IN THE GENERAL ASSEMBLY STATE OF _____

An Act

Be it enacted by the People of the State of_____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the "Patient Protections from Unanticipated Out-of-Network Care Act."

Section 2. Purpose. The Legislature hereby finds and declares that:

(A) Health insurance companies are increasingly offering narrow network plans and regularly removing providers from networks;

(B) Patients should be able to access in-network primary care physicians and specialists in a timely manner, including facility-based physicians;

(C) Patients must be supplied with full knowledge of the facts to make informed decisions concerning the health insurance coverage they purchase and where, and from which providers, they seek health care services;

(D) Physicians should give fee information to patients and discuss their out-of-network fees in advance of services, whenever possible;

(E) Health insurance plans should clearly disclose the scope and limitations of any out-of-network benefit they purport to provide, in language that is meaningful to the consumer;

(F) Patients should be assured that the higher premiums they pay to make affordable access to out-of-network providers reasonably reflect the actuarial value of the out-of-network benefit provided; and

(G) It is imperative that patients be protected from the financial impact that can result from narrow networks and cost-shifting trends within health insurance.

Section 3. Definitions.

Assignment of Benefits: any written instrument executed by a patient which assigns to a physician or other health care provider the participant's, beneficiary's or enrollee's right to receive reimbursement for medical services or items rendered to the patient.

Commissioner: The insurance commissioner ofthis state.

Cost-sharing: Any expenditure required by or on behalf of an enrollee with respect to health benefits, including co-insurance, deductibles, and co-pays. Cost-sharing does not include premiums, balance billing amounts for out-of-network providers, and spending for non-covered services.

Emergency medical condition: "Emergency medical condition" means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, which 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 patient's mental or behavioral health or, with respect to a pregnant woman, the woman's or her fetus' health in serious jeopardy;

(2) Serious impairment to a bodilyfunction;

(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; or

(5) A threat to the individual's safety or the safety of others.

Emergency services: (1) A physical, mental or behavioral 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 determine the presence of and evaluate the emergency medical condition; and (2) any further physical, mental or behavioral 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.

Enrollee: a patient eligible for services covered by a specific health insurance plan.

Facility-based health care professional: a health care professional who provides services to patients in a facility, and typically includes anesthesiologists, radiologists, pathologists, emergency physicians, and hospitalists, but may also include other specialists such as those that provide on-call services, as well as non-physicians health care professionals such as nurses, physical therapists, and nutritionists.

Health care facility: institutions, including mobile facilities which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. "Health care facility" includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities, nursing homes, free standing emergency centers, home health agencies, outpatient or independent surgical, diagnostic or therapeutic centers or facilities,

including, but not limited to, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories (including independent imaging facilities), cardiac catheterization laboratories and radiation therapy facilities.

Health care professional: a physician or other health care practitioner licensed, accredited or certified to perform specified physical, mental or behavioral health care services consistent with their scope of practice under state law.

Health care services: services for the diagnosis, prevention, treatment or cure of a health condition, illness, injury or disease**.**

Health insurance company: a company that sells a health insurance plan.

Health insurance plan: any hospital and medical expense incurred policy, non-profit 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.

Health care provider: a health care professional, hospital, health care facility or other provider who/that is accredited, licensed or certified where required in the state of practice and performing within the scope of that accreditation, license or certification.

Health plan allowable: the maximum amount the health plan will pay for a covered service.

In-network level of coverage: the portion of the cost for a health care service a health insurance plan agrees to pay to a health care provider who/that participates in the health insurance plan's network. An enrollee is generally responsible for the remaining portion of the cost of care.

In-network provider: a health care provider who/that, through a contract with the health insurance plan, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health insurance company.

Out-of-network level of coverage: the portion of the cost for a health care service a health insurance plan is obligated to pay a health care provider who does not participate in the health insurance plan's network for health care services provided to an enrollee under an enrollee's health insurance plan.

Out-of-network care: care provided to a patient by a health care provider who/that does not participate in the patient's health insurance plan's network.

Out-of-network provider: a health care provider who does not have a contract with a health insurance plan to provide care to enrollees of that health insurance plan.

Patient: participant, beneficiary, enrollee or authorized representative.

Primary care physician: a physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care.

Provider network: all the providers contracted to provide services to a specified group of enrollees under a health insurance plan.

Specialist: a physician who focuses on a specific area of physical, mental or behavioral health or a group of patients and has successfully completed required training and certification. "Specialist" includes a subspecialist who has additional training and certification above and beyond his or her specialty training.

Tier: to structure a network that identifies and groups some or all types of providers into specific groups to which different provider payment, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Unanticipated out-of-network care: Services received by a patient in a facility from an out-of-network health care professional when the patient did not have the ability or control to select such services from an in-network health care professional, or emergency services provided to a

patient by an out-of-network health care professional. Unanticipated out-of-network care does not include non-emergency services received by a patient when the patient voluntarily selects in writing an out-of-network health care professional prior to the provision of the care.

Usual and customary rate: the eightieth percentile of all charges for the particular health care service performed by a health care professional 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 health insurance company.

Section 4. Applicability and Scope: This Act applies to all health insurance companies that offer health insurance plans with provider networks in the State.

Section 5. Network Adequacy

[*States may have sufficient network adequacy requirements in place and, therefore, may not need to enact Section 5. Strong network adequacy requirements are an essential component of protecting patients from the financial burdens associated with out-of-network costs.*]

(A) A health insurance company providing a health insurance plan that uses a provider network shall maintain a provider network that is sufficient in numbers and types of appropriate providers, including those that serve predominantly low-income, medically underserved individuals, and those that provide care to individuals with substance use disorder, to assure that all covered services to enrollees, including children and adults, will be accessible without unreasonable travel or delay.

(B) For purposes of networks that are tiered, sufficiency shall be determined through evaluation of the lowest cost-sharing tier.

(C) Enrollees shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

(D) The commissioner shall determine sufficiency in accordance with the requirements of this section, and shall establish sufficiency by reference to any reasonable criteria that shall include but not be limited to:

(1) Minimum full-time specialist to enrollee ratios by specialty, including facility-based healthcare professionals;

(2) Minimum full-time primary care physician to enrollee ratios;

(3) Geographic accessibility of health care providers, including primary care physicians, specialists, facility-based health care professionals, and hospitals using maximum time and maximum distance requirements that account for geographic variation and population dispersion;

(4) Maximum waiting times for an appointment with in-network health care providers;

(5) The hours of operation of health care providers in the provider network;

(6) The ability of the network to meet the needs of enrollees, 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; and

(7) The volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services.

(E) Sufficiency shall be determined by the commissioner based on the access plan prior to a health insurance plan being sold in the state:

(1) A health insurance company shall provide the commissioner with an access plan for each of its health insurance plans as a condition of offering its products in the state, and shall notify the commissioner of any material change to an existing network within three (3) business days after the change occurs. The notice to the commissioner shall include a reasonable timeframe within which the health insurance company will submit to the commissioner for approval an update to an existing access plan. For the purposes of this Section, "material change" means any change to the network or plan population that impacts the ability of a network to satisfy requirements of this Act, as determined by the commissioner.

(2) The access plan shall describe or contain at least the following:

(i) The factors used by the health insurance plan to build its provider network, including a description of the provider network and the criteria used to select and tier providers.

(ii) The health insurance plan's procedures for making and authorizing referrals within and outside its network, if applicable;

(iii)The health insurance plan'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;

(iv)The health insurance plan's efforts to address the needs of enrollee's, 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, including substance use disorder;

(v) The health insurance plan's methods for assessing the health care needs of

enrollees and their satisfaction with services;

(vi) The health insurance plan's method of informing enrollees of the plan's covered services and features,

(vii) The health insurance plan's grievance and appeals procedures;

(viii) The health insurance plan's process for choosing and changing providers;

(ix) The health insurance plan's process for updating its provider directories for each of its network plans;

(x) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable;

(xi)The health insurance plan's procedures for covering and approving emergency, urgent and specialty care, if applicable;

(xii) The health insurance plan's system for ensuring the coordination and continuity of care:

a. For enrollees referred to specialty physicians; and

b. For enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(xiii)The health insurance plan's process for enabling enrollees to change primary care professionals, if applicable;

(xiv)The health insurance plan's plan for providing continuity of care in the event of contract termination between the health insurance plan and any of its participating providers, or in the event of the health insurance plan's insolvency or other inability to continue operations. The description shall

explain how enrollees will be notified of the contract termination, or the health insurance plan's insolvency or other cessation of operations, and transitioned to other health care providers in a timely manner;

(xv) The health insurance plan's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at its in-network hospitals; and

(xvi) Any other information required by the commissioner to determine compliance with the provisions of this Act.

(F) A health insurance plan shall have a process to assure that an enrollee obtains a covered benefit at an in-network level of coverage or shall make other arrangements acceptable to the commissioner when:

(1) The health insurance plan has a sufficient network, but does not have an appropriate type of in-network provider available to provide the covered benefit to the enrollee or it does not have an in-network provider available to provide the covered benefit to the enrollee without unreasonable travel or delay; or

(2) The health insurance plan has an insufficient number or type of appropriate in-network providers available to provide the covered benefit to the enrollee without unreasonable travel or delay.

(G) The health insurance plan shall specify and inform enrollees of the process an enrollee may use to request access at an in-network cost-sharing rates to obtain a covered benefit from an out-of-network provider as provided in Paragraph (1) when:

(1) The enrollee is diagnosed with a condition or disease that requires specialized

health care services or medical services; and

(2) The health insurance plan:

(i) Does not have an in-network 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) Cannot provide reasonable access to an in-network 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) For purposes of an enrollee's financial responsibilities, the health insurance plan shall treat the health care services the enrollee receives from an out-of-network provider pursuant to this section as if the services were provided by an in-network provider, including counting the enrollee's cost-sharing for such services toward the enrollee's deductible and maximum out-of-pocket limit applicable to services obtained from in-network providers under the health insurance plan.

(4) The process described in this section shall ensure that requests to obtain a covered benefit from an out-of-network provider are addressed in a timely fashion appropriate to the enrollee's condition, but in no case more than five (5) business days from the date on which the health insurance plan receives that request.

(5) The health insurance plan shall report bi-annually to the commissioner the frequency with which the process outlined in this section is use.

Section 6. Disclosure

(A) A health insurance plan shall provide information in writing and through an internet website that reasonably permits an enrollee or prospective 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 the health insurance plan's allowables for out-of-network health care services and the usual and customary rate for out-of-network health care services, including, but not limited to:

(1) a clear description of the methodology used by the health insurance plan to determine reimbursement for out-of-network health care services;

(2) a description of the amount that the health insurance plan will pay under the methodology for out-of-network health care services set forth as a percentage of the usual and customary rate 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.

(B) Upon request from a patient, a health care provider shall provide an estimate of their charge for a health care service within seven (7) days of the patient's request. Such request may be made prior to the patient scheduling an appointment with the health care professional.

(1) A health care professional shall not be required to provide information specific to the patient's cost-sharing under the patient's health insurance plan.

(2) The requirement under this subsection does not apply to emergency services.

Section 7. Unanticipated Out-of-Network Care

[States that already have requirements in place addressing unanticipated out-of-network care that both financially protect patients and maintain incentives for health insurance plans and physician to enter into fair contracts should defer to those requirements.]

(A) A health care professional shall send a bill for his or her charges for unanticipated out-of-

network care to the patient's health insurance company. The health insurance company shall pay the health care professional directly pursuant to Section 8 of this Act.

(1) The health insurance company shall pay the health care professional based on the lesser of (1) the usual and customary rate and (2) the health care professional's charge.

(2) Under Part (A)(1) of this section, if payment is based on the usual and customary rate, a health care professional shall not send a bill to the patient for any difference between the payment received and payment that would have been received if payment was based on the health care professional's charge.

(B) When unanticipated out-of-network care is provided, the providing health care professional may bill a patient for no more than the cost-sharing requirements that would be applicable if the care had been provided by a health care professional in the patient's provider network.

(1) Cost-sharing requirements on the patient will be at the in-network level of coverage, based on the lesser of (1) the usual and customary rate and (2) the health care professional's charge.

(2) The patient's health insurance company shall inform the health care professional of its enrollee's cost sharing requirements within ten (10) business days of receiving a bill from the health care professional for services provided.

(3) Cost-sharing payments to the health care professional shall be treated by the health insurance company as though they were paid to an in-network health care professional for purposes related to the enrollee's deductibles and out-of-pocket maximums.

Section 8. Assignment of Benefit

[NOTE: States that already have acceptable assignment of benefits requirements in place or where enactment of acceptable language has not been feasible may elect to forego this section.]

(A) Where an out-of-network health care professional has an assignment of benefits, the health care professional must provide notice of such assignment to the health insurance company.

(B) The health insurance plan shall be required to send benefit payments directly to the health care professional who has the assignment.

(C) When payment is made directly to the health care professional, the health insurance company shall give written notice of such payment to the patient.

(D) If an assignment of benefits is made, but the health insurance company pays the benefits to the patient, the health insurance company shall also pay those benefits to the health care professional who received the assignment within 10 days of receiving notice of the incorrect payment from the health care professional.

(E) Where there is a good faith dispute regarding the legitimacy of a claim, the appropriate amount of payment, or the authorization for the assignment of benefits, notice that a dispute exists shall be promptly (and in no event later than 14 days after receiving the claim) furnished by the health insurance company to the health care professional upon receipt of the claim.

Section 9. Mediation

(A) The commissioner shall ensure access to a mediation process when a health care professional objects to the application of the established payment outlined in Section 7 of this Act.

(B) A health care professional may initiate mediation if the health care professional believes payment received for unanticipated out-of-network care under Section 7 does not properly recognize:

(1) the health care professional's training, education, and experience;

(2) the nature of the services provided;

(3) the health care professional's usual charge for comparable services provided;

(4) the circumstances and complexity of the particular case, including the time and place of the services; and

(5) other aspect of the health care professional's practice that may be relevant to the payment.

(C) Health care professional shall be permitted to bundle similar claims and claims presenting common issue of fact to be adjudicated in a single mediation process.

Section 10. Effective. This Act shall become effective six months from the date of enactment.

Section 11. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

Section 12. Nullification. Any contract provision violating this Act shall be considered null and void.