

**NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)  
 Healthcare Balance Billing Disclosure Model Act**

*Adopted by the NCOIL Executive Committee on March 6, 2011, and by the Health, Long-Term Care & Health Retirement Issues Committee on March 5, 2011.*

*Sponsored for discussion by Sen. Ann Cummings (VT) and Rep. Charles Kleckley (LA)*

<b>Table of Contents</b>		<b>Page Numbers</b>
Section 1.	Purpose	(1)
Section 2.	Definitions	(1-2)
Section 3.	Applicability	(2-3)
Section 4.	Facility Disclosure Requirements	(3-4)
Section 5.	Facility-Based Provider Disclosure Requirements	(4)
Section 6.	Health Benefit Plan Disclosure Requirements	(4-6)
Section 7.	Penalties	(6)
Section 8.	Severability	(6)
Section 9.	Effective Date	(6)

**Section 1. Purpose**

The purpose of this Act is to provide transparency, accountability, and disclosure by healthcare facilities, facility-based providers, and health benefit plans regarding billing practices, notice of network benefits, and financial responsibilities in the delivery of non-emergency medical care.

**Section 2. Definitions**

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

*Drafting Note: States should review their regulation of billing and payment practices for network and non-network providers.*

B. "Enrollee" means an individual who is eligible to receive non-emergency medical care through a health benefit plan.

C. "Emergency medical care" includes any healthcare services provided in a healthcare 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. "Facility-based provider" means an individual or group of healthcare providers:
1. to whom the facility has granted clinical privileges; and
  2. who provides services to patients treated at the facility under those clinical privileges.
- E. "Healthcare facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing non-emergency medical care, which is licensed by *[Insert State Department of Health Services]*.
- F. "Healthcare provider" means an individual who is licensed to provide and provides non-emergency medical care.
- G. "Provider network" means all of the physicians and health care providers 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 that issues a health benefit plan, including an insurance company.

**Section 3. Applicability**

- A. This Act applies to any health benefit plan that:
1. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
    - (a) an insurance company;
    - (b) a group hospital service corporation operating under *[Insert Applicable State Statute]*;
    - (c) a fraternal benefit society operating under *[Insert Applicable State Statute]*;
    - (d) a stipulated premium company operating under *[Insert Applicable State Statute]*;
    - (e) a health maintenance organization operating under *[Insert Applicable State Statute]*;
    - (f) a multiple employer welfare arrangement that holds a certificate of authority under *[Insert Applicable State Statute]*;
    - (g) an approved nonprofit health corporation that holds a certificate of authority under *[Insert Applicable State Statute]*; or
    - (h) an entity not authorized under this code or another insurance law of this state that contracts directly for non-emergency medical care on a risk-sharing basis, including a capitation basis;  
or
  2. provides health and accident coverage through a risk pool created under *[Insert Applicable State Statute]*.
- B. This Act applies to a person to whom a health benefit plan contracts to:

1. process or pay claims;
  2. obtain the services of physicians or other providers to provide non-emergency medical care to enrollees; or
  3. issue verifications or preauthorizations.
- C. The Act applies to all healthcare facilities and facility-based providers that are providing medical care to patients, except for those providing care in Section 3(D).
- D. 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. emergency medical care as defined under Subsection 2(C) of this Act;
  6. care as provided in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA); or
  7. “excepted benefit” products as defined under 42 U.S.C. 300gg-91(c).

**Section 4. Facility Disclosure**

- A. Each healthcare facility shall develop, implement, and enforce written policies for the billing of non-emergency medical care. The policies must address:
1. the providing of a conspicuous written disclosure to a consumer at the time the consumer is first treated on a non-emergency basis at the facility, at pre-admission, or first receives non-emergency or post-stabilization services at the facility that:
    - (a) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; and
    - (b) informs consumers that if a facility-based provider who provides services to the consumer while the consumer is in the facility is not a participating provider with the same third-party payors as the facility, then the consumer may be billed for medical services for the amount unpaid by the consumer's health benefit plan.
  2. the requirement that a facility provide a list, on request, to a consumer to be admitted to or who is expected to receive services from the facility, that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility; and
  3. if the facility operates a website that includes a listing of physicians who have been granted medical staff privileges to provide medical services at the facility, the posting on the facility's

website of a list that contains the name and contact information for each facility-based provider or facility-based provider group that has been granted medical staff privileges to provide medical services at the facility and the updating of the list in any calendar quarter in which there are any changes to the list.

#### **Section 5. Facility-Based Provider Disclosure**

- A. If a facility-based provider bills a patient treated at the facility for non-emergency medical care who is covered by a health benefit plan described in Section 3 that does not have a contract with the facility-based provider, requesting payment on the balance of the provider's charge that is not related to co-pays, coinsurance payments, or deductible payments and is not covered by the health benefits plan, the facility-based provider shall send a billing statement that:
1. contains an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;
  2. contains a conspicuous, plain-language explanation that:
    - (a) the facility-based provider is not within the health plan provider network; and
    - (b) the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider billed amount;
  3. contains 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. contains a statement that the patient may call to discuss alternative payment arrangements;
  5. contains a notice that the patient may file complaints with the *[Insert State Medical Board]* and includes the *[Insert State Medical Board]* mailing address and complaint telephone number; and
  6. for billing statements that total an amount greater than \$200, over any applicable copayments or deductibles, states, in plain language, that if the patient finalizes a payment plan agreement within 30 days of receiving the first billing statement that includes all insurance payments and reflects the final amount owed by the enrollee or six months after the receipt of medical treatment, whichever occurs first and substantially complies with the agreement, the facility-based provider may not furnish adverse information to a consumer reporting agency regarding an amount owed by the patient for the receipt of medical treatment.
- B. A patient may be considered by the facility-based 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.

*Drafting Note: States may wish to consider using an existing mediation process or establishing a mediation process to manage disputes that may arise regarding balance bills.*

#### **Section 6. Health Benefit Plan Disclosure**

- A. Each health benefit plan that reimburses healthcare through a provider network shall provide notice to its enrollees that:
1. a facility-based provider or other healthcare provider may not be included in the health benefit plan's provider network; and

2. a healthcare provider described by Section 6A(1) may balance bill the enrollee for amounts not paid by the health benefit plan.

B. 1. The health benefit plan shall provide the disclosure in writing to each enrollee:

- (a) in any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;
- (b) in an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and
- (c) conspicuously displayed on any health benefit plan website that an enrollee is reasonably expected to access.

2. The commissioner by rule may prescribe specific requirements for the disclosure required under B(1). The form of the disclosure must be substantially as follows:

NOTICE: "IF YOU HAVE RECEIVED NON-EMERGENCY MEDICAL CARE IN A FACILITY THAT IS IN YOUR HEALTH PLAN'S NETWORK, BUT THE CARE IS DELIVERED BY A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO IS NOT IN THAT NETWORK, YOU MAY BE RESPONSIBLE FOR PAYING SOME OR ALL OF THAT PHYSICIAN'S OR PROVIDER'S FEE THAT IS NOT COVERED BY YOUR HEALTH INSURANCE."

C. A health benefit plan must clearly identify healthcare facility-based providers who participate in the health benefit plan's provider network. Facility-based providers identified under this subsection must be identified in a separate and conspicuous manner in any provider network directory or website directory.

*Drafting note: States may wish to consider amending their health plan network adequacy statutes to require that plans contract with an adequate number of facility-based providers at each in-network health care facility to serve their enrollees.*

D. Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the department's consumer protection division for complaints regarding payment.

E. A health benefit plan shall provide to an insured by electronic or written correspondence, upon request for a healthcare service or supply but no later than 48 hours after pre-certification, information on:

1. whether a facility-based provider or other healthcare provider is a participating provider in the insurer's preferred provider network;
2. whether proposed non-emergency medical care is covered by the health insurance policy;
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 7. Penalties**

- A. The commissioner may take disciplinary action against a health benefit plan issuer that violates this Act, in accordance with *[Insert Applicable State Statute]*.
- B. A violation of this Act by a facility or a facility-based provider is grounds for disciplinary action and imposition of an administrative penalty by the *[Insert State Medical Board or Appropriate State Authority]*.

*Drafting Note: States should review administrative laws to ensure that appropriate notice, opportunity to cure, and other relevant administrative law provisions that may be applicable are appropriately incorporated into this model.*

**Section 8. Severability**

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

**Section 9. Effective Date**

This Act shall take effect on *[insert months]* following enactment of the bill.