WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

House Bill 4061

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[Introduced January 08, 2020; Referred to the Committee on Health and Human Resources then the Judiciary]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-53-1, §33-53-2, §33-53-3, §33-53-4, §33-53-5, §33-53-6, §33-53-7, §33-53-8, §33-53-9, §33-53-10, §33-53-11, §33-53-12 and §33-53-13, all relating to health plan benefit networks; and creating the Health Benefit Plan Network Access and Adequacy Act.

Be it enacted by the Legislature of West Virginia:

ARTICLE 53. HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT.

§33-53-1. Definitions.

For purposes of this article

"Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person;

(B) A person authorized by law to provide substituted consent for a covered person; or

(C) The covered person's treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

"Balance billing" means the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.

"Commissioner" means the Insurance Commissioner of this state.

"Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Emergency medical condition" means a physical, mental, or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(A) Placing the individual's physical, mental, or behavioral health or, with respect to a pregnant woman, the woman's or her fetus' health in serious jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious impairment of any bodily organ or part; or

(D) With respect to a pregnant woman who is having contractions:

(i) That there is inadequate time to affect a safe transfer to another hospital before delivery; or

(ii) That transfer to another hospital may pose a threat to the health or safety of the woman or fetus.

"Emergency services" means, with respect to an emergency condition:

(A) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(B) Any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

"Essential community provider" or "ECP" means a provider that:

(A) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(B) Is described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by Section 221 of Pub.L.111-8.

"Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

"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 health care services.

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

"Health care provider" or "provider" means a health care professional, a pharmacy or a facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance use disorders.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

"Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

"Limited scope dental plan" means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Limited scope vision plan" means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

"Network" means the group or groups of participating providers providing services under

a network plan.

"Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

"Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Primary care" means health care services for a range of common physical, mental, or behavioral health conditions provided by a physician or nonphysician primary care professional.

"Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Specialist" means a physician or non-physician health care professional who:

(A) Focuses on a specific area of physical, mental, or behavioral health or a group of patients; and

(B) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

"Specialty care" means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions which may manifest

in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

"Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

"Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing, or provider access requirements, or any combination thereof, apply for the same services.

"To stabilize" means with respect to an emergency medical condition to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

"Transfer" means the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(A) Has been declared dead; or

(B) Leaves the facility without the permission of any such person.

§33-53-2. Applicability and scope.

(a) Except as provided in subsection (b) of this section, this article applies to all health carriers that offer network plans.

(b) The following provisions of this article do not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) §33-53-3(a)(2) of this code;

(2) §33-53-3(f)(7)(E), §33-53-3(f)(8)(E) and §33-53-3(f)(11) of this code;

(3) §33-53-4(m)(2)(A)(i)(I) and (III), and §33-53-4(m)(2)(C)(iii)(III) of this code;

(4) §33-53-6 of this code;

(5) §33-53-7(b)(2) and (3) of this code; and

(6) §33-53-7(c)(1)(A) and (B), §33-53-7(c)(2), and §33-53-7(c)(3) of this code.

§33-53-3. Network adequacy.

(a)(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons have access to emergency services 24 hours per day, seven days per week.

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

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs

of covered persons requiring technologically advanced or specialty care services.

(c)(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a nonparticipating provider, or make other arrangements acceptable to the commissioner when:

(A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in subdivision (1) of this subsection when:

(A) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

(B) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a nonparticipating provider pursuant to subdivision (2) of this subsection as if the services were provided by a participating provider, including counting the covered person’s cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating

providers under the health benefit plan.

(4) The process described under subdivisions (1) and (2) of this subsection shall ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this article nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(d)(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(e)(1) Beginning January 1, 2021, a health carrier shall file with the commissioner for review prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this article.

(2)(A) The health carrier may request the commissioner to deem sections of the access

plan as proprietary information that may not be made public. The health carrier shall make the access plans, absent proprietary information, available online, at its business premises, and to any person upon request.

(B) For the purposes of this subsection, information is proprietary if revealing the information would cause the health carrier's competitors to obtain valuable business information.

(3) The health carrier shall prepare an access plan prior to offering a new network plan and shall notify the commissioner of any material change to any existing network plan within 15 business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

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

(1) The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

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

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the health care needs of covered persons

and their satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including, but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

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

(E) Its procedures for covering and approving emergency, urgent, and specialty care, if applicable;

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialty physicians; and

(B) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

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

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals; and

(12) Any other information required by the commissioner to determine compliance with the

provisions of this article.

§33-53-4. Requirements for health carriers and participating providers.

(a) A health carrier offering a network plan shall satisfy all the requirements contained in this section.

(b) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

(c) Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

(d) Every contract between a health carrier and a participating provider shall set forth that

in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

(e) The contract provisions that satisfy the requirements of subsections (b) and (c) of this section shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections (b) and (c) of this section.

(f) In no event may a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(g)(1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2)(A) The standards shall be used in determining the selection of participating providers by the health carrier and its intermediaries with which it contracts.

(B) The standards shall meet the requirements of §30-1-1 *et seq.* of this code

(3)(A) Selection criteria may not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by

excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health care services utilization.

(B)(i) In addition to paragraph (A) of this subdivision, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of subparagraph (B) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.

(4) Subdivision (3) of this subsection may not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this article.

(5) The provisions of this article do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under §33-53-3 of this code.

(h) A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

(i) A health carrier shall notify participating providers of the providers' responsibilities with

respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

(j) A health carrier may not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.

(k) A health carrier may not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

(l) Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of, or amend their of medical and health records.

(m)(1)(A) A health carrier and participating provider shall provide at least 60 days written notice to each other before the provider is removed or leaves the network without cause.

(B) The health carrier shall make a good faith effort to provide written notice of a provider's removal or leaving the network within 30 days of receipt or issuance of a notice provided in accordance with paragraph (A) of this subdivision to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether

it is for cause or without cause.

(C) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with paragraph (A) of this subdivision, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2)(A) For purposes of this subdivision, the following terms have the meanings indicated:

(i) “Active course of treatment” means:

(I) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;

(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) “Life-threatening health condition” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) “Serious acute condition” means a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

(B) For purposes of subparagraph (i), paragraph (A) of this subdivision, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an “active course of treatment.”

(C)(i) When a covered person’s provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under subdivision (1) of this

subsection, and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria listed in subdivision (2) of this subsection and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care are subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

(AA) The termination of the course of treatment by the covered person or the treating provider;

(BB) 90 days unless the medical director determines that a longer period is necessary;

(CC) The date that care is successfully transitioned to a participating provider;

(DD) Benefit limitations under the plan are met or exceeded; or

(EE) Care is not medically necessary.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

(I) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original

provider contract; and

(II) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

(m) The rights and responsibilities under a contract between a health carrier and a participating provider may not be assigned or delegated by either party without the prior written consent of the other party.

(n) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(o) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered services.

(p) A health carrier may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(q) A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

(r) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the health carrier.

(s) A contract between a health carrier and a provider may not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

(t)(1)(A) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(B) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(C) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

§33-53-5. Requirements for participating facilities with non-participating facility-based providers.

(a) For purposes of this section, "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology, or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility's general business operations, and a covered person or the covered person's health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

(b) *Nonemergency out-of-network services. --*

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of nonemergency services to a covered person, the facility

shall provide the covered person with an out-of-network services written disclosure that states the following:

(A) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

(B) That those facility-based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;

(C) That the service(s) therefore will be provided on an out-of-network basis;

(D) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;

(E) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance, or rely on whatever other rights and remedies that may be available under state or federal law; and

(F) A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

(2) At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in subdivision (1) of this subsection, and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

(c) *Out-of-network emergency services.* --

(1) For out-of-network emergency services, the nonparticipating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network

cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in subsection (g) of this section if the difference in the billed charge and the plan's allowable amount is more than $500.

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in subsection (g) of this section.

(d) Limitation on balance billing covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice in subdivision (2) of this subsection.

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

"Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation – copayment, coinsurance, or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: (1) You may choose to pay the balance of the bill; or (2) if the difference in the billed charge and the plan's allowable amount is more than $500, you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by this article; (3) you may rely on other rights and remedies that may be available in your state."

(3) Nonparticipating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's nonparticipating facility-based provider billing process described in subsection (e)

of this section.

(4) Nonparticipating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined in subdivision (2) of this subsection, may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept and pay the bill received from the nonparticipating facility-based provider and not using the Provider Mediation Process described in subsection (g) of this section.

(e) *Health carrier out-of-network facility-based provider payments. --*

(1) Health carriers shall develop a program for payment of nonparticipating facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark established in subsection (f) of this section.

(3) Nonparticipating facility-based providers who object to the payment(s) made in subdivision (2) of this subsection may elect the Provider Mediation Process described in subsection (g) of this section.

(4) This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

(f) *Benchmark for non-participating facility-based provider payments.* -- Payments to non-participating facility-based providers shall be presumed to be reasonable if they are based on the higher of the health carrier's contracted rate or 25 percent of the Medicare payment rate for the same or similar services in the same geographic area.

(g) *Provider Mediation Process. --*

(1) Health carriers shall establish a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in subsection (f) of this section.

(2) The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(A) The Uniform Mediation Act;

(B) Mediation.org, a division of the American Arbitration Association;

(C) The Association for Conflict Resolution (ACR); or

(D) The American Bar Association Dispute Resolution 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 nonparticipating facility-based provider.

(4) A health carrier provider mediation process may not be used when the health carrier and the nonparticipating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the nonparticipating facility-based provider's charges for the out-of-network service(s).

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

(h) The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

(i) *Enforcement.* -- The Consumer Protection Division within the Office of the Attorney General and the Office of the Insurance Commission shall be responsible for enforcement of the requirements of this section.

(j) *Applicability.* --

(1) The provisions of this section do not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by §33-47-2 of this code, vision care, or any other limited supplemental benefit or to a Medicare supplement policy

of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in §33-53-3(c) of this code.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

§33-53-6. Disclosure and Notice Requirements.

(a)(1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of precertification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a nonparticipating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available

to access covered services from a participating provider.

(b) For nonemergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the carrier within 10 days of an appointment for in-patient or outpatient services at the facility or at the time of a nonemergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist, or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

§33-53-7. Provider directories.

(a)(1)(A) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in subsection (b) of this section.

(B) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)(A) The health carrier shall update each network plan provider directory at least monthly.

(B) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection (b) of this section upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(A) In plain language, a description of the criteria the carrier has used to build its provider network;

(B) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(C) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example by name, symbols, or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(D) If applicable, note that authorization or referral may be required to access some providers.

(5)(A) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(B) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to subsections (b), (c), and (d) of this section in a provider directory pertaining to a health care professional, a hospital, or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(A) Name;

(B) Gender;

(C) Participating office location(s);

(D) Specialty, if applicable;

(E) Medical group affiliations, if applicable;

(F) Facility affiliations, if applicable;

(G) Participating facility affiliations, if applicable;

(H) Languages spoken other than English, if applicable; and

(I) Whether accepting new patients.

(2) For hospitals:

(A) Hospital name;

(B) Hospital type (i.e. acute, rehabilitation, children's, cancer);

(C) Participating hospital location;

(D) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility location(s).

(c) For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under subsection (b) of this section:

(1) For health care professionals:

(A) Contact information;

(B) Board certification(s); and

(C) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

(d)(1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(A) For health care professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, *i.e.* acute, rehabilitation, children's, cancer; and

(iii) Participating hospital location and telephone number; and

(C) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in subdivision (1) of this subsection included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.

§33-53-8. Intermediaries.

A contract between a health carrier and an intermediary shall satisfy all the requirements

contained in this section.

(a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of §33-53-4 of this code.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons may not be delegated or assigned to the intermediary.

(c) A health carrier has the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days prior written notice from the health carrier.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for two years in a manner that facilitates regulatory review.

(g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this article.

(h) A health carrier has the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier remains obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

(i) Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this article.

§33-53-9. Filing requirements and state administration.

(a) At the time a health carrier files its access plan, the health carrier shall file for approval with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

(b) A health carrier shall submit material changes to a contract that would affect a provision required under this article or implementing regulations to the commissioner for approval at least 30 days prior to use.

(c). The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon 20 days prior written notice from the commissioner.

§33-53-10. Contracting.

(a) The execution of a contract by a health carrier does not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

(b) All contracts shall be in writing and subject to review.

(c) All contracts shall comply with applicable requirements of the law and applicable regulations.

§33-53-11. Enforcement.

(a) If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this article, or that a health carrier has not complied with a provision of this

Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this article.

(b) The commissioner will not act to arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries, or one or more providers arising under or by reason of a provider contract or its termination.

§33-53-12. Rule-making.

The commissioner shall propose for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code to implement the provisions of this article.

§33-53-13. Penalties

A violation of this article shall be penalized in accordance with §33-4-8 of this code.

NOTE: The purpose of this bill is to create and implement the Health Benefit Network Access and Adequacy Act.

Strike-throughs indicate language that would be stricken from a heading or the present law, and underscoring indicates new language that would be added.