receiving the first billing statement that includes all insurance payments and reflects the final amount owed by the enrollee or six months after the receipt of medical treatment, whichever occurs first and substantially complies with the agreement, the facility-based provider may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment. Section 5B A patient may be considered by the facility-based provider to be out of substantial compliance with the payment plan agreement if payments in compliance with the agreement have not been made for a period of 45 days. *Drafting Note: States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance bills.*

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services are scheduled; and information as to how to determine the healthcare plans in which the physician participates.		
FACILITY NOTICE TO CONSUMER		
Section 6 E A hospital shall establish, update and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the federal social security act. Section 6 F A hospital shall post on the hospital's website: a. the health care plans in which the hospital is a participating provider; b. a statement that: (1) physician services provided in the hospital are not included in the hospital's charges; (2) physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital, and (3) the prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates	Section 7B 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 (OON) 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 OON; (c) That the service(s) therefore will be provided on an OON basis; (d) A description of the range of charges for the OON services 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 OON services, 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/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.*	Section 4 Each healthcare facility shall develop, implement, and enforce written policies for the billing of nonemergency medical care. The policies must address: 1. the providing of a conspicuous written disclosure to a consumer at the time the consumer is first treated on a non-emergency basis at the facility, at pre-admission, or first receives non-emergency or post-stabilization services at the facility that: (a) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; and (b) informs consumers that if a facility-based provider who provides services to the consumer while the consumer is in the facility is not a participating provider with the same third-party payors as the facility, then the consumer may be billed for medical services for the amount unpaid by the consumer's health benefit plan. 2. the requirement that a facility provide a list, on request, to a consumer to be admitted to

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c. as applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions how to contact these groups to determine the health care plan participation of the physicians in these groups; and d. as applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate Section 6G In registration or admission materials provided in advance of non-emergency hospital services, a hospital shall: a. advise the patient or prospective patient to check with the physician arranging the hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology and/or radiology is reasonably anticipated to be provided to the patient; and b. provide patients or prospective patients with information as to how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide services to the patient at the hospital, as	(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, 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.	or who is expected to receive services from the facility, that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility; and 3. if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility's website of a list that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

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determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services including anesthesiology, radiology and/or pathology		
BALANCE BILLING REQUIREMENTS UNRELATED TO DISCLOSURES		
	[Editor's Note: For the most part, the provisions related to balance billing in the NCOIL Proposed Network Adequacy Model Act and the NCOIL Balance Billing Model Act relate to disclosures to the enrollee by the carrier, the provider, and the facility. As noted above, the NAIC Network Adequacy Model Act contains disclosure provisions as well, but it also contains requirements unrelated to disclosures. In the interest of keeping this side-by-side comparison to as few pages as possible, the NAIC language related to these requirements is found in the addendum to this document.	
OUT OF NETWORK REFERRAL DENIALS		
Section 5A "Out-of-network referral denial" means a denial under a managed care product of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial. An out-		

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
of-network referral denial under this subsection does not constitute an adverse determination. Section 5B A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify: a. whether the services are considered in-network or out-of-network; b. whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; c. as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and d. as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services Section 5C	Section 6A 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.	

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
An insured or the insured's designee may appeal an out-of-network referral denial by a health care plan by submitting a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, provided that: a. the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service Section 5D For external appeals requested relating to an out-of-network referral denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network referral shall be covered by the health plan, provided that such determination shall: a. be conducted only by one or a greater odd number of clinical peer reviewers; b. be accompanied by a written statement: (1) that the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of		

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the attending physician's recommendation, the insured's medical record, and any other pertinent information, that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and that the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome; or (2) upholding the health plan's denial of coverage c. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan; d. be binding on the plan and the insured; and e. be admissible in any court proceeding		
DISPUTE RESOLUTION		
	Section 6R A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and a health carrier.	Section 5B *Drafting Note: States may wish to consider using an existing mediation process or establishing a*

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
	Section 6S 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. Section 7G. 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 7F. (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 OON service(s). (5) A health carrier shall maintain records on all requests for mediation and completed mediations under this section during a	*mediation process to manage disputes that may arise regarding balance bills.*

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
	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 rule making process should consider a number of provisions related to this section, 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*. Section 13H. 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. Section 13B 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 regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of provider contract or its termination.	
ENFORCEMENT		
	Section 7I Requirements for Participating Facilities with Non-Participating Facility-Based Providers 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. Section 13A 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	Section 7A The commissioner may take disciplinary action against a health benefit plan issuer that violates this Act, in accordance with *[Insert Applicable State Statute]*. Section 7B A violation of this Act by a facility or a facility-based provider is grounds for disciplinary action and imposition of an administrative penalty by the *[Insert State Medical Board or Appropriate State Authority]*.

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
	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 insisting 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 OON benefits.* Section 15 A violation of this Act shall [insert appropriate administrative penalty from state law].	*Drafting Note: States should review administrative laws to ensure that appropriate notice, opportunity to cure, and other relevant administrative law provisions that may be applicable are appropriately incorporated into this model.*
SEVERABILITY		
	Section 16 If any provision of this Act, or the application of the provision of 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 8 If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

NCOIL Proposed Network Adequacy Model Act	NAIC Network Adequacy Model Act	NCOIL Balance Billing Model Act
EFFECTIVE DATE		
Section 7 This Act shall take effect on [insert months] following enactment.	Section 17 This Act shall be effective [insert date]. [If applicable: The [insert year of adoption] amendments to this act shall be effective [insert date]]. **[Editor's Note: The remainder of the NAIC model language related to Effective Date is found in the addendum to this side-by-side.]**	Section 9 This Act shall take effect on [*insert months*] following enactment of the bill.

ADDENDUM

Side-by-Side Comparison of

NAIC Health Benefit Plan Network Access and Adequacy Model Act (or "NAIC Network Adequacy Model Act")

NCOIL Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers (or "NCOIL Proposed Network Adequacy Model Act")

NCOIL Health Care Balance Billing Disclosure Model Act (or "NCOIL Balance Billing Model Act")

NAIC MODEL ACT PROVISIONS RELATED TO PROVIDER DIRECTORIES

As noted on page 21 of the side-by-side comparison document, portions of Sections 4A and 4B of the NCOIL Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers, and Section 6 C of the NCOIL Health Care Balance Billing Disclosure Model Act refer either directly or indirectly to the information provided in health plan provider directories. Section 9 of the NAIC Network Adequacy Model Act discusses provider directories in detail. In the interest of keeping the comparison document to as few pages as possible, the NAIC language has been shifted from the narrow center column of the comparison document and provided below.

Section 9A

(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 herein.

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.

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.

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 feels 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 refer 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.

(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 below, 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;
   (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.

(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 pieces of information required in a provider directory pertaining to a health care professional, a hospital or 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.

Section 9B

The health carrier shall make available through an electronic provider directory, for each network plan, the following information 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).

Section 9 C

For 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.

Section 9D

(1) The health carrier shall make available in print, upon request, the following provider directory information for 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 print directory that 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 phone number] to obtain current provider directory information.

Drafting Note: In addition to the information required, 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.

NAIC MODEL ACT LANGUAGE THAT DOES NOT DIRECTLY CORRESPOND TO LANGUAGE IN THE PROPOSED NCOIL NETWORK ADEQUACY MODEL BILL OR THE NCOIL BALANCE BILLING MODEL

The NAIC Health Benefit Plan Network Access and Adequacy Model Act is 32 pages long and addresses some topics not directly addressed in either the Proposed NCOIL Network Adequacy model bill or the NCOIL Balance Billing Model Act. To reduce the number of pages in this side-by-side comparison, we have moved that NAIC language from the middle column to this addendum.

In addition, some of the lengthier drafting notes from the NAIC model language shown below have been omitted but are available in the NAIC model (link provided **here** and in the column header at the top of each page of the side-by-side).

BALANCE BILLING REQUIREMENTS UNRELATED TO DISCLOSURES

Section 7E

(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 7F below.
(3) Non-participating facility-based providers who object to the payment(s) made above may elect the Provider Mediation Process described in 7G.
(4) This section does not preclude a health carrier and an OON facility-based provider from agreeing to separate payment arrangements.

Section 7F
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: This section proposes that states set a benchmark(s) 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 above, 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. Others can include: 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 the usual, customary, and reasonable (UCR) charges in the state, if defined in state law or

regulation. In setting a benchmark(s), 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.

Section 7H

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.

APPLICABILITY EXEMPTIONS

Section 4

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 visions plans:

(1) Section 5A(2) of this Act. [Note: Covered person access to emergency services 24/7]
(2) Section 5F(7)(e), (8)(b) and (11) of this Act. [Note: A method for informing covered persons of the plan's procedures for covering and approving emergency, urgent, and specialty care; a system for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources and for ensuring appropriate discharge planning; and a process for monitoring access to physician specialist services in ERs, anesthesiology, radiology, hospitalist care and pathology/laboratory services at participating hospitals
(3) Section 6L(2)(a)(i)(I) and (III) and (c)(iii)(III) of this Act. [Note: An active course of treatment for ongoing course of treatment for a life-threatening condition; an active course of treatment for the second or third trimester of pregnancy and a continuity of care period for covered persons who are in their second or third trimester of pregnancy through the post-partum period]
(4) Section 8 of this Act [Note: Disclosure and notice requirements]
(5) Section 9B(2) and (3) of this Act [Note: Electronic provider directory information for hospitals or facilities other than hospitals]
(6) Section 9C(1)(a) and (b), (2) and (3) of this Act. [Note: Contact information and board certification within an electronic provider directory information for health care professionals; and phone numbers for hospitals and facilities within an electronic provider directory.

ACCESS PLAN

Section 5 E

(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. The above paragraph provides for this by giving states the option to file and use the access plan, or to require prior approval before using the access plan. In states where prior approval is required, states may want to consider, for example, whether access to specific types of provider 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 review or approve access plans.

(2) 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, available online, at its business premises, and to any person upon request.

For 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 the above paragraphs 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 a 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. State insurance regulators also should review their laws or regulations to determine which term is appropriate to use. State insurance regulators should rely on the state law or regulation that defines trade secret or proprietary.

(3) 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 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.

Drafting Note: State insurance regulators may want to consider defining "material change" for purposes of Paragraph (3) above. **[Editor's Note: The drafting note goes on to provide examples of how a state could define the phrase.]**

Section 5F

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;
(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) 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) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
(7) 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." Those states with existing definitions may want to consider using the definition in this Act.

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

(10) 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 -

(a) 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) 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 types 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) 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 use the term "access plan."

PROVIDER SELECTION AND TIERING

Section 6 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 state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(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.

(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 (b)(i) shall 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.

(4) This 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.

Section 6G
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.

Section 6H
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 discontinuances of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Section 6I
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.

Section 6J
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 person 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.

Section 6K

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 persons' right to see, obtain copies of, or amend their medical and health records.

Section 6L

(1)

(a) A health carrier and a participating provider shall provide at least 60-days written notice to each other before the provider is removed or leaves the network without cause.

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 within 30 days of receipt or issuance of a notice provided 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 with 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, 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) [See Definitions section above for definitions of "active course of treatment," "life threatening health condition" and "serious acute condition."]

(b) For purposes of subparagraph (a)(i), a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered 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, 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 information about how the covered person may request continuity of care as provided.

(iii) The procedure 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 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 2nd or 3rd 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. [90 days] unless the medical director determines that a longer period is necessary;
c. The data 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.

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; 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.

Section 6M
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.

Section 6N
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.

Section 6O
A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments 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.

Section 6P
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.

Section 6Q
A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are 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.

Drafting Note: There are situations that may arise when using the mechanism established 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 ACA. Providers in this situation may 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.

Section 6T

(1) 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.

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.

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 in order to determine if the provisions in the contract defining what is to be considered time 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, 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.

REGULATIONS

Section 7K

The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in section 7I] 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 14
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].

INTERMEDIARIES

Section 10

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 applicable requirements of Section 6 of this Act (requirements for health carriers and participating providers).
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 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, 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.

FILING REQUIREMENTS AND STATE ADMINISTRATION

Section 11

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 same contract forms filed 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 for 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, co-payments 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 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 20 days prior written notice from the commissioner.

CONTRACTING

Section 12

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.

EFFECTIVE DATE

Section 17

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 18 months after [insert effective date]. The commissioner may extend the 18 months for an additional period not to exceed six 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 months after the effective date of this Act] shall comply with this Act.
C. A provider contract or intermediary contract not described above, shall comply with this Act no later than 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 [12 months] after [insert effective date of amendments], each health carrier offering or renewing network plan 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 [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.

February 6, 2017