AHIP COMMENTS AND REDLINED RECOMMENDED CHANGES TO

DRAFT NCOIL OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

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Section 1. Title

This Act shall be known as the Out-of-Network Balance Billing Transparency Act.

Section 2. Purpose

The purpose of this Act is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network physicians. Improved disclosures by health benefit plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate ~~the~~ insurance processes and reduce the incidence of costly, surprise bills.

Section 3. Applicability

A. Except as provided in subsection B, this Act applies to any health benefit plan, provider, and health care facility as defined in Section 4.

B. 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; or
   5. "excepted benefit" products as defined under 42 U.S.C. 300gg-91(c).

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Section 4. Definitions

A. "Balance billing" means the practice by a provider, who does not participate in an enrollee's health benefit 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 required by the health benefit plan.

B. "Carrier" or "health 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. Carriers include 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.

C. [1] "Emergency services" are ~~includes~~ any health care services to treat an emergency medical condition provided in the emergency department of ~~provided in~~ a health care facility, ~~after the sudden onset of a medical condition~~ that manifests itself by acute symptoms of sufficient severity, including severe pain, such 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.

D. "Enrollee" means an individual who is eligible to receive ~~medical care through the~~ benefits ~~of~~ through a health benefit plan.

E. "Facility-based provider" means an individual or group of health care providers:
1. to whom the health care facility has granted clinical privileges; and
2. who provides services to patients treated at the health care facility under those clinical privileges.

F. "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, and/or behavioral] health care services.

G. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing medical care, and which is licensed by [Insert appropriate state agency].

H. "Network" means the providers and health care facilities ~~who~~ that 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

[1] *Recommended amendments make this definition consistent with PHSA/ERISA definition of emergency medical conditions, which substituted "acute" for "sudden onset." This definition is also used in the NAIC's Model 73 - "Utilization Review and Benefit Determination Model Act," and Model 74 – "Health Benefit Plan Network Access and Adequacy Model Act. "*

organization, or another entity (including an insurance company) that issues a health benefit plan.

I. "Network plan" means a health benefit plan that uses a network to provide services to enrollees.

J. "Out-of-network facility" means a health care facility that has not contracted with a carrier to provide services to enrollees of a health benefit plan.

K. "Out-of-network provider" means a health care provider who has not contracted with a carrier to provide services to enrollees of a health benefit plan.

L. "Out-of-network referral denial" means a denial by a health benefit plan of a request for an authorization or referral to an out-of-network provider on the basis that the health benefit plan has an in-network provider with appropriate training and experience to meet the particular health care needs of the enrollee and who is able to provide the requested health service.

M. "Provider" means an individual who is licensed to provide and provides medical care.

Section 5. Determination of Network Adequacy

A. A health carrier~~benefit plan~~ that contracts with a network of health care providers shall ensure that the network is adequate to meet the health needs of ~~insureds~~ its enrollees and to provide an appropriate choice of providers sufficient to render the services covered by the health benefit plan.

B. The commissioner of [insert applicable state agency] shall review the network of health care providers for adequacy at the time of the commissioner's initial approval of a health benefit plan network~~insurance policy~~ or contract; at least every three to five years thereafter; and upon application for expansion of any service area associated with the network~~policy~~ or contract.

C. To the extent that the network has been determined by the commissioner to meet the standards set forth in [insert applicable section law], such network shall be deemed adequate by the commissioner.

D. Nothing in this ~~sub~~section shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.

Section 6. Coverage Option Mandate

~~E.~~ [2]This section shall not apply to emergency care services in health care facilities or pre-hospital emergency medical services as defined by [insert applicable section of state law].

A.

~~F.~~B. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers shall, if requested by the group policyholder or contract holder, make ~~available and, if requested by the policyholder or contract holder, provide at~~available at least one option through which out-of-network providers are paid at least eighty percent of the~~for coverage for at least eighty percent of the usual and customary~~ allowed amount~~cost~~[3] ~~of each~~ paid to in-network providers for the same services, ~~provided by an out-of-network provider~~ after imposition of a deductible or any permissible benefit maximum.

~~G.~~C. If there is no coverage available pursuant to ~~sub~~paragraph (B~~A~~) of this section in a rating region, then the commissioner may require a carrier issuing a comprehensive group health benefit plan in the rating region, to make available ~~and~~, if requested by the group policyholder or contract holder, ~~provide~~ at least one option, ~~for coverage of eighty percent of the usual and customary cost of each service provided by an out-of-network provider~~through which out-of-network providers are paid at least eighty percent of the allowed amount paid to in-network providers for the same services, after imposition of any permissible deductible or benefit maximum. The commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this paragraph on behalf of another carrier, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of services provided by out-of-network providers to be made available pursuant to this subsection if the commissioner determines that it would pose an undue hardship upon a carrier or reduce the availability of participating providers.

[2] This subsection is relocated to the top of the section for consistency with other section in this Model Act.

[3] The use of "usual and customary cost" as the metric to determine how much carriers will be obligated to pay the out-of-network provider in certain circumstances is not in keeping with the industry standard, which has long held that "usual, customary, and reasonable" is the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

To avoid discouraging enrollees from choosing in-network providers, we suggest that carriers be required to provide at least one option for coverage for services provided by an out-of-network provider that is at least eighty percent of the allowed amount paid to in-network providers for the same services after imposition of a deductible or any permissible benefit maximum.

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~~A.~~ For the purposes of this ~~sub~~section, "~~usual and customary cost~~allowed amount" shall mean the amount determined from ~~eightieth~~seventieth ~~percentile of all~~ charges for the particular health care service performed by ~~a~~ providers in the same or similar specialty and provided in the same geographical area ~~as reported in a benchmarking database maintained by a nonprofit organization determined to be impartial, transparent, and operating in the public interest, specified by the commissioner. The nonprofit organization shall not be affiliated with a carrier.~~[4]

~~B.~~

~~H.~~D. ~~This section shall not apply to emergency care services in health care facilities or pre-hospital emergency medical services as defined by [insert applicable section of state law].~~

~~I.~~E. Nothing in this ~~sub~~section shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and subscriber contracts, to require additional coverage options for services provided by out-of-network providers, or to provide for standardization and simplification of coverage.

Section 7. Emergency Services Provided by Out-of-Network Provider

A. When an enrollee in a health benefit plan that covers emergency services receives the emergency services from an out-of-network provider, the health benefit plan shall ensure that the enrollee shall incur no greater out-of-pocket costs for ~~the~~those emergency services than the enrollee would have incurred with an in-network provider.

B. [5]An out-of-network facility or provider providing such emergency services, shall accept the carrier's payment and not balance bill the enrollee if the carrier provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified in these three paragraphs:

1. The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the enrollee. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this paragraph is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the enrollee. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-

[4] *Alternatively, of the 70th percentile of the Medicare allowed amount for out-of-network services may be used as the benchmark for payments these services.*

[5] *To bring this model into consistency with federal law, we recommend adding this subsection related to payments for out-of-network services.*

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network providers (such as under a capitation or other similar payment arrangement), the amount under (A) is disregarded.

2. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the enrollee. The amount in this paragraph is determined without reduction for out-of-network cost sharing that generally applies under the health benefit plan or with respect to out-of-network services. Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

3. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the enrollee.

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Section 8. Health Benefit Plan Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

~~A.~~B. Where applicable, ~~-~~and through its website, a health benefit plan must give to an enrollee:

~~B.~~1. a listing of providers in the health plan network, pursuant to Section 14.

~~a.~~ notice

2.

~~b.~~ that the enrollee may obtain a referral or preauthorization for services from an out-of-network provider when the health benefit plan does not have in its network a provider who is geographically accessible to the enrollee or~~and~~[6] has the appropriate training and experience to meet the particular health care needs of the enrollee; and

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[6] *As currently drafted, this language would limit carriers' ability to use centers of excellence and telemedicine. Furthermore, "geographically accessible providers" may not exist for in-network or out-of-network providers in many rural cases for certain less common specialties, such as pediatric oncology and neurology.*

~~c.~~

~~d.~~a.

~~e.~~b. the procedure for requesting and obtaining such referral or preauthorization;

~~C.~~3. notice

~~f.~~a. that the enrollee with a condition ~~which~~ that requires ongoing care from a specialist may request a standing referral to such a specialist and

~~g.~~b.the procedure for requesting and obtaining such a standing referral;

~~D.~~4. notice

~~h.~~a. that the enrollee with a life-threatening condition or disease, or 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 enrollee's medical care; and

~~i.~~b. the procedure for requesting and obtaining such a specialist;

~~E.~~5. notice

~~j.~~a. that the enrollee with a life-threatening condition or disease, or 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

~~k.~~b.the procedure for requesting and obtaining such access may be obtained;

~~F.~~6.[7] notice that 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. If the enrollee is pregnant at the time of enrolling in a health plan and in an active course of care with an out-of-network obstetrician/provider, they may request to continue under the care of that provider, which shall be granted for enrollees in their second or third trimester of pregnancy and extend through the postpartum period.

~~a listing of providers in the health plan network, pursuant to Section 14.~~

~~G.~~7. with respect to out-of-network coverage:

~~A.~~a. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services;

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[7] *As drafted, this subsection is currently overbroad. We have added language that will encourage enrollees to use in-network providers to the fullest extent possible while incorporating continuity of care provisions for pregnant women.*

~~B.~~b. ~~a description~~ [8]an estimate of the amount that the carrier 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

~~C.~~c. examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

d. information that reasonably permits an enrollee 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 health benefit plan will reimburse for out-of-network health care services and the usual and customary ~~cost~~charge amount for out-of-network health care services

C. Nothing in this section prevents a carrier from reviewing the quality of care and appropriateness of services being provided by out-of-network providers.[9]

~~D.~~

~~A.~~D. Upon request of an enrollee and no later than 48 hours after the carrier has been notified that the enrollee has been pre-certified to receive non-emergency services at a facility, a health benefit plan shall provide by electronic or written correspondence, information on:

1. whether the enrollee's provider is a participating provider in the health benefit plan network;
2. whether proposed non-emergency medical care is covered by the health benefit plan;
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.

Section 9. Provider Notice to Enrollees

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[8] *See Footnote 3 for discussion on "Usual and Customary Cost."*

[9] *Carriers maintain the right to monitor the quality of care and the appropriateness of services being provided by out-of-network providers. This type of review is routinely carried out to pinpoint fraud and abuse.*

A. This section applies to the provision of non-emergency services only.

B. Verbally at the time an appointment is scheduled and in writing or through a website prior to providing services, a health care provider or the provider's representative shall disclose to the enrollee ~~in writing or through an internet website~~, the health benefit plans in which the provider participates and the hospitals with which the provider is affiliated.

~~C.~~ If a provider does not participate in the enrollee's health benefit plan network, the provider shall~~, :~~

~~1.~~C. prior to providing services, inform the enrollee of~~that~~ the amount or estimated amount the provider will bill ~~the enrollee~~ for health care services absent ~~,~~unforeseen medical circumstances that might arise when the services are provided.~~is available upon request; and~~

~~2. Upon request, provide the enrollee with a written amount or estimated amount the provider anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.~~

D. When services rendered in a provider's office require referral to, or coordination with, another physician or specialist, including but not limited to an anesthesiologist, laboratory, pathologist, radiologist, and/or assistant surgeon, the provider or provider's representative initiating the referral or coordination shall give to the enrollee~~, the following information in writing~~ information to enable the enrollee ~~about the aforementioned who will be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and (2) how~~ to determine ~~in which~~ the health benefit plan networks in which each participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

~~E.~~ At the time a provider or the provider's representative is scheduling an enrollee to receive services at a health care facility, that provider or provider's representative shall give to the enrollee~~, the following (1)~~ information regarding how to determine the network status of the following providers that might be rendering services to the enrollee while in the facility: ~~in writing about~~ any anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeons. ~~who will also be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and~~enrollee and ~~(2) how to determine in which health benefit plan networks each participates.~~

~~F.~~E.

Section 10. Health Care Facility Notice to Enrollees

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A. This section applies to the provision of non-emergency services only.

B. A health care facility shall establish, update and make public through posting on its website, to the extent required by federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the federal Social Security Act.

C. A health care facility shall post on its website:

1. the networks in which the health care facility is a participating provider;

2. a statement that:

a. not all physician services provided in the health care facility are ~~not~~ included in the facility's charges;

b. physicians who provide services in the facility may or may not participate with the same health benefit plans as the facility participates in;

~~b.~~c. enrollees can learn whether their providers participate in their health benefit plan network or will accept the health benefit plan as payment in full, minus ~~once the enrollee pays~~ any required cost sharing;

~~c.~~d. if an enrollee in a health benefit plan receives services in the facility that is in that health benefit plan's network, but receives those services at the facility from a ~~facility-based~~ provider who is not in that network, the enrollee may be billed for the amount between what that~~e~~ provider charges and what the enrollee's health benefit plan pays that provider, including any co-pays, co-insurance, and/or deductibles that are the enrollee's responsibility; and

~~d.~~e. the enrollee should check with the provider arranging for the enrollee to receive services in the facility to determine whether that provider participates in the enrollee's health benefit plan~~s~~ network.

3. as applicable, information on how to contact the out-of-network ~~the name, mailing address and telephone number of the~~ facility-based providers and facility-based provider groups that the facility has employed or contracted with to provide services including anesthesiology, pathology, and/or radiology, and instructions about how to determine in which health benefit plan networks each participates.

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~~At the time of any pre-admission review, the health care facility shall advise the enrollee of the network status of their facility-based providers, whether participating in the enrollee's network or not.~~

D. In registration or admission materials provided at the pre-admission or pre-operative review conducted in advance of non-emergency services, a health care facility shall:

1. advise the enrollee of the network status of their facility-based providers, whether participating in the enrollee's network or not;

~~1.~~2. advise the enrollee to check with the physician arranging for the services to determine the name, practice name, mailing address and telephone number of any other physician who is reasonably anticipated to be providing services to the enrollee while in the health care facility, including but not limited to physicians employed by or contracting with the health care facility; and

~~2.~~3. inform the enrollee about how to timely determine in which health benefit plan networks the providers referenced in Section 10 C 3 participate.

E. Upon request, a facility shall provide the enrollee with a written amount or estimated amount that the facility anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

Section 11. Balance Billing

A. If an out-of-network provider bills an enrollee for non-emergency medical care, 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 billing statement from that provider must contain:

1. an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;
2. a conspicuous, plain-language explanation that:
   ~~1.~~a. the provider is not within the health plan network; and
   ~~2.~~b. the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider's billed amount;

3. 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;

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4. a statement that the enrollee may call to discuss alternative payment arrangements;

4.5. a notice that the enrollee may file complaints with the [Insert State Medical Board] and includes the [Insert State Medical Board] mailing address and complaint telephone number; and

5.6. a notice that if an enrollee owes more than $200 to the provider (over any applicable co-payments, co-insurance, or deductibles and insurance payments) and the enrollee agrees to a payment plan

a. the provider will not furnish adverse information to a consumer reporting agency if the enrollee substantially complies with the terms of the payment plan (1) within six months of having received the medical services or (2) within 30 days of receiving the first billing statement that reflects all insurance payments and the final amount owed by the enrollee; and

b. a patient may be considered by the 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 60 days.[10]

B. Provider Mediation Process for Out-of-Network Balance Bills of Over [$500].[11]

1. Carriers shall establish a provider mediation process for payment of non-participating provider bills for providers objecting to carrier's payment amount.
2. The provider mediation process shall be established in accordance with one of the following recognized mediation standards:
   a. The Uniform Mediation Act
   b.Mediation.org, a division of the American Arbitration Association;
   c.The Association for Conflict Resolution
   d.The American Bar Association Dispute Resolution Section; or
   e.The State of [XX] [state dispute resolution, mediation, or arbitration section.]
3. Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating provider
4. A carrier's provider mediation process may not be used when the health carrier and the non-participating provider agree to a separate payment arrangement or when the

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[10] *We recommend that this period be increased to allow for a first bill and a reminder notice of late payment.*

[11] *In the model, there is currently no mediation tool to resolve carrier/provider payment disputes. We recommend adding this provision, which is an adaptation of the mediation process provided for in other national standards.*

covered person agrees to accept and pay the non-participating provider's charges for the out-of-network service(s).

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

Section 12. Out-of-Network Referral Denials

A. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. The notice of an out-of-network referral denial provided to an enrollee shall include information regarding how the enrollee can appeal the denial, including but not limited to what information must be submitted with the appeal.

C. Appeals

1. An enrollee or enrollee's designee may appeal an out-of-network referral denial by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty appropriate to treat the enrollee for the health service sought~~,~~. The appeal may be submitted, provided that:

   a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee 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 enrollee, and who is able to provide the requested health service.

~~b.~~

~~2.~~ If an out-of-network referral denial has been upheld by the health benefit plan's internal appeals process and the enrollee wishes to pursue an external appeal, the appeal shall be provided and administered in accordance with the state's [cite external appeal statute and/or regulation].~~,~~ [12]~~the external appeal agent shall~~

~~a. review the utilization review agent's health benefit plan's final adverse determination; and~~

[12] *We recommend striking the rest of this section because the language is redundant and unnecessary, as federal law already mandates an external review process. We recommend the deletion of this sub-section.*

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b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall:

i. be conducted only by one or a greater odd number of clinical peer reviewers;

ii. based upon review of the (1) training and experience of the in-network health care provider or providers proposed by the plan, (2) the training and experience of the requested out-of-network provider, (3) the clinical standards of the plan, (4) the information provided concerning the insured, (5) the attending physician's recommendation, (6) the insured's medical record, and (7) any other pertinent information; and

iii. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

iv. be binding on the plan and the insured; and

v. be admissible in any court proceeding.

c. Upon reaching its decision, the external appeals agent shall submit to the enrollee and the health benefit plan, a written statement that:

i. 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 that (1) 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 (2) 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

ii. the external appeal agent is upholding the health plan's denial of coverage.

2.

Section 13. Prior Authorization

A. For health care services that require pre-authorization, aA health benefit plan shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a that determination to the enrollee or enrollee's designee authorized representative and the enrollee's health care provider by telephone and in writing within three business days of receipt of the information necessary to make the determination. To the extent practicable, such written notification to the enrollee and 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:

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1. whether the services are considered in-network or out-of-network;

2. whether the enrollee will be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

3. as applicable, the dollar amount the health benefit plan will pay if the service is out-of-network; and

4. as applicable, information explaining how an enrollee can 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 benefit plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

Section 14. Provider Directories

A. A carrier shall provide ~~a~~ provider directories~~ry~~ on ~~both~~ the carrier's website and, upon request, in print ~~format~~.

1. The carrier shall periodically audit at least a reasonable sample size of its provider directories~~yies~~ for accuracy and retain documentation of such an audit to be made available to the insurance commissioner upon request.

2. The provider directories~~y~~ on the carrier's website and in print ~~format~~ shall contain the following general information in plain language for each network plan:

   a. a description of the criteria the carrier has used to build its network;
   b. if applicable, a description of the criteria the carrier has used to tier providers;
   c. if applicable, 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~~;
   ~~c.~~d. [13]an indication of (for example by name, symbol, or grouping) the tier in which each provider and health care facility has been placed;
   ~~d.~~e. if applicable, a statement that authorization or referral may be required to access some providers;
   ~~e.~~f. which~~hat~~ provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in the~~is~~ state;

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[13] *Language in subsection A2c is edited and moved into this subsection for clarity.*

~~f.~~g. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the provider directories~~y~~ posted online, the carrier shall

1. update the provider directory at least monthly;

2. ensure that the public is able to view all of the ~~current~~ providers for a network plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

3. make available in a searchable format the following information for each network plan:

   a. For health care professionals: name; gender; participating office location(s); specialty, if applicable; medical group affiliations, if applicable; facility affiliations; if applicable; participating facility affiliations, if applicable; languages spoken other than English, if applicable; ~~and whether the provider is accepting new patients.~~[14]
   b. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; and
   c. For facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).

4. make available the following information in addition to the information available under Subsection B 3:

   a. for health care professionals: contact information; board certification(s); and languages spoken other than English by clinical staff, if applicable;
   b. for hospitals: telephone number; and
   c. for facilities other than hospitals: telephone number.

C. Regarding the provider directory in print format, the carrier shall include a disclosure that the directory is accurate as of the date of printing and that enrollees and prospective enrollees 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.

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[14] *Information regarding whether a provider is accepting new patients is one of the hardest elements to accurately maintain in a carrier's provider directory, as this is often a decision that changes based on a particular office's business model and capacity. For this reason, we recommend that carriers be required to remind enrollees to confirm with a provider whether they are accepting new patients, and have added that language below.*

~~c.~~D. Upon request of an enrollee or a prospective enrollee, the carrier shall make available in print format, the following provider directory information for the applicable network plan:

~~a.~~1. for health care professionals: name; contact information; participating office location(s); specialty, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;

~~b.~~2. for hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and

3. for facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s) and telephone number.

~~c.~~E. [15] The carrier shall post on its provider directory website, a reminder to enrollees that when calling providers to set up appointments, the enrollees should confirm that the providers are accepting new patients.

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Section 15. Effective Date

This Act shall take effect on [insert months] following enactment.

October 3, 2017

[15] *See Footnote 12 regarding Section 14 B3a*