# DEPARTMENT OF INSURANCE

## OFFICE OF THE COMMISSIONER

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

## FINAL

**ORDER**
**Docket No. 3252-2016**

**1317 Network Disclosure and Transparency**

Proposed Regulation 1317 relating to Network Disclosure and Transparency was initially published in the Delaware *Register of Regulations* on September 1, 2016, and re-published on December 1, 2016. The initial comment period remained open until October 3, 2016, and the second comment period remained opened until January 3, 2017. There was no public hearing on proposed Regulation 1317. Public notices of the proposed Regulation 1317 were published in the *Register of Regulations* in conformity with Delaware law.

**SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED**

Comments were received on the proposed Regulation 1317 after the initial publication on September 1, 2016 from:

- Delaware Department of Justice, Consumer Protection Unit - Christian Douglas Wright, Director
- Quest Diagnostics, Incorporated - Deirdre Flannery, Director of Government Affairs
- America's Health Insurance Plans (AHIP) - Joshua Keepes, J.D., Regional Director

Following the initial publication of proposed Regulation 1317 on September 1, 2016, the Department 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 of the comments, and re-published the proposed Regulation 1317 on December 1, 2016, as modified.

Comments were received on the proposed Regulation 1317 after the second publication on December 1, 2016 from:

- The Delaware Healthcare Association ("DHA")- Wayne A. Smith, President & CEO

DHA requested changes to Sections 3.1 and 4.1 of proposed Regulation 1317 to change the timing of the provision of the out-of-network disclosures to within five business days preceding the performance of the procedure. The Department has determined not to accept this proposed change, as the language currently reflected in Regulation 1317 provides consumers with the benefit of the additional time to review and consider any cost information related to a scheduled procedure. The current language in the Regulation 1317 allows a provider to provide an additional out-of-network disclosure at a later date if the insurance status of the covered person has changed. DHA also proposed adding language to the end of these two sections to give providers the authority to determine whether a particular encounter should be treated as an emergency. The Department has determined to reject this proposal. The authority to determine what constitutes an emergency was not expressly provided for in the statute and there are other provisions in the Insurance Code that define what constitutes an "emergency medical condition."

DHA requested changes to Section 5.0 to expand the provision to all diagnostic services. The Department has determined to reject this proposal. The Department has recognized the unique nature of laboratory services and the necessity to highlight the procedure for laboratory services that do not require an in-person visit to that laboratory (for instance, when labs or cultures are drawn at the health care provider's office and sent to the laboratory for processing). Other diagnostic services that are incidental to an in-patient or ambulatory surgery visit are contemplated in the disclosures required under Sections 3.1 and 4.1 of Regulation 1317.

DHA requested a revision to Appendices 1 and 2 to clearly state that a parent or guardian is the signature for a child. The Department has added a "Relationship to Patient" line on these Appendices in response to that comment. I have determined these changes to be non-substantive and, therefore, no further re-proposal of the regulation is required.

DHA requested that Appendices 1 and 2 be revised so that they are appropriate for a wider range of reading levels. The Department has determined to reject this proposal. The language in the Appendices mirrors the language of the statutes pursuant to which Regulation 1317 is promulgated.

DHA requested that Appendix 1, paragraph 6 be revised because it joins separate time periods for the provision of the out-of-network disclosures and the provider responsibility to provide an estimate of charges. The Department has revised Appendix 1, paragraph 6 to correct a typographical error. The language in that paragraph was intended to define the timeliness of an out-of-network provider providing an estimate of the range of charges a covered person might incur as set forth in Section 3.4 of Regulation 1317. I have determined these changes to be non-substantive and, therefore, no further

re-proposal of the regulation is required.

DHA requested clarity as to whether the out-of-network disclosure/consent could be provided verbally with signed documentation provided by the patient at the time of admission. The Department has determined that such a clarification within the regulation is not necessary. The express language of 18 **Del.C.** §§3370A and 3571S requires timely written notice. Initially providing these disclosures verbally would not satisfy the requirements of the law.

The Department has determined that no further modifications will be made to the proposed Regulation 1317.

## FINDINGS OF FACT

Based on Delaware law and the record in this docket, I make the following findings of fact:

1. 18 **Del.C.** §§3370A and 3571S require a regulation to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the Code.
2. The requirements of proposed Regulation 1317 best serve the interests of the public and of insurers and comply with Delaware law.

## DECISION AND EFFECTIVE DATE

Based on the provisions of 18 **Del.C.** §§3370A and 3571S; and 29 **Del.C.** Ch. 101, and the record in this docket, I hereby adopt proposed Regulation 1317 as may more fully and at large appear in the version attached hereto to be effective 10 days after being published as final.

## TEXT AND CITATION

The text of proposed Regulation 1317 last appeared in the *Register of Regulations* Vol. 20, Issue 6, pages 420-421.

IT IS SO ORDERED this 17th day of January 2017.

Trinidad Navarro
Insurance Commissioner

## 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~~ estimate of range of charges]** shall be considered timely if it is provided to the covered person within three (3) business days **[~~after such procedure is scheduled~~ of such request]** 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.

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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: _____
**[Relationship to Patient: _____]**
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.

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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: _____
**[Relationship to Patient: _____]**
Date: _____