Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 3370A, and 3571S (18 **Del.C.** §§3370A & 3571S)

PROPOSED

PUBLIC NOTICE

1317 Network Disclosure and Transparency

INSURANCE COMMISSIONER KAREN WELDIN STEWART hereby gives notice of proposed Department of Insurance Regulation 1317 relating to Network Disclosure and Transparency. The docket number for this proposed regulation is 3252.

The proposed regulation establishes the standards for the form and content of network disclosures that are required to be made by out-of-network providers and the written consent that must be obtained by such a provider prior to balance billing an insured. The proposed regulation also requires health insurers to maintain and publish accurate, complete and up-to-date provider directories and to make those directories easily accessible to covered persons. The Delaware Code authority for this proposed regulation is 18 **Del.C.** §§3370A and 3571S; and 29 **Del.C.** Ch. 101.

Proposed Regulation 1317 was initially published in the Delaware *Register of Regulations* on September 1, 2016. Following the initial publication, the Department has changed the Delaware Code references for §3371 to §3370A; modified Section 1.0 and subsections 3.1, 3.4, 4.1, 4.3, and 6.3; inserted a new Section 5.0; renumbered original Sections 5.0, 6.0, 7.0, and 8.0; modified Appendix 1, paragraph 6; and added a new Appendix 2, in response to certain comments received, and is re-publishing the proposed Regulation 1317 on December 1, 2016, as modified.

The Department of Insurance does not plan to hold a public hearing on the proposed regulation. The proposed regulation appears below and can also be viewed at the Delaware Insurance Commissioner's website at http://www.delawareinsurance.gov/departments/documents/ProposedRegs/.

Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed regulation. Any written submission in response to this notice and relevant to the proposed regulation must be received by the Department of Insurance no later than 4:30 p.m. EST, Tuesday, January 3, 2017. Any such requests should be directed to:

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1317 Network Disclosure and Transparency

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 **Del.C.** §§3370A and 3571S, which require (1) health insurers to maintain accurate and complete provider directories, to update provider directories frequently, to audit the accuracy and completeness of such directories and make the directories easily accessible to covered persons in a variety of formats, and (2) facility-based providers and non-network providers to provide timely written out-of-network disclosures to patients that fully inform such patients of the potential that out-of-network providers may be rendering care and the associated costs thereof. This Regulation is promulgated pursuant to 18 **Del.C.** §§3370A and 3571S; and 29 **Del.C.** Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

1.2 Consistent with 18 **Del.C.** §§3370A and 3571S, this regulation applies to every policy or contract of health insurance which is delivered or issued for delivery in this State, including each policy or contract issued by a health-service corporation, which provides medical, major medical, or similar comprehensive-type coverage, and which designates network physicians or providers (hereinafter referred to collectively as "network providers"). However, this regulation applies only to items, services or conditions for which coverage is provided by those policies or contracts (hereinafter referred to as "covered services").

2.0 Definitions

"**Facility-based provider**" means a provider who provides health care services to covered persons who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

"**Health care provider**" means any provider who provides health care services to covered person who are not in a facility-based setting, and includes a provider who provides health care services to a covered person based upon a referral from another provider without the knowledge of or input from the covered person.

3.0 Network Disclosure Requirements by Facility-Based Providers

3.1 When a facility-based provider schedules a procedure, seeks prior authorization from a health insurer for the provision of non-emergency covered services to a covered person, or prior to the provision of any non-emergency covered services, the facility shall ensure that the covered person has received a timely, written out-of-network disclosure required by 18 **Del.C.** §§3370A or 3571S, as applicable, in the form attached hereto as Appendix 1 (the "facility-based provider disclosure"). The provision of the facility-based provider disclosure shall be considered timely if it is provided to the covered person within (3) business days after such procedure is scheduled if the medical necessity of a procedure allows such time, and if not, in as timely a manner as possible.

3.2 The facility-based provider shall, prior to the provision of services, obtain from the covered person a signed copy of the written consent form included with the facility-based provider disclosure. A copy of the completed form, including the signed written consent, should be given to the covered person, and the original placed in his or her medical file.

3.3 The facility-based provider disclosure shall not be required if the facility and all facility-based providers participate in the covered person's network.

3.4 If a covered person requests from an out-of-network provider an estimate of the range of charges for any out-of-network services for which the covered person may be responsible, the out-of-network provider shall provide the estimate in writing to the covered person within three business days of the request if the medical necessity of a procedure allows such time, and if not, in as timely a manner as possible. Failure to provide such estimate within the required timeframe shall be considered a failure to comply with the disclosure requirements set forth in this Section 3.0 and shall result in the balance billing prohibition set forth in Section 6.0.

4.0 Network Disclosure Requirements by Health Care Providers

4.1 Prior to the provision of any non-emergency covered services, the health care provider shall ensure that the covered person has received a timely, written out-of-network disclosure required by 18 **Del.C.** §§3370A or 3571S, as applicable, in the form attached hereto as Appendix 2 (the "health care provider disclosure"). The provision of the health care provider disclosure shall be considered timely if it is provided to the covered person within three (3) business days after the services are scheduled if the medical necessity of a procedure allows such time, and if not, in as timely a manner as possible.

4.2 The health care provider shall, prior to the provision of services, obtain from the covered person a signed copy of the written consent form included with the health care provider disclosure. A copy of the completed form, including the signed written consent, should be given to the covered person, and the original placed in his or her medical file.

5.0 Laboratory Services

When a facility-based provider or a health care provider requests a laboratory service for a covered person that does not require an in-person visit, that provider must provide disclosure to the covered person if the facility being utilized is an out-of-network facility. If the requesting provider does not provide the required disclosure to the covered person, the covered person shall not be subject to any balance billing of the out-of-network service(s). If the laboratory service being requested requires an in-person visit, the laboratory must provide the covered person written disclosure of the out-of-network service(s) and a consent form prior to rendering any service(s). If the laboratory does not provide the required disclosure to the covered person, the covered person shall not be subject to any balance billing.

6.0 Balance Billing Prohibition

6.1 A facility-based provider may not balance bill a covered person for health care services not covered by an insured's health insurance contract if the facility-based provider fails to provide the facility-based provider disclosure or fails to obtain the signed copy of the written consent form included with the facility-based provider disclosure prior to rendering services.

6.2 A health care provider may not balance bill a covered person for health care services not covered by an insured's health insurance contract if the health care provider fails to provide the health care provider

disclosure or fails to obtain the signed copy of the written consent form included with the health care provider disclosure prior to rendering services.

7.0 Provider Directory Requirements

7.1 Network provider directories shall be updated pursuant to the requirements set forth in this section. 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.

7.2 An insurer shall post its current network provider directory or directories on its internet website and inform its covered persons of the availably of the network provider directory or directories through its coverage materials. The information provided on the website shall be updated weekly. All network provider directories shall be available online to both covered persons and consumers shopping for coverage without requirements to log on or enter a password or a policy number.

7.3 An insurer shall allow insureds, potential insureds, providers, and members of the public to request a printed copy of the online network provider directory or directories by contacting the insurer through the insurer's toll free telephone number, electronically, or in writing. The availability of such printed materials must be posted on the insurer's website and noticed in its coverage materials.

7.4 All provider directories shall identify providers who are currently accepting new patients.

7.5 An insurer must process any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under this regulation unless the insurer notified the covered person of the network change prior to the service being provided. This paragraph does not apply if the insurer is able to verify that the insurer's website displayed the correct provider network status at the time the service was provided.

7.6 An insurer shall make it clear in both its electronic and print directories which provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State.

7.7 Insurers shall include in both their 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 insurer of inaccurate provider directory information.

7.8 Insurer shall, either in its provider directory or other coverage materials, inform covered persons in writing of their right not to be balanced billed by a non-network provider if the non-network provider or the facility-based provider employing non-network facility-based providers fails to provide the covered person with the network disclosures required by this regulation.

8.0 Computation of Time

In computing any period of time prescribed or allowed by this Regulation, the day of the act or event after which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday or Sunday, or other legal holiday, or other day on which the Department is closed, in which event the period shall run until the end of the next day on which the Department is open. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and other legal holidays shall be excluded in the computation. As used in this section, "legal holidays" shall be those days provided by statute or appointed by the Governor or the Chief Justice of the State of Delaware.

9.0 Effective Date

This Regulation shall become effective ten days after being published as a final regulation.

__ DE Reg. __ (__/__/2017)

APPENDIX 1 – FORM OF FACILITY-BASED PROVIDER DISCLOSURE

Network Disclosure Statement for [Insert Facility Name]

PLEASE RETURN THIS FORM TO [INSERT FACILITY NAME] ON OR PRIOR TO YOUR DATE OF SERVICE

This Facility-Based Provider Disclosure is designed to help ensure that patients receiving medical care from [Insert Facility

Name] or any of its facility-based providers have the necessary information to make an informed decision about their medical benefits and care. “Facility-based provider” means a provider who provides health care services to covered persons who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

In connection with your upcoming scheduled appointment, [Insert Facility Name] hereby provides the following disclosures:

1. [Insert Facility Name] [is/is not] a participating provider with your current health insurer.

2. Certain facility-based providers may be called upon to render care to you during the course of treatment.

3. Those facility-based providers may not have a contract with your health insurer and are therefore considered to be out-of-network.

4. Services that are provided by an out-of-network provider will be provided on an out-of-network basis, **which may result in additional charges for which you may be responsible.** These charges are in addition to any coinsurance, deductibles and copayments applicable under your health insurance policy.

5. The following is a list of those facility-based providers that may be called upon to render care to you during the course of treatment. You should contact your health insurer to determine the network status of these facility-based providers:

    a. [Include list of relevant facility-based providers, including contact information]

6. An estimate of the range of charges charged by an out-of-network provider for any out-of-network services for which you may be responsible may be requested from, and will be timely provided by, the out-of-network provider. The provision of the facility-based provider disclosure shall be considered timely if it is provided to the covered person within three (3) business days after such procedure is scheduled if the medical necessity of a procedure allows such time, and if not, in as timely a manner as possible.

7. You may contact your health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

8. A facility-based provider may not balance bill you for health care services not covered by your insurance policy if the facility-based provider fails to provide you with a copy of this Facility-Based Provider Disclosure and obtain your below-printed consent prior to rendering any services.

PATIENT ACKNOWLEDGEMENT/CONSENT

I hereby acknowledge that a provider rendering services to me may be an out-of-network provider and that the services provided by that out-of-network provider may not be covered by my insurance policy. I further acknowledge that I have been informed of my right to request from the out-of-network providers an estimate of the range of charges for any out-of-network services for which I may be responsible. **I AFFIRMATIVELY ELECT TO OBTAIN THE SERVICES AND AGREE TO ACCEPT AND PAY THE CHARGES FOR THE OUT-OF-NETWORK SERVICES NOT COVERED BY MY INSURANCE POLICY.**

Name of Patient: _____
Signature of Patient or Authorized Representative: _____
Date: _____

APPENDIX 2 – FORM OF HEALTH CARE PROVIDER DISCLOSURE

Network Disclosure Statement for [Health Care Provider]

PLEASE RETURN THIS FORM TO [HEALTH CARE PROVIDER] ON OR PRIOR TO YOUR DATE OF SERVICE

This Health Care Provider Disclosure is designed to help ensure that patients receiving medical care from [Insert Health Care Provider Name] have the necessary information to make an informed decision about their medical benefits and care. "Health care provider" means any provider who provides health care services to covered person who are not in a facility-based setting, and includes a provider who provides health care services to a covered person based upon a referral from another provider without the knowledge of or input from the covered person.

In connection with your upcoming scheduled appointment, [Insert Health Care Provider Name] hereby provides the following disclosures:

1. [Insert Health Care Provider Name] is not a participating provider with your current health insurer and, therefore, the services provided to you will be provided on an out-of-network basis.

2. **Services provided on an out-of-network basis may result in additional charges for which you may be responsible.** These charges are in addition to any coinsurance, deductibles and copayments applicable under your health insurance policy.

3. The following is a list of the range of charges charged by [Insert Health Care Provider Name] for any out-of-network services for which you may be responsible:

    a. [Insert List of Range of Charges]

4. You may contact your health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

5. [Insert Health Care Provider Name] may not balance bill you for health care services not covered by your insurance policy if [Insert Health Care Provider Name] fails to provide you with a copy of this Health Care Provider Disclosure and obtain your below-printed consent prior to rendering any services.

PATIENT ACKNOWLEDGEMENT/CONSENT

I hereby acknowledge that [Insert Health Care Provider Name] may be an out-of-network provider and that the services provided by [Insert Health Care Provider Name] may not be covered by my insurance policy. I further acknowledge receipt of the range of charges for any out-of-network services for which I may be responsible. **I AFFIRMATIVELY ELECT TO OBTAIN THE SERVICES AND AGREE TO ACCEPT AND PAY THE CHARGES FOR THE OUT-OF-NETWORK SERVICES NOT COVERED BY MY INSURANCE POLICY.**

Name of Patient: _____
Signature of Patient or Authorized Representative: _____
Date: _____