

HJR 20 Study: *Considerations Related to NAIC Surprise Bill Provisions*

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Background

In 2015, the National Association of Insurance Commissioners (NAIC) updated its model legislation setting standards for adequacy of health insurer provider networks. Montana adopted an earlier version of the model law in 1997.

The new NAIC legislation includes two sections specific to billing for health care services provided at an in-network facility by a provider who is outside of the network.

This briefing paper discusses the key provisions of those sections of the NAIC model and poses questions the subcommittee may want to consider if it decides to recommend that Montana adopt similar legislation to prevent so-called "surprise medical bills."

Key Elements of NAIC's Surprise Bill Provisions

The table below summarizes the key provisions of each relevant section of the model legislation.

Section 7	Participating Facilities With Nonparticipating Providers
A: Definitions	<ul style="list-style-type: none"> • Defines facility-based provider
B: Non-Emergency Out-of-Network Services	<ul style="list-style-type: none"> • Participating facility must provide a written disclosure that some services may be out of network and provide a range of costs for those services • Statement must be provided to a person at the time a procedure is scheduled or prior authorization is sought or when a person is admitted to the facility
C: Out-of-Network Emergency Services	<ul style="list-style-type: none"> • Non-participating facility-based provider (NPFBP) must include on any billing notice a statement that the person is responsible for in-network cost-sharing payments but may not be balance billed • Statement must tell patient to forward bill to insurer for consideration of mediation if billed charge exceeds the allowed charge by more than \$500 • Patient may agree to pay the balance and avoid triggering the mediation process
D: Limitation on Balance Billing Covered Persons	<ul style="list-style-type: none"> • NPFBP must send a Patient Responsibility Notice when sending a bill to a covered person • Notice must state that the patient owes the in-network cost-sharing amount and may either pay the balance of the bill, send the bill to the insurer if the balance exceeds \$500, or seek other remedies under the law • NPFBPs may not try to collect payment if the mediation process is triggered

Section 7	Participating Facilities With Nonparticipating Providers
E: Health Care Out-of-Network Facility Based Payments	<ul style="list-style-type: none"> • Insurers may choose to pay an NPFBP bill as submitted or according to a benchmark payment • If the NPFBP objects to the benchmark payment, the provider may elect to go to the mediation process • Insurer and NPFBP may come to a different payment arrangement outside of the mediation process, if desired
F: Benchmark for NPFBP Payments	<ul style="list-style-type: none"> • Payments to NPFBPs are presumed reasonable if they reflect either the higher of the insurer's contracted rate or a specified percentage of the Medicare payment for the same service
G: Provider Mediation Process	<ul style="list-style-type: none"> • Insurers must establish a mediation process for resolving billing disputes with NPFBPs, using one of five possible options • Provider and insurer must split the costs of mediation evenly • Insurer must maintain a record of mediations
H: Rights and Remedies	<ul style="list-style-type: none"> • Requirements of this law do not prevent providers or individuals from seeking other remedies allowed by law
I: Enforcement	<ul style="list-style-type: none"> • A designated state agency or agencies must enforce the law
K: Regulations	<ul style="list-style-type: none"> • Specified state agencies may make rules to carry out the provisions of the law
Section 8	Disclosure and Notice Requirements
	<ul style="list-style-type: none"> • Insurers must develop a written disclosure to be provided at the time of precertification for services at a facility in the plan's network if it's possible the person may be treated by a NPFBP • Disclosure must state that the person may be subject to higher cost-sharing and balance billing if a NPFBP provides care, that information on potential costs is available on request, and that the insurer will provide options for accessing services from a participating provider • Facilities must develop a written disclosure for nonemergency services and provide it within 10 days of an appointment to confirm that the facility is a participating provider and inform the person that an NPFBP may also be providing services.

NAIC Definitions of Terms Used in Sections 7 and 8

Sections 7 and 8 of the model legislation use several terms that are defined elsewhere in the NAIC model bill. Those terms and their NAIC definitions are as follows:

- **Authorized agent:** a person to whom a covered person has given express written consent to represent the covered person; a person authorized by law to provide substituted consent for a covered person; or 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:** the practice of a provider billing for the difference between the provider's charge and the health carrier's allowed amount.
- **Emergency medical condition:** 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: placing the individual's physical, mental or behavioral health or with respect to a pregnant woman, the woman's or her [fetus'] [unborn child's] health in serious jeopardy; serious impairment to a bodily function; serious impairment of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer to another hospital may pose a threat to the health or safety of the woman or [fetus][unborn child].
- **Emergency services:** with respect to an emergency condition, as defined above, 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 any further medical or mental health examination and treatment to the extent that they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.
- **Facility:** an institution providing [physical, mental or behavioral] 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:** a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.
- **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 carrier:** 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.
- **Participating provider:** A provider who, under a contract with the health carrier or 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.

Subcommittee Decision Points

If the subcommittee decides to recommend that the Children, Families, Health, and Human Services Interim Committee introduce legislation containing the NAIC surprise bill provisions, members may want to refine their recommendation by answering the following questions.

1. Should all provisions of the model legislation be included in the bill?
 - a. If not, which provisions should be removed?
2. Should any of the definitions used in the model bill be changed?
 - a. If so, which definitions should be changed and in what manner?
3. The requirement that NPFBSs may not balance bill for out-of-network emergency services conflicts with 33-32-215, MCA. Does the committee want to include this prohibition on balance billing? If so, the existing statute will need to be revised or repealed.
4. If the balance billing prohibition for emergency services is kept in the bill, should the mediation process be triggered when the difference between the billed and the allowable charge is \$500, as suggested in the model bill, or at a different dollar amount?
5. What percentage of the Medicare rate should be used as a benchmark for NPFBS payments? (Subsection F, Section 7)
6. Which agencies should have enforcement responsibilities? (Subsection I, Section 7)
7. Should there be penalties in statute for noncompliance or should those be set by the agencies by rule?
8. Should the written disclosure notice apply to both insurers and facilities? (Section 8)
 - a. Should the 10-day notice requirement for a provider be shortened, lengthened, or left as is?