CHAPTER 339
FORMERLY
HOUSE SUBSTITUTE NO. 1 FOR
HOUSE BILL NO. 439
AS AMENDED BY
HOUSE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO HEALTH INSURANCE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3371. Network Disclosure and Transparency.

(a) This section 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 section applies only to items, services or conditions for which coverage is provided by those policies or contracts (hereinafter referred to as "covered services").

(b) For purposes of this section "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.

(c) For purposes of this section "health care provider" means any provider who provides health care services to covered persons 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.

(d) Non-emergency out-of-network services.

(1) When a facility-based provider schedules a procedure, seeks prior authorization from a health carrier 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 that states the following:

a. That discloses whether the facility is a participating or out-of-network facility;

b. That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

c. That those facility-based providers may not have a contract with the covered person's health insurer and are therefore considered to be out-of-network;

d. That the services therefore will be provided on an out-of-network basis, which may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the covered person's health insurance policy;

e. A listing, including name and contact information, of those facility-based providers who may be called upon to render care to the covered person during the course of treatment, and a statement that the covered person should contact their health insurer to determine the network status of those facility-based providers;

f. Notification that an estimate of the range of charges charged by the out-of-network provider for any out-of-networks services for which the covered person may be responsible may be requested from, and will be timely provided by, the out-of-network provider; and

g. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

h. The written out-of-network disclosure required by this paragraph (d)(1) shall include a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network

provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the covered person's policy; (iii) acknowledge receipt of the notification that an estimate of the range of charges for any out-of-network services for which the covered person may be responsible may be obtained from the out-of-network providers; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

i. 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.

j. If the facility and all facility-based providers participate in the covered person's network, this disclosure shall not be required.

(2) Prior to the delivery of non-emergency covered services to a covered person, an out-of-network health care provider shall provide the covered person with a timely, written out-of-network disclosure that states the following:

a. That the health care provider is an out-of-network provider and the services therefore will be provided on an out-of-network basis;

b. That out-of-network services may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the person's health insurance policy;

c. Identification of the range of charges charged by the out-of-network health care provider for any out-of-network services for which the covered person may be responsible; and

d. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

e. The written out-of-network disclosure required by this paragraph (d)(2) shall contain a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the insured's policy; (iii) acknowledge receipt of the identification of the range of charges for any out-of-network services for which the covered person may be responsible; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

(3) A facility-based provider or 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 facility-based provider or health care provider:

a. Fails to provide to the covered person the written out-of-network disclosure required by paragraphs (1) or (2) of this subsection.

b. Fails to obtain from the covered person in a timely manner, before the health care services are provided, a copy of the consent form required by paragraphs (1) or (2) of this subsection that has been signed by the covered person.

(4) Nothing in paragraph (3) of this subsection shall prevent the operation of policy provisions involving coinsurance, deductibles and copayments payable under the insured health insurance policy.

(5) In the event a facility-based provider or a health care provider fails to comply with the requirements of paragraphs (3)a. or (3)b. of this subsection, and the provider of services and insurer cannot agree on the appropriate rate of reimbursement, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following arbitration of the dispute pursuant to the procedures set forth in section 333 of this title and any regulation promulgated thereunder.

(6) This section shall not apply to those out-of-network services provided pursuant to Section 3348 and 3349 of this chapter.

(e) Health insurers shall be required 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 the covered person in a variety of formats.

(f) The Insurance Commissioner shall adopt regulations to implement the requirements of this section, including:

(1) Regulations concerning the form and content of the written out-of-network disclosures and written consent form required by paragraphs (1) and (2) of subsection (d) of this section.

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

(3) Regulations concerning the provisions of subsection (e) of this section.

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

Section 2. Amend Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as show by underline as follows:

§ 3571S. Network Disclosure and Transparency.

(a) This section 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 section applies only to items, services or conditions for which coverage is provided by those policies or contracts (hereinafter referred to as "covered services").

(b) For purposes of this section "facility-based provider" means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

(c) For purposes of this section "health care provider" means any provider who provides health care services to patients 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.

(d) Non-emergency out-of-network services.

(1) When a facility-based provider schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency covered services to a covered person, the facility shall ensure that the covered person has received a timely written out-of-network disclosure that states the following:

a. That discloses whether the facility is a participating or out-of-network facility;

b. That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

c. That those facility-based providers may not have a contract with the covered person's health carrier and are therefore considered to be out-of-network;

d. That the services therefore will be provided on an out-of-network basis, which may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the covered person's health insurance policy;

e. A listing, including name and contact information, of those facility-based providers who may be called upon to render care to the covered person during the course of treatment, and a statement that the covered person should contact their health insurer to determine the network status of those facility-based providers;

f. Notification that an estimate of the range of charges for any out-of-networks services charged by the out-of-network provider for which the covered person may be responsible may be requested from, and will be timely provided by, the out-of-network provider; and

g. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

h. The written out-of-network disclosure required by this paragraph (d)(1) shall include a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the covered person's policy; (iii) acknowledge receipt of the notification that an estimate of the range of charges for any out-of-network services for which the covered person may be responsible may be obtained from the out-of-network providers; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

i. 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.

j. If the facility and all facility-based providers participate in the covered person's network, this disclosure shall not be required.

(2) Prior to the delivery of non-emergency covered services to a covered person, an out-of-network health care provider shall provide the covered person with a timely, written out-of-network disclosure that states the following:

a. That the health care provider is an out-of-network provider and the services therefore will be provided on an out-of-network basis;

b. That out-of-network services may result in additional charges for which the covered person may be responsible, and a statement that these charges are in addition to any coinsurance, deductibles and copayments applicable under the person's health insurance policy;

c. Identification of the range of charges for any out-of-network services charged by the out-of-network provider for which the covered person may be responsible; and

d. That the covered person may contact the covered person's health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

e. The written out-of-network disclosure required by this paragraph (d)(2) shall contain a written consent form which would enable a covered person who wishes to utilize the services of an out-of-network provider to: (i) acknowledge a provider may be a non-network provider; (ii) acknowledge that the services provided by the non-network provider may not be covered by the insured's policy; (iii) acknowledge receipt of the identification of the range of charges for any out-of-network services for which the covered person may be responsible; and (iv) affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services.

(3) A facility-based provider or 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 facility-based provider or health care provider:

a. Fails to provide the covered person the written out-of-network disclosure required by paragraph (1) or (2) of this subsection.

b. Fails to obtain from the covered person in a timely manner, before the health care services are provided, a copy of the consent form required by paragraph (3) of this subsection that has been signed by the covered person.

(4) Nothing in paragraph (3) shall prevent the operation of policy provisions involving coinsurance, deductibles and copayments payable under the covered person's health insurance policy.

(5) In the event a facility-based provider or a health care provider fails to comply with the requirements of paragraphs (3)a. or (3)b. of this subsection, and the provider of services and insurer cannot agree on the appropriate rate of reimbursement, the provider shall be entitled to those charges and rates allowed

by the Insurance Commissioner or the Commissioner's designee following arbitration of the dispute pursuant to the procedures set forth in section 333 of this title and any regulation promulgated thereunder.

(6) This section shall not apply to those out-of-network services provided pursuant to Section 3564 and 3565 of this chapter.

(e) Health insurers shall be required 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 the covered person in a variety of formats.

(f) The Insurance Commissioner shall adopt regulations to implement the requirements of this section, including:

(1) Regulations concerning the form and content of the written out-of-network disclosures and written consent form required by paragraphs (1) and (2) of subsection (d) of this section.

(2) Regulations requiring health insurers and out-of-network providers to inform covered persons of their rights with respect to payment of balance bills.

(3) Regulations concerning the provisions of subsection (e) of this section.

The regulations adopted and arbitrations authorized pursuant to this section shall reflect the objectives of protecting consumers from surprise bills and not creating incentives for providers to be out-of-network.

Section 3. This Act shall be effective on January 1 the year following its enactment.

Approved July 29, 2016