

**NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
 RENTAL NETWORK CONTRACT ARRANGEMENTS MODEL ACT**

Adopted by the NCOIL Executive Committee on November 23, 2008, and by the Health, Long-Term Care, and Health Retirement Issues Committee on November 21, 2008.

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Section I. Definitions

For purposes of this Act, the following definitions shall apply:

- A. “Contracting entity” means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.
- B. “Covered individual” means an individual who is covered under a health insurance plan.
- C. “Direct notification” is a written or electronic communication from a contracting entity to a provider documenting third party access to a provider network.
- D. “Health care services” means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.
- E.
 - 1. “Health insurance plan” means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
 - 2. “Health insurance plan” shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based

care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or other similar limited benefit supplemental coverages.

- F. 1. “Provider” means a physician, a physician organization, or a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider’s participation in health care contracts.
- 2. “Provider” does not include a physician organization or physician hospital organization that leases or rents the physician organization’s or physician hospital organization’s network to a third party.
- G. “Provider network contract” means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered individuals.
- H. “Third party” means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

Section II. Scope

- A. This Act does not apply to provider network contracts for services provided to Medicaid, Medicare, or State Children’s Health Insurance Program (SCHIP) beneficiaries.
- B. This Act does not apply in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.
- C. This Act does not apply to a contract between a contracting entity and a discount medical plan organization.

Drafting Note:

Each state will determine whether this legislation should apply to self-funded employer-sponsored health insurance plans and/or third-party administrators operating on their behalf (as regulated under the Employee Retirement Income Security Act of 1974 [ERISA]).

Section III. Registration

- A. Any person that commences business as a contracting entity shall register with the (*Appropriate State Agency*) within 30 days of commencing business in this State unless such person is licensed by the (*Appropriate State Agency*) as an insurer. Upon passage of this Act, each person, not licensed by the (*Appropriate State Agency*) as a contracting entity shall register with the (*Appropriate State Agency*) within 90 days of the effective date of this Act.
 - 1. Registration shall consist of the submission of the following information:
 - (a) the official name of the contracting entity, including any d/b/a designations used in this state;
 - (b) the mailing address and main telephone number for the contracting entity’s main headquarters; and

- (c) the name and telephone number of the contracting entity's representative who shall serve as the primary contact with the Department.
2. The information required by this Section shall be submitted in written or electronic format, as prescribed by the (*Appropriate State Agency*).
3. The (*Appropriate State Agency*) may collect a reasonable fee for the purpose of administering the registration process.

Section IV. Contracting Entity Rights and Responsibilities

- A. A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:
 1. the provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and
 2. the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.
- B. A contracting entity that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:
 1. identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract;
 2. maintain an internet website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract;
 3. provide the third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;
 4. require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a health care provider when such discount is pursuant to the contracting entity's provider network contract; and
 5.
 - (a) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than (*insert number*) days prior to the effective date of the final termination of the provider network contract; and
 - (b) require those that are by contract eligible to claim the right to access a

provider's discounted rate to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

- (c) The notice required under subsection IV(B)(5)(a) can be provided through any reasonable means, including but not limited to: written notice, electronic communication, or an update to electronic database or other provider listing.

C. Subject to any applicable continuity of care requirements, agreements, or contractual provisions:

1. a third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;
2. claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and
3. claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

- D.
1. All information made available to provider in accordance with the requirements of this Act shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.
 2. Nothing contained in this Act shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

Section V. Third Party Rights and Responsibilities

- A. A third party, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party is obligated to comply with the rights and responsibilities imposed on contracting entities under Sections IV and VI of this Act.
- B. A third party that enters into a contract with another third party to access a provider's health care services and contractual discounts pursuant a provider network contract is obligated to comply with the rights and responsibilities imposed on third parties under Section V of this Act.
- C.
1. A third party will inform the contracting entity and providers under the contracting entity's provider network contract of the location of a website, toll-free number, or other readily available mechanism, to identify the name of the person or entity to which the third party subsequently grants access to the provider's health care services and contractual discounts pursuant to the provider network contract.
 2. The website will be updated on a routine basis as additional persons or entities are granted access. The website shall be updated to reflect all current persons and entities with access every 90 days. Upon request, a contracting entity shall make access information available to a provider via telephone or through direct notification.

Section VI. Unauthorized Access to Provider Network Contracts

- A. It is an unfair insurance practice for the purposes of *(insert applicable reference to state insurance code unfair trade practices section)* to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party, as specified in this Act.
- B. Contracting entities and third parties are obligated to comply with Sections IV(B)(2) or V(C)(1) and (2) concerning the services referenced on a remittance advice (RA) or explanation of payment (EOP). A provider may refuse the discount taken on the RA or EOP if the discount is taken without a contractual basis or in violation of these sections. However, an error in the RA or EOP may be corrected within 30 days following notice by the provider.
- C. A contracting entity may not lease, rent, or otherwise grant to a third party, access to a provider network contract unless the third party accessing the health care contract is:
1. a payer or third party administrator or another entity that administers or processes claims on behalf of the payer;
 2. a preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or
 3. an entity engaged in the electronic claims transport between the contracting entity and the payer that does not provide access to the provider's services and discount to any other third party.

Section VII. Enforcement

Enforcement of this model will follow that of *(insert applicable reference to state insurance code unfair trade practices section)*.

Section VIII. Effective Date

This Act shall be effective *(insert date)*.