



IN THE GENERAL ASSEMBLY STATE OF _____

“Truth in Out of Network Healthcare Benefits Act”

1 Be it enacted by the People of the State of _____, represented in the General
2 Assembly:

3
4 **Section I. Title.** This Act shall be known and may be cited as the “Truth in Out of
5 Network Healthcare Benefits.”

6
7 **Section II. Purpose.** The Legislature hereby finds and declares that:

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9 (a) 70 percent of privately insured Americans choose more expensive health insurance
10 coverage that offers access to both in-network and out-of-network physicians.¹
11 Consumers typically pay more for the right to have the health insurer cover a portion
12 of the cost of accessing an out-of network physician because the choice of physician
13 is such a critical decision. Unfortunately, consumers have not always received the
14 benefit of higher premiums that they have been charged for insurance products
15 offering out-of-network coverage;

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17 (b) Health insurers have traditionally defined the out-of-network benefit as a stated
18 percentage of the “usual, customary and reasonable (UCR) charge” for health care
19 services provided by an out-of-network physician or other health care provider.

20 While health insurers have in recent years used various iterations of this language,

¹ 2008 Kaiser/HRET Employer Health Benefits Survey
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1 the words “usual charge,” “customary charge,” and “reasonable charge” commonly
2 have the meanings given to them under Section II of this Act. Because physicians
3 generally bill at a rate which is typical for their specialty, consumers purchasing
4 health insurance coverage with an out-of-network benefit have reasonably expected
5 their health insurance to cover the percentage of the out-of-network bill promised in
6 the health insurance policy;

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8 (c) Recent events have shown that the health insurance industry has manipulated UCR
9 criteria to underpay amounts due out-of-network physicians and unlawfully shift
10 financial responsibility from health insurers to consumers. Numerous health
11 insurers utilize defective databases to pay out-of-network physicians substantially
12 less than the amount physicians would be entitled to receive under properly applied,
13 accurate UCR data;

14

15 (d) As a result of private litigation and investigations by the New York Attorney
16 General Andrew Cuomo, a significant number of health insurers entered into
17 settlements under which they agreed to discontinue utilizing a flawed database to
18 determine UCR, and to pay more than 90 million dollars to finance the creation of a
19 new and accurate database to determine the UCR charges for medical care provided
20 by out-of-network physicians;

21

22 (e) Many health insurers are now replacing “UCR charges” as the basis for calculating
23 out-of-network physician payments with language referencing the Medicare fee
24 schedule or other terminology. These emerging, “non-UCR charge” methods of
25 determining out-of-network physician payment typically give consumers no clear
26 idea of how much of the out-of-network physician’s bill the health insurer will pay,
27 and how much of that bill will remain the subscriber’s financial responsibility; and

1 (f) Consumers must be armed with full knowledge of the facts to make informed
2 decisions concerning the health insurance coverage they purchase and where, and
3 from which providers, they seek health care services. Central to making an
4 informed decision is understanding the amount that an out-of-network physician will
5 charge for providing a medical service. Physicians should, therefore, volunteer fee
6 information to patients and to discuss their out-of-network fees in advance of
7 services. Additionally, only when health insurers clearly disclose the scope and
8 limitations of any out-of-network benefit they purport to provide, in language that is
9 meaningful to the average consumer, will consumers (1) be able to shop intelligently
10 for health insurance, and (2) be assured that the higher premiums they pay to make
11 affordable access to out-of-network physicians reasonably reflect the actuarial value
12 of the out-of-network benefit actually provided.

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14 **Section III. Definitions.**

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16 (a) “Customary charge” means a charge that is within a range of usual fees currently
17 charged by physicians of similar training and experience, for the same service
18 within the same specific and limited geographic area.

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20 (b) “Health Insurer” means any person that offers or administers a health insurance
21 plan.

22

23 (c) “Out-of-network physician charge” means the usual, customary and reasonable
24 charge (UCR charge) a non-contracted physician bills a patient for medical
25 services, as “usual charge,” “customary charge,” and “reasonable charge” are
26 defined in this Section II.

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1 (d) “Reasonable charge” means a charge that is usual and customary, and is justifiable
2 considering the special circumstances of the particular case in question, without
3 regard to payments that have been discounted under governmental or non-
4 governmental health insurance plans or policies.

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6 (e) “Retail charge” means the charge that the physician bills on those claims where the
7 physician is not billing a charge that reflects a payment discounted under
8 governmental or non-governmental health insurance plans or policies.

9
10 (f) “Usual charge” means a charge for a given service that the physician usually
11 charges to his or her private patients.

12
13 **Section IV. Standardized definition of “out-of-network physician charge.”** Any
14 insurer offering health insurance coverage with an out-of-network benefit that calculates
15 payment amounts for services provided by out-of-network physicians using a physician
16 charge-based methodology must do so based on the out-of-network physician charge as
17 “out-of-network physician charge” and “usual charge,” “customary charge,” and
18 “reasonable charge” are defined in Section II of this Act, and may not add or subtract
19 language from those definitions.

20
21 **Section V. Requirements concerning the data on which charge-based methodologies**
22 **to determine payments to out-of-network physicians can be based.**

23
24 (a) Conflict of interest. A health insurer shall not use any person or entity as the
25 source of the database from which payments to out-of-network physicians are
26 calculated if that person or entity owns or controls, or is owned or controlled by, or
27 is an affiliate of, any person or entity with a pecuniary interest in the development
28 or use of the database. The person or entity who is the source of the database must

1 also be granted tax-exempt status by the Internal Revenue Service under 26 U.S.C.
2 § 501(c)(3) of the United States Internal Revenue Code. An insurer, health
3 maintenance organization, medical association, or health care provider shall not be
4 prohibited from nominating an individual to serve on the board of the tax-exempt
5 person or entity, although no such individual may receive compensation from the
6 tax-exempt person or entity beyond reimbursement for reasonable expenses
7 associated with that service.

8
9 (b) **Data integrity.**

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11 i) **Data analytics.** Any health insurer using a charge-based methodology for
12 determining payments to out-of-network physicians must ensure that the
13 database from upon which payments to out-of-network physicians are
14 calculated satisfies the following criteria:

- 15
16 1. The health insurer must calculate an out-of-network physician's charge
17 based on either: (a) 100% of the available retail charge data from all
18 legally separate and distinct physician practices in the relevant
19 geographic area and specialty or subspecialty (if applicable); or (b) data
20 from a random sample of no less than (10) legally separate and distinct
21 physician practices in the relevant geographic area and specialty or
22 subspecialty (if applicable). "Random sample" means that every separate
23 and distinct physician practice within the relevant geographic area and
24 specialty or subspecialty (if applicable) has an equal opportunity to be
25 included in the sample upon which the out-of-network physician's usual,
26 customary, and reasonable charge is calculated;

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2. In determining an out-of-network physician’s charge, the data in the database must consistently account for factors reflecting the physician’s experience and expertise, including but not limited to, the date of the physician’s graduation from medical school, any board certifications held by the physician, any of the physician’s academic appointments, and the site where the physician provides the service;

3. The data in the database cannot include physician charges that reflect payments discounted under governmental or non-governmental health insurance plans; and

4. The data in the database cannot:

- (1) Exclude valid high charges;
- (2) Exclude charges accompanied by modifiers that indicate procedures with complications; and
- (3) Pool data from physicians and nonphysician providers.

ii) Data sources. The health insurer must ensure that the data upon which a charge-based methodology is based is both drawn from a sufficient number and diversity of health insurers and health care providers, and supported by independent research by the person or entity that is the source of the data, to ensure compliance with the requirements of Section V(b)(i) of this Act.

iii) Single database. Regardless of the charge-based methodology used to calculate out-of-network physician payment amounts, all such calculations

1 must be based on a single database that complies with the requirements of this
2 Section V.

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4 iv) Updating. The health insurer is obligated to ensure that the data in the database
5 from which payments to out-of-network physicians are calculated is updated
6 regularly to reflect accurately current physician retail charges. This obligation
7 to update includes, but is not limited to, an obligation to remove data from the
8 database that contains charge information satisfying the earlier of the
9 following: when the charge data is older than three years from the current
10 year, or when the medical expense index applicable to prior charge data is 15
11 percent less than the current year's medical expense index.

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13 v) Audits and certifications. Annually, the health insurer will obtain a
14 certification from an independent auditor certifying that:

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16 1. The data in the database, and the charge-based methodology used to
17 calculate out-of-network physician payments satisfy the requirements of
18 this Act; and

19
20 2. The sources of the data used to create and update the data in the single
21 database from which payments to out-of-network physicians are
22 calculated comply with Section V(b) 1 (b), (d), (e) and (f).

23
24 vi) Approval and statistical analyses by the department.

25
26 1. A health insurer shall not utilize a database or methodology for
27 determining an out-of-network physician's charge unless the Department
28 determines that the health insurer, database and methodology from which

1 payment to out-of-network physicians are calculated satisfy the
2 requirements of Section V of this Act.

- 3
- 4 2. The Department shall annually perform a statistical analysis to ensure
5 that the sample error of the sample size specified in Section V (b) 1 (b) is
6 not greater than 5.5 percent. The Department will perform other
7 appropriate statistical analyses to determine the validity of the
8 methodology described in Section V (b) 1 (b) and to ascertain whether
9 adjustments need to be made to that methodology to ensure that
10 calculations based on that methodology accurately reflect the usual,
11 customary, and reasonable charge of out-of-network physicians.

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13 **Section VI. Restrictions concerning non-charge-based methodologies.** A health
14 insurer shall not utilize a non-charge based methodology for determining the amount of
15 payments due out-of-network physicians unless the Department annually approves the
16 use of that methodology. The Department must on an annual basis approve the use of the
17 non-charge-based methodology.

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19 **Section VII. Disclosure concerning how payment amounts to out-of-network**
20 **physicians are calculated.**

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- 22 (a) Disclosures concerning charge-based methodologies to subscribers and prospective
23 purchasers. A health insurer utilizing a charge-based methodology to calculate
24 payment amounts for services provided by out-of-network physicians must disclose
25 in the summary plan description and to a prospective purchaser of out-of-network
26 coverage the following information:

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- 28 i) The definition of “usual,” “customary,” and “reasonable,” as defined under
29 Section II of this Act;

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- ii) The source of the database from which payment amounts due out-of-network physicians are calculated;
- iii) The name of the entity, if any, from which payments due out-of-network physicians are calculated;
- iv) The Web site address at which a subscriber or prospective purchaser may access the database from which payments due out-of-network physicians are calculated;
- v) A description of how the charge-based methodology is used to calculate amounts due out-of-network physicians, including but not limited to the percentile of UCR-charges that the health insurer will be obligated to pay under the out-of-network benefit; and
- vi) That the payment due pursuant to the out-of-network benefit may be lower than the out-of-network physician’s retail charges, and that the subscriber may be responsible to pay the physician the difference between the physician’s retail charges and the amount that the health insurer is obligated to pay the physician, in addition to any other cost sharing imposed under the subscriber’s benefit plan.

(b) Disclosures concerning non-charge-based methodologies to subscribers and prospective purchasers. A health insurer utilizing a non-charge based methodology to calculate payment amounts for services provided by out-of-network physicians must disclose in the summary plan description and to a prospective purchaser of out-of-network coverage the following information:

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- i) The health insurer’s description of the data source upon which the payment amounts for services provided by out-of-network physicians are calculated;
- ii) The Web site address at which a subscriber or prospective purchaser may access that data source;
- iii) The name of the entity, if any, that the health insurer relies on to calculate the non-charge-based payments due out-of-network physicians;
- iv) The methodology the health insurer uses to calculate payment amounts for services provided by out-of-network physicians using the data source described above, including instructions on how to calculate the amount of the out-of network benefit which will be paid for any physician service using that Web site;
- v) A description of the average percentage of an out-of-network physician’s usual, customary, and reasonable charge the consumer will likely still owe even after the physician receives the out-of-network benefit payment, so that the consumer will understand what his or her payment obligation will likely be as a percentage of usual, customary, and reasonable charges, in addition to any non-charge based description provided to the consumer. The usual, customary, and reasonable charges must be calculated as provided in this Section VII for charge-based methodologies; and
- vi) That the payment due the out-of-network provider by the health insurer may be lower than the out-of-network physician’s retail charges, and that the subscriber may be responsible to pay the physician the difference between

1 the physician's retail charges and the amount that the health insurer is
2 obligated to pay the physician, in addition to any other cost sharing imposed
3 under the subscriber's policy.
4

5 (c) Disclosure of estimated payment. A health insurer must make the following
6 information available to the general public in order to ensure that the subscriber or
7 physician with an objective good faith estimate of: (1) the amount of the out-of-
8 network benefit the health insurer would expect to pay for a particular elective
9 medical service or services provided by the out-of-network physician to the
10 subscriber, and (2) the amount for which the subscriber would still be financially
11 responsible, assuming the health insurer paid the expected benefit amount. The
12 health insurer must permit subscribers and physicians to request these estimates by
13 e-mail or other electronic means. This disclosure must be provided in writing not
14 later than one (1) business day after the health insurer receives the subscriber's or
15 physician's request.
16

17 (d) Required Web site disclosure. A health insurer utilizing either a charge-based or
18 non-charge based methodology to determine payment due an out-of-network
19 physician must establish a Web site that can perform the following functions:
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- 21 i) Allow subscribers, prospective purchasers, and physicians to select medical
22 services by CPT Code, physician specialty, and the zip codes for the areas
23 where the services are sought;
24
- 25 ii) The search result must clearly indicate the UCR charge amount at least the
26 50th, 80th, and 90th percentile in a given geographic area for a physician
27 specialty;
28

- 1 iii) The Web site must advise users of the Web site to refer to applicable benefit
2 plan documents or the respective plan administrator for further information
3 concerning the applicable benefit plan, including, with respect to charge-based
4 out-of-network methodologies the percentile of the UCR that will be applied to
5 determine the applicable out-of-network benefit amount;
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- 7 iv) The search result must also remind users of the Web site that they may be
8 financially responsible for the balance of the out-of-network physician’s retail
9 charges that exceed the amount paid by the health insurer;
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- 11 v) The Web site must describe in a transparent manner the purpose of the website,
12 and its search function; and
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- 14 vi) A description of the average percentage of an out-of-network physician’s
15 charge the user of the Web site will likely still owe even after the physician
16 receives the out-of-network benefit payment, so that the user will understand
17 what the user’s payment obligation will likely be as a percentage of usual,
18 customary, and reasonable charges. The usual, customary, and reasonable
19 charges must be calculated as provided in this Section VII for charge-based
20 methodologies.
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- 22 (e) Manner of disclosures. The disclosure obligations required under A through D of
23 Section VII of this Act must be:
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- 25 i) Made in easily understood language by subscribers and prospective
26 purchasers;
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- 28 ii) Made in a uniform, clearly organized manner;

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iii) Of sufficient detail and comprehensiveness as to provide for full and fair disclosure; and

iv) Updated as necessary to ensure that all disclosures required by this Act remain accurate.

(f) Required annual disclosures to the Department. Health insurers must annually disclose to the Department the information described in Section VII, (a) (1) through (5) and Section VII, (b) (1) through (5).

Section VIII. Physician fee schedule disclosure.

(a) A physician practice must maintain a current schedule of retail fees for the medical services that it typically provides;

(b) Prior to providing elective services to a subscriber, a physician practice that is not contracted with the subscriber’s health insurer must provide the subscriber with a copy of the physician practice’s most current fee schedule as it applies to the elective services that the physician practice expects to furnish to the subscriber; and

(c) A physician practice must disclose to any patient or prospective patient a copy of the practice’s retail fee schedule applicable to at least its one hundred (100) most commonly provided services by CPT code. The practice may make the required disclosure publicly available via hard copy, electronically or via a Web site.

1 **Section IX. Subscriber and physician appeal rights.**

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3 (a) Any subscriber or physician who disagrees with the information disclosed pursuant
4 to Section VII, (a) through (d) of this Act may appeal the health insurer's
5 determination.

6
7 (b) Any subscriber or physician that submits an appeal to the health insurer as provided
8 under this Section IX may request in writing from the health insurer any and all
9 information that was used to determine the information required to be disclosed
10 under Section VII (a) through (d) of this Act. The health insurer is responsible under
11 this Act for ensuring that the subscriber or physician receives the requested
12 information within 2 (two) business days of receiving the written request.

13
14 (c) A health insurer may not prohibit or in any way interfere with a physician's or
15 subscriber's ability to assist one another in making an appeal described in this
16 Section IX.

17
18 **Section X. Actuarial certification.**

19
20 (a) Any health insurer that offers a health insurance product purporting to provide in-
21 network and out-of-network coverage must disclose to the Insurance Commissioner
22 a written certification by an independent, professional actuary stating:

23
24 i) The difference in value for the purchaser between (a) the in-network coverage
25 without the out-of-network coverage, and (b) the in-network and out-of-
26 network coverage combined; and

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1 ii) That the difference between (a) the premium that the purchaser will be
2 charged for in-network coverage without the out-of-network coverage, and (b)
3 the premium that the purchaser will be charged for in-network and out-of-
4 network coverage combined, reasonably reflects the difference in value
5 certified pursuant to Section X (a) (1).

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7 (b) The certifications required by Section X (a) must be made in easily understood
8 language, in a uniform, clearly organized manner, and be of sufficient detail and
9 comprehensiveness as to provide for full and fair disclosure to an average
10 consumer. The difference between the value of the in-network benefit coverage
11 and the combined in-network/out-of-network coverage must be expressed terms of
12 a percentage, although use of a percentage alone will not be sufficient to satisfy the
13 obligations required by this Section X.

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15 (c) The certifications required by this Section X must be made by a professional
16 actuary currently licensed in [*the state in which the insurance product is being*
17 *offered*] and currently certified [*by a nationally-recognized actuarial certification*
18 *organization*] who is not affiliated with the health insurer or any of its subsidiaries.

19
20 (d) The certifications required by this Section X must be updated annually and made
21 readily available to the general public.

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23 **Section XI. Enforcement and remedies.**

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25 (a) Investigation. Where the Department has reason to believe that a health insurer is
26 not compliant with the requirements of this Act, the Department shall:

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- 1 i) Require the health insurer to conduct a statistically valid survey of a sample of
2 physicians approved by the Department, within the same specialty or
3 subspecialty within the same five digit zip code with respect to services
4 identified by the Department using the services' CPT Codes;
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- 6 ii) Require the health insurer to conduct a statistically valid survey of a sample of
7 subscribers who have received services within the prior three months from an
8 out-of-network physician;
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- 10 iii) Interview the health insurer, subscribers, prospective purchasers, and
11 physicians; and
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- 13 iv) Any other requirements that the Department determines is necessary to ensure
14 compliance with the requirements of this Act.
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- 16 (b) Remedies. A violation of this Act constitutes an unfair and deceptive act or
17 practice in the business of insurance. Where the Department has found or it is
18 otherwise determined that a health insurer has failed to meet any of the Act's
19 requirements, the Department shall perform the following:
20
- 21 i) Institute all appropriate corrective action and use any of its other enforcement
22 powers to obtain the health insurer's compliance; and
23
- 24 ii) Where the violation results in a subscriber's use of an out-of-network
25 physician, the health insurer must pay the out-of network physician's retail
26 charge(s) as indicated on the applicable claim form(s).

1 (c) Independent jurisdiction of the Attorney General. The Attorney General has
2 jurisdiction independent of the Department of Insurance to bring actions to enforce
3 the provisions of this Act.

4

5 **Section XII. Severability.** If any provision of this Act or the application thereof to any
6 person or circumstance is held invalid, such invalidity shall not affect other provisions of
7 applications of the Act which can be given effect without the invalid provision or
8 application, and to this end the provisions of this Act are declared to be severable.

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10 *[Drafting Note: The Advocacy Resource Center (ARC) strongly advises that this model*
11 *bill be introduced in conjunction with the ARC's model bill requiring covered entities to*
12 *honor valid assignments of benefits].*