PROPOSED REDLINE AMENDMENTS OF THE COALITION OF MEDICAL SPECIALTIES (AAOS, AAOMS, ACEP, ACR, ASA, ASPS, CAP, PFC)

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

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

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. "Emergency services" includes any health care service provided in a health care 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.

D. "Enrollee" means an individual who is eligible to receive medical care 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 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 (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.

N. "Usual and customary rate" 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 financially affiliated with, or otherwise supported by an insurance carrier

Section 5. Determination of Network Adequacy

A. A health 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 and provide an appropriate choice of providers sufficient to render the services covered by the health benefit plan.

- **a. The Commissioner shall in consultation with interested stakeholders adopt regulations to establish quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefits plans subject to this act**
- **b. In adopting the regulations, the Commissioner shall take into consideration:**
  - **i. Geographic accessibility of primary care and specialty care providers, with consideration for geographic variation and population dispersion, to establish maximum distance standards**
  - **ii. Waiting times for an appointment with participating primary and specialty care providers to establish maximum wait time standards**
  - **iii. Provider-to-enrollee ratios for primary and specialty care providers to establish provider-to-enrollee ratio standards**
  - **iv. Hours of operation**
  - **v. The ability of the network to meet the needs of enrollees**

B. A carrier shall annually submit a network access plan to the Commissioner with information necessary to document compliance with this provision, including:

- **a. a report for each network hospital that provides the percentage of physicians in each of the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and hospitalists practicing in the hospital who are in the insurer's network(s) so as to ensure enrollees with reasonable and timely access to these in-network physicians**

b. a report on the percentage of primary care and specialty care physicians who are in the insurer's network(s) as to ensure enrollees with reasonable and timely access to necessary medical care

C. 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 insurance policy or contract; at least every ~~three~~ **two** years thereafter; and upon application for expansion of any service area associated with the policy or contract.

D. When determining the adequacy of a proposed provider network, the commissioner must consider whether the carrier's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the proposed network to reasonably ensure enrollees have in-network access for covered benefits delivered at that in-network facility

~~C~~**. E.** 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~~**. F.** Nothing in this subsection 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

A. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers shall make available and, if requested by the policyholder or contract holder, provide ~~at least one option for~~ coverage **at** ~~at least eighty percent of~~ the usual and customary **rate** ~~cost of~~ **for** each service provided by an out-of-network provider after imposition of **any applicable** deductible, co-payment or co-insurance. ~~or any permissible benefit maximum.~~

B. If there is no coverage available pursuant to subparagraph (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 policyholder or contract holder, provide at least one option for~~ coverage ~~of eighty percent of~~ at the usual and customary **rate** ~~cost~~ of each service provided by an out-of-network provider 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.

~~C. 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 a carrier.~~

~~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].~~

~~E.~~ C. Nothing in this subsection 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 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 emergency services than the enrollee would have incurred with an in-network provider.

1. Upon receipt of an out-of-network provider or facility's bill for emergency health care services, the carrier must make payment at the usual and customary rate, or the provider's charge, whichever is lower, directly to the provider or facility, rather than the covered person.

Section 8. Health Benefit Plan Notice to Enrollees

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

1. notice

a. 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 and has the appropriate training and experience to meet the particular health care needs of the enrollee; and

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

2. notice

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

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

3.notice

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

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

4. notice

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

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

5. 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.

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

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

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

b. a description of the amount that the carrier will reimburse under the methodology for out-of-network health care services set forth as a percentage of **t**he usual and customary **rate** ~~cost~~ for out-of-network health care services; and

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~~ rate for out-of-network health care services

B. Upon request of an enrollee and no later than 48 hours after 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

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, **who has a scheduled appointment with the enrollee,** or the provider's representative shall **ascertain the enrollee's insurance information and** 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. prior to providing services, inform the enrollee that the amount or estimated amount the provider will bill the enrollee for health care services 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.~~ **C.** When services rendered in a provider's office require referral to, or coordination with, 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 about the aforementioned who will be providing services to the enrollee: ~~(1)~~ name, practice name, mailing address, telephone number, ~~and (2) how~~ **in order for the enrollee** to determine in which health benefit plan networks each participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

~~E.~~ **D**. 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 information in writing about any

anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services to the enrollee: ~~(1)~~ name, practice name, mailing address, telephone number, ~~and (2) how~~ **for the enrollee** to to determine in which health benefit plan networks each participates.

Section 10. Health Care Facility Notice to Enrollees

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. 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;

c. 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 from a provider who is not in that network, the enrollee may be billed for the amount between what the 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. 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 plans network.

3. as applicable, 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.

D. In registration or admission materials provided in advance of non-emergency services, a health care facility shall:

1. 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. 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~~ Out-of-Network Billing and Payment

A. ~~If an~~ Out-of-network provider bills sent to an enrollee for non-emergency medical care, requesting payment ~~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. ~~1.~~ a conspicuous, plain-language explanation that the provider is not within the health plan network; and ~~b.~~ the health benefit plan has paid **a usual and customary** rate, as determined by the health benefit plan, ~~which is below the facility-based provider's billed amount;~~
3. ~~2.~~ 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. ~~3.~~ a statement that the enrollee may call to discuss ~~alternative~~ payment arrangements **for those amounts that the enrollees is financially responsible for under their plan of insurance or for any other amounts not paid by their health plan;**
5. ~~4.~~ **a statement affirming that the out-of-network provider has billed in an amount no greater than the usual and customary rate for the out-of-network service and that if the health plan pays the the provider's charge in full or at that rate in full the enrollee will only be financially responsible for applicable deductibles, co-insurance and co-payments .**

~~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. 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 days.

B. A health insurance carrier for an out-of-network non-emergency bill from a physician shall:

1. provide the physician with an explanation of benefits as to any payment determination thereof; and

2. Upon receipt of an out-of-network provider or facility's bill for health care services, make payment at the usual and customary rate, or the provider's charge, whichever is lower, directly to the provider or facility, rather than the covered person.

3. Count any amount paid by the enrollee that exceeds applicable deductibles, co-insurance or co-payments towards the enrollees annual limitation on cost sharing.

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, 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.

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 external appeal agent shall

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

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.

Section 13. Prior Authorization

A. A 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 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:

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**, based upon applicable co-payments, deductibles and co-insurance and the usual and customary payment rate for such 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 directory on both the carrier's website and in print format.

1. The carrier shall **conduct a monthly review of each plan's network directory for accuracy** ~~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 insurance commissioner upon request.

2. The directory 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;
d. if applicable, a statement that authorization or referral may be required to access some providers;

e. 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;
f. 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 directory 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 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.
b. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; provided however,; and
c. For facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).
d. **A carrier with a provider network shall not state nor imply in communications with or directed toward enrollees or potential enrollees that a hospital, licensed under xxx , is an in-network health care facility if the health care providers who provide the following specialty services at such hospital do not also participate in the health benefit plan's network: Anesthesiology, emergency medicine, radiology and pathology. A violation of this provision shall be considered a deceptive or unfair trade practice subject to sanction under [ ]**

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. A carrier shall:

b. Contact the facilities and providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the facility or provider intends to remain in the carrier's provider network

c. Update the information within 15 working days after receiving notice from the participating facility or provider of a change

D. 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.

E. If a patient receives care from a provider listed in the directory as participating, but unintentionally receives out-of-network care due to an inaccurate carrier directory, the carrier is required to compensate the provider at the provider's full rate at no expense to the patient

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. 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. for hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and
c. for facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s) and telephone number.

Section 15 Waiver of Out-of-Network Charges

Any out-of-network provider who, on a case by case basis, determines to waive any cost for an enrollee in a health benefit plan based upon economic circumstances of the enrollee, including any balance billed amount, co-payment, coinsurance or copayment, shall not be subject to: 1) any civil cause of action by a health plan; (2) subject to prosecution for any violation in any court of jurisdiction, or (3) any sanction before any state oversight board (4) any approval requirement of a health benefit plan.

Section ~~15~~.16 Effective Date

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

6-13-17, 5 p.m. (Edits to correct punctuation, alphabetizing, numbering, inconsistent language.)