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# California

**California SB 537 - Workers' compensation: treatment and disability**

**Links:**

- 9/16/2019 Enrolled Version
- 9/6/2019 Version
- 9/3/2019 Version
- 8/13/2019 Version
- 7/2/2019 Version
- 4/11/2019 Version
- 3/27/2019 Version
- 2/21/2019 Version

**Summary For 10/09/2019**
This measure requires the Administrative Director of the Division of Workers' Compensation to issue a report to the Legislature, on or before January 1, 2023, comparing potential payment alternatives for providers to the official medical fee schedule.

This measure requires the Administrative Director to publish on the Division's internet website provider utilization data for physicians who treat ten or more injured workers during the twelve months before July 1 of the previous year, including the number of injured workers treated by the physician and the number of utilization review decisions that resulted in a modification or denial of a request for authorization of medical treatment based on a determination of medical necessity. The measure authorizes the Administrative Director to withhold data if deemed necessary to protect patient privacy. This measure requires the Administrative Director to use individually identifiable information for the purposes of creating the provider medical utilization data.

This measure, starting on July 1, 2021, requires every medical provider network to post on its internet website a roster of participating providers and to provide to the administrative director the internet website address of the network and of its roster of participating providers.

This measure revises the authority of the Administrative Director by giving the Administrative Director authority and discretion to investigate complaints, conduct random reviews, and take enforcement action against medical provider networks, an entity that provides ancillary services, or an entity providing services for or on behalf of the medical provider network or its providers, regarding noncompliance with the internet address and roster requirements imposed on those networks.

This measure prohibits an entity other than the requesting physician or provider from altering or amending a request for authorization for medical treatment prior to the submission of the request to the claims administrator.

This measure requires an itemized request for payment for services to be submitted to an employer with the physician's or provider's national provider identifier number.

This measure, on and after January 1, 2021, requires an entity that provides physician or ancillary network service to provide a payor with a written disclosure of the reimbursement amount paid to the provider with a rate sheet if a contracted reimbursement rate is more than 20% below the official medical fee schedule.

This measure authorizes an entity that provides physician or ancillary network services to require a payor to sign a nondisclosure agreement before providing that disclosure.

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**California SB 1419 - Health Information. An Act to Amend Section Sections 123115 and 123148 of, and to Add Section 1374.196 To, the Health and Safety Code, and to Add Section 10133.12 to the Insurance Code, Relating to Health Care.**

**Links:**

- 9/30/2022 Chaptered Version
- 8/23/2022 Version
- 6/16/2022 Version
- 4/18/2022 Version
- 3/17/2022 Version
- 2/18/2022 Version

**Summary For 10/05/2022**
This measure requires health care service plans and health insurers to establish and maintain application program interfaces (API).

This measure applies to insurers.

This measure directs insurers to facilitate patient and provider access to health information. Health care service plans must establish and maintain application programming interfaces (API) for enrollees and contracted providers including a patient access API, a provider directory API, a payer-to-payer exchange API, a provider access API, and a prior authorization support API. This section will commence beginning on January 1, 2024.

This measure removes the requirement that a health care professional review the results before the results are disclosed to the patient by internet posting or other electronic means. This measure does not prevent the disclosure of HIV test results, including viral load and CD4 count test results by secure internet website or other electronic means on a patient's viral load if the patient has previously been informed about the results of a positive HIV test pursuant to the requirements of this section.

This measure defines "test" to apply to both clinical laboratory tests and imaging scans, such as x-rays, magnetic resonance imaging, ultrasound, or other similar technologies and would also make conforming changes.

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## Georgia

**Georgia HB 789 - Insurance; creation of a surprise bill rating system based upon the number of certain physician specialty groups contracted with a hospital within a health insurer's network; provide**

**Links:**

- 6/24/2020 Final Enrolled Version
- 2/4/2020 Version
- 1/16/2020 Version

**Summary For 07/23/2020**
This measure amends Chapter 20C of Title 33 of the Official Code of Georgia to create a surprise bill rating system.

This measure applies to insurers, providers, and the Commissioner of Insurance.

This measure sets up a surprise bill rating system based upon the number of physician specialty groups contracted with a hospital within a health insurer's network. The specialty groups include anesthesiologists, pathologists, radiologists, and emergency medicine physicians.

This measure requires that insurers include hospital surprise bill ratings online and in print provider directories and requires each insurer that advertises any hospital as in-network to disclose such hospital's surprise bill rating within such advertisement.

This measure allows the Commissioner of insurance to promulgate rules and regulations which require insurers to provide explanatory footnotes to each health benefit plan surprise bill rating in such special circumstances as the Commissioner may determine to be appropriate.

This measure also states that if an insurer processes a claim on a covered person from an out-of-network qualified hospital-based specialty group provider at out-of-network rates, the insurer must update the relevant health benefit plan surprise bill rating within 30 days to reflect any necessary reduction in such rating.

This measure allows the Commissioner to submit an annual report on surprise billing to the House Committee on Insurance and the Senate Insurance and Labor Committee beginning January 1, 2022.

Provider Directory Requirements:

(a) The insurer shall make available through an online provider directory, for each network plan, the following information, in a searchable format:

(1) For health care healthcare professionals:

(A) Name;

(B) Gender;

(C) Contact information;

(D) Participating office location or locations;

(E) Specialty, if applicable;

(F) Board certifications, if applicable;

(G) Medical group affiliations, if applicable;

(H) Participating facility affiliations, if applicable;

(I) Languages spoken other than English by the health care healthcare professional or

clinical staff, if applicable;

(J) Tier; and

(K) Whether they are accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer;

(C) Participating hospital location;

(D) Hospital accreditation status; and

(E) Telephone number; and

(F) Health benefit plan surprise bill rating; and

(3) For facilities other than hospitals:

(A) Facility name;

(B) Facility type;

(C) Types of services performed;

(D) Participating facility location or locations; and

(E) Telephone number. 103 (b) Paragraphs (2) and (3) of subsection (a) of this Code section shall not apply to standalone dental plans.

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## Illinois

**Illinois SB 332 - Ins-Telehealth Provider Info Amends the Network Adequacy and Transparency Act.**

**Links:**

- Public Act 102-0092

**Summary For 12/13/2021**
This measure amends the Illinois Network Adequacy and Transparency Act to require insurers to provide a directory of practitioners that offer the use of telehealth.

This measure is applicable to health insurers.

This measure provides that a network plan must make available, through a directory, information about whether a provider offers the use of telehealth or telemedicine to deliver services, what modalities are used and what services via telehealth or telemedicine are provided, and whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient so wishes and provides his or her consent. It also requires providers to notify the network plan of changes to their information listed in the provider directory, including the information concerning the use of telehealth or telemedicine.

"Family Care Giver" means a relative, partner, friend, or anyone that has a significant relationship with the patient and administers or assists them with activities of daily living, instrumental activities of daily living, or other medical or nursing tasks for the quality and welfare of that patient.

Directory Requirements:

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) The network plan shall update the online provider directory at least monthly. Providers shall notify the plan electronically or in writing of any changes to their information as listed in the provider directory, including the information required in subparagraph (K) of paragraph (1) of subsection (b). The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 10 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) The network plan shall audit periodically at least 25% of its provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The network plan shall submit the audit to the Director upon request. As part of these audits, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network.

(4) A network plan shall provide a print copy of a current provider directory or a print copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Print copies must be updated quarterly and an errata that reflects changes in the provider network must be updated quarterly.

(5) For each network plan, a network plan include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the insurer or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; and

(D) if applicable, a notation that authorization or referral may be required to access some providers.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) 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.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) specialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable; (G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients; and

(J) board certifications, if applicable; and

(K) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); (C) participating hospital location; and

(D) hospital accreditation status; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations.

(c) For the electronic provider directories, for each network plan, a network plan shall make available all the following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number; and

(3) for facilities other than hospitals, telephone number.

(d) The insurer or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information;

(C) participating office location or locations;

(D) specialty, if applicable;

(E) languages spoken other than English, if applicable; and

(F) whether accepting new patients; and.

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); and

(C) participating hospital location and telephone number; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations and telephone numbers.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the insurer's electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

## Kentucky

**Kentucky HB 140 - AN ACT relating to telehealth.**

**Links:**

- 3/3/2021 Version
- 2/11/2021 House floor amendment 4
- 2/9/2021 House floor amendment 3
- 2/9/2021 House floor amendment 2
- 2/9/2021 House floor amendment 1
- 2/4/2021 Version
- 12/11/2020 Version

**Summary For 10/03/2021**
This measure creates and amends Kentucky code regarding telehealth, including to: (i) standardize terminology, (ii) conduct a study on the effects of telehealth, (iii) place restrictions on what and how state agencies may promulgate regulations regarding telehealth, and (iv) and provide for parity in Medicaid services and for all insurers for services provided by a home health agency.

**Telehealth Standardization**

This provision directly applies to the Cabinet for Health and Family Services but will affect telehealth providers.

This measure directs the Cabinet to consult with the Division of Telehealth Services to:

1. Provide guidance and direction to providers delivering telehealth services;

2. Promote access to healthcare services provided via telehealth;

3. Maintain an online telehealth provider director for consumer use; and

4. Within 30 days of the effective date, promulgate administrative regulations to (i) establish a glossary of telehealth terminology to provide standard definitions, (ii) establish minimum requirements for confidentiality and data integrity, privacy and security, informed consent, privileging, and credentialing, reimbursement, and technology, (iii) establish minimum requirements to prevent waste, fraud, and abuse related to telehealth, and (iv) maintain the discretion of state agencies authorized or required to promulgate regulations relating to telehealth.

# Massachusetts

**Massachusetts HB 4210 - An act relative to children's health and wellness**

**Links:**

- 11/18/2019 Version

**Summary For 11/19/2019**

This measure implements standards to ensure the accuracy of health insurance carrier provider directories.

A carrier shall ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan and shall review and update the entire provider directory for each network plan.

A provider directory that is electronically available shall: (i) be in a searchable format; and (ii) make accessible to the general public the current health care providers for a network plan through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information or demonstrate coverage or an interest in obtaining coverage with the network plan.

Each electronic network plan provider directory shall be updated not less than monthly; provided, however, that an electronic network plan provider directory shall be updated more frequently than monthly if required by state or federal law or regulations promulgated by the commissioner, when informed of and upon confirmation by the plan of:

(i) a contracting provider no longer accepting new patients for that network plan or an individual provider within a provider group no longer accepting new patients;

(ii) a provider or provider group no longer being under contract for a particular network plan;

(iii) a change of a provider's practice location or of other information required under this section;

(iv) a provider's retirement or cessation of practice; or

(v) any other information that affects the content or accuracy of the provider directory.

(b) A provider directory shall not list or include information on a provider who is not currently under contract with the network plan.

(c) A carrier shall periodically audit its provider directories for accuracy and retain documentation of the audit to be made available to the commissioner upon request.

(d) A carrier shall provide a print copy of the provider directory information of a current provider directory upon the request of an insured or a prospective insured. The print copy of the requested provider directory information shall be provided to the requester by mail postmarked not later than 5 business days after the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(e) A carrier shall include in both the electronic and print formats of the provider directory a dedicated customer service email address and telephone number or electronic link that insureds, providers and the general public may use to notify the carrier of inaccurate provider directory information. This customer service information shall be disclosed prominently in the provider directory and on the carrier's website. The carrier shall investigate reports of inaccuracies within 30 days of the notice and modify the provider directory in accordance with any findings within 30 days of the findings.

(f) A provider directory shall inform enrollees and potential enrollees that they are entitled to:

(i) language interpreter services at no cost to the enrollee; and

(ii) full and equal access to covered services that are required under the federal Americans with Disabilities Act of 1990 and Section 504 of the federal Rehabilitation Act of 1973. 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, including how to obtain interpretation and translation services.

(g) A carrier shall include a disclosure in the print format of the provider directory that the information included in the provider directory is accurate as of the date of printing and that an insured or prospective insured may consult the carrier's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information.

(h) A carrier shall update the print copies of the carrier's provider directory not less than annually; provided, however, that the carrier shall update the print provider directories more frequently than annually if required by federal law; and provided further, that the division may promulgate regulations requiring that the print provider directories be updated more frequently than annually.

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## Nevada

**Nevada SB 379 - An Act Relating to Health Care; Requiring the Director of the Department of Health and Human Services to Establish and Maintain a Database Comprised of Information Concerning Providers of Health Care Who Are Licensed, Certified or Registered In This State; Requiring or Authorizing Certain Professional**

**Licensing Boards and Agencies That License, Certify or Register Providers of Health Care to Collect Information from Applicants For the Renewal of a License, Certificate or Registration; Establishing the Health Care Workforce Working Group Within the Department to Analyze the Information In the Database and Perform Certain Related Duties; and Providing Other Matters Properly Relating Thereto.**

**Links:**

- 4/19/2021 Version
- 4/6/2021 Work Session Document
- 3/26/2021 Version

**Summary For 06/01/2021**
This measure requires that the director establish and maintain a database with a variety of information about applicants for renewal of licenses and permits the various licensing boards and authorities to request this information from applicants, who are not obligated to answer and cannot be penalized for refusal to answer.

This measure requires that the Director establish and maintain a database regarding applicants for renewal of licenses, certificates, and registrations as a provider of health care with certain required information including their race, specialty, county, and address, and any other specified information. This measure directs the Director to develop and make available to licensing boards an electronic data request to obtain information for inclusion in the database. The director will publish an annual report with this data and report to the legislature and department on how to attract more persons in underrepresented groups and improve health outcomes.

This measure requires that the director establish a Health Care Workforce Working Group consisting of representatives of various stakeholders. The working group will make recommendations to the director, the Department of Health and Human Services, the Department of Education, the Board of Regents of the University of Nevada, the legislature, professional licensing boards, and other relevant persons on how to attract members of underrepresented groups and improve health outcomes.

The director will enact regulations necessary for this bill including entering into contracts.

This measure directs the board to make a data request available to applicants for license renewal or biennial registration. This measure permits the medical board and other licensing boards to request that each applicant for renewal of a biennial license or license or certificate provide requested information, which is confidential and not required to be provided. A person is not required to complete the data request.

This measure is effective as of May 26 for regulations and performing preparatory administrative tasks and July 1, 2021, for all other purposes.

# New York

**New York AB 9007 - Enacts into Law Major Components of Legislation Necessary to Implement the State Health and Mental Hygiene Budget For the 2022-2023 State Fiscal Year**

**Links:**

- 4/8/2022 Version
- 3/12/2022 Version
- 2/22/2022 Version
- 1/19/2022 Version
- Executive Budget Hearing Chart

**Summary For 10/31/2022**
This measure provides a directory for fee-for-service private duty nursing services to medically fragile adults.

This measure requires a health care professional, or group practice of health care professionals, a diagnostic and treatment center, or a health center to make publicly available, and if applicable, post on their public websites, and provide to individuals who are enrollees of health care plans, a one-page written notice, in clear and understandable language, containing information on the requirements and prohibitions under 42 U.S.C. §§ 300gg-131 and 300gg-132 and article six of the financial services law relating to prohibitions on balance billing for emergency services and surprise bills, and information on contacting appropriate state and federal agencies if an individual believes a health care provider has violated any requirement (Pg. 51).

**Summary For 10/31/2022**
This measure requires an insurer or corporation that uses a network of providers and is not a managed care health insurance contract must maintain procedures for healthcare professional applications and terminations and requires a healthcare plan to make available and disclose to healthcare facilities written application procedures and minimum qualification requirements that a facility must meet. Provisions in this measure removed by the March 12 amendments were returned by the April 8 amendments.

This measure requires an insurer or corporation that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract must establish and maintain procedures for healthcare professional applications and terminations and procedures for healthcare facility applications.

This measure requires a healthcare plan to make available and disclose to healthcare facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the healthcare plan for participation in the in-network benefits portion of the healthcare plan's network. The healthcare plan is required to complete a review of a facility's application to participate in the in-network portion of the plan's network and respond within 60 days (Pg. 52-54).

**Summary For 06/12/2022**
This measure requires insurers, corporations, or healthcare plans and healthcare providers to include a provision within a contract between an insurer and a health care provider that requires the healthcare provider to have in place business processes to ensure the timely provision of provider directory information to the insurers, corporations, or healthcare plans. Provisions in this measure removed by the March 12 amendments were returned by the April 8 amendments.

This measure requires that contracts between insurers, corporations, or healthcare plans and healthcare providers include a provision that requires the healthcare provider to have in place business processes to ensure the timely provision of provider directory information to the insurers, corporations, or healthcare plans. A health care provider must submit such provider directory information to insurers, corporations, or healthcare plans, at a minimum, when a provider begins or terminates a network agreement with an insurer, corporation, or healthcare plan when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer, corporation, or healthcare plan's request, as the health care provider determines to be appropriate.

This measure requires that a contract between an insurer, corporation, or healthcare plan and healthcare provider contain a provision guaranteeing that the provider will reimburse the insurer, corporation, or healthcare plan for the full amount paid by the insured or corporation in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent (Pg. 48).

## Texas

**Texas SB 1742 - Relating to physician and health care provider directories for certain health benefit plans**

**Links:**

- 5/26/2019 Version
- 5/17/2019 Amendment
- 5/17/2019 Amendment
- 5/17/2019 Amendment
- 5/17/2019 Amendment
- 5/17/2019 Amendment
- 4/11/2019 Version
- 3/6/2019 Version

**Summary For 11/19/2019**
This measure requires a health plan's network directory to clearly identify which radiologists, anesthesiologists, pathologists, emergency physicians, neonatologists, and assistant surgeons are in-network at network facilities.

**Provider Directory Requirements (Effective January 1, 2020)**

The measure requires that for all health-care providers that are facility-based physicians, an insurance company provider directory must list each health benefit plan issued by the insurer that may issue coverage for the physician.

"Facility" includes: ambulatory surgery center, birthing center, hospital, and freestanding emergency center.

"Facility-based physician" means a radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon: (A) to whom a facility has granted clinical privileges; and (B) who provides services to patients of the facility under those clinical privileges.

This measure requires the physician and health care provider directory to include the name, street address, specialty, if any, and telephone number of each physician and health care provider described by Subsection (a) (relating to requiring health benefit plan issuers to develop and maintain a physician and health care provider directory) and indicate whether the physician or provider is accepting new patients.

This measure requires the directory to list a facility-based physician individually and, if the physician belongs to a physician group, as part of the physician group.

The directory must be electronically searchable by physician or health care provider name, specialty, if any, and location, rather than electronically searchable by physician or health care provider name and location.

This measure creates requirements for provider directories regarding facility-based physicians.

This measure defines "facility-based physician" as an anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon.

The measure requires that for all health-care providers that are facility-based physicians, an insurance company provider directory must list each health benefit plan issued by the insurer that may issue coverage for the physician.

The measure stipulates for each specialty of a facility-based physician practicing at the facility, the name, street address, and telephone number of any facility-based physician that is a preferred provider, exclusive provider, or network physician or of the physician group in which the facility-based physician practices must be listed in the health care provider directory. The measure also stipulates that the directory must list a facility-based physician individually and, if the physician belongs to a physician group, as part of the physician group.

The measure requires that insurance carriers provide notice to providers of any coding changes that will result in a change of payment to the physician or provider.

The measure requires a managed care plan to determine with the state whether to credential a physician or health care practitioner not eligible for expedited credentialing.

The measure requires that to qualify for credentialing, an applicant must:
(i) be licensed with the appropriate licensing authority
(ii) submit all documentation required by the issuer of the managed care plan
(iii) agree to comply with the terms and conditions of the applicable managed care plan

The measure requires that upon receiving an application to be a participating provider, the issuer must treat the applicant as if the applicant is a participating provider. If the applicant is deemed to not meet the credentialing requirements, the managed care plan issuer may recover from the applicant an amount equal to the difference between payments for in-network benefits and out of network benefits, while enrollees are held harmless.

The measure requires a health benefit plan issuer to update its directory to reflect a change in a provider's network participation status no later than two business days after the effective date of the change.

The measure requires directories to include information for individuals to report inaccuracies in the provider directory.

This measure requires the state to review mediation request information collected for the preceding calendar year and identify the two issuers with the highest percentage of claims subject to mediation requests and determine the quality and adequacy of the networks of the aforementioned insurers.

The measure requires the two insurers to pay the cost of the examination.

This measure defines "termination without cause" as the termination of the provider network of a preferred provider contract between a physician, practitioner, health care provider, or facility for a reason other than the request of the provider or fraud or material breach of contract.

The measure requires that on the 15th day of each month, insurers must notify the state of all terminations without cause made during the preceding month.

The measure requires the state to impose an administrative penalty on an insurer if the terminations made without cause led to an inadequate network.

The measure requires that, if a health benefit plan issuer has given prior authorization for health care or dental services, the health benefit plan issuer may not deny or reduce the payment to the provider based on medical necessity or appropriateness of care unless the provider materially misrepresented the proposed services.

The measure prohibits a health maintenance organization from using extrapolation to complete an audit of a participating provider.

The measure requires an insurer that uses preauthorization requirements to make the requirements readily accessible to enrollees, physicians, providers, and the general public.

This measure requires, no later than the 60th day before the date of a new or amended preauthorization requirement takes effect, an insurer must provide each participating physician provider of written notice of the new requirement.

The measure requires a utilization review of an emergency care claim to be made by a physician.

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## Virginia

**Virginia SB 1436 - Eligible Health Care Provider Reserve Directory; Established.**

**Links:**

- 3/31/2021 Governor's Amendments
- 2/3/2021 Version
- 1/28/2021 Version
- 1/15/2021

**Summary For 04/12/2021**
This measure directs the Department of Health to establish a provider directory to allow providers to better assist the state during a public health emergency.

This measure provides that the Department of Health will establish an Eligible Health Care Provider Reserve Directory to collect information regarding eligible health care providers in the state who are qualified and who may be available to assist in the response to a public health emergency. The Directory shall include the name, contact information, and licensure, certification, or registration type and status of the eligible health care provider or, if the eligible health care provider is a fourth-year medical student, academic standing and anticipated graduation date of the fourth-year medical student. Every health regulatory board of the Department of Health Professions, the Office of Emergency Medical Services of the Department of Health, and each medical school located in the Commonwealth, upon the request of a fourth-year medical student, shall provide such information to the Department for inclusion in the Directory.

Every health regulatory board of the Department of Health Professions, the Office of Emergency Medical Services of the Department of Health, and each medical school located in the Commonwealth, upon the request of a fourth-year medical student, will provide such information to the Department for inclusion in the Directory. However, a health regulatory board will not report information for any such person who has notified the health regulatory board in writing that he does not want his information included in the Eligible Health Care Provider Reserve Directory

During a declared public health emergency, the Governor may request, and the Commissioner may provide information regarding eligible health care providers from the Directory.

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## Washington

**Washington HB 1065 - Protecting consumers from charges for out-of-network health care services.**

**Links:**

- 5/21/2019 Version
- 4/8/2019 Amendments
- 3/29/2019 Version
- 2/1/2019 Version
- 12/17/2018 Version

**Summary For 08/12/2019**
This measure prohibits an out-of-network provider or facility from balance billing an enrollee for emergency services provided to an enrollee; and nonemergency health care services provided to an enrollee at an in-network hospital or an in-network ambulatory surgical facility if the services: involve surgical or ancillary services and are provided by an out-of-network provider.

**Notification Requirements:**

This measure requires the Commissioner, in consultation with stakeholders, must develop standard template language for notifying consumers of the circumstances under which they may or may not be balance billed. The template must include contact information for the OIC so that consumers may contact the OIC if they believe they have been improperly balance billed. The OIC must determine by rule when and in what format health carriers, health providers, and health facilities must provide consumers with the notice. Health carriers, health providers, and health facilities must post the notice on their website. A hospital or ambulatory surgical facility must post on its website a list of the carrier health plan provider networks with which the facility is an in-network provider. A hospital or ambulatory surgical facility also must provide an updated list of these providers within 14 calendar days of a request for an updated list by a carrier.

A health care provider's website must list the carrier health plan provider networks with which the provider contracts. An in-network provider must submit accurate information to a carrier regarding network status in a timely manner, consistent with the contract between the carrier and the provider. A carrier must update its website and provider directory within 30 days of an addition or termination of a facility or provider. A carrier must provide an enrollee with: a clear description of the plan's out-of-network benefits; notice of rights regarding balance billing using the standard template; notification regarding out-of-network financial responsibility; information

on how to use the carrier's transparency tools; upon request, information on a provider's network status, and whether there are in network providers available to provide surgical or ancillary services at the specified in-network facility; and upon request, an estimated range of out-of-pocket costs. Carriers must make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the balance billing provisions. Provider contracts filed by carriers must identify the network or networks to which the contract applies.

**Enforcement and Rulemaking:**

If the Commissioner has reason to believe any person or facility is violating statutes relating to balance billing, the Commissioner may submit information to the Department of Health (DOH) or the appropriate disciplining authority for action. If a provider or facility has engaged in a pattern of unresolved violations relating to balance billing, the DOH or appropriate disciplining authority may levy a fine or cost recovery upon the health care provider or facility or take other action as permitted under the authority of the DOH or disciplining authority. Upon completion of its review of any potential violation, the DOH or the disciplining authority must notify the Commissioner of the results of the review. A pattern of violations of the balance billing provisions also constitutes unprofessional conduct under the Uniform Disciplinary Act. It is an unfair or deceptive practice for a health carrier to initiate arbitration with such frequency as to indicate a general business practice. A health carrier violating the balance billing provisions is subject to fines and other remedies imposed by the Commissioner. Violations of the provisions relating to balance billing subjects a provider or facility to a fine of up to $1,000 per violation.

Hospitals or ambulatory surgical facilities must post information on their website listing the carrier health plan provider networks with which the hospital or ambulatory surgical facility is an in-network and a notice of consumer rights. Hospitals and ambulatory surgical facilities, before executing a contact with a carrier, provide the carrier with a list of the non-employee providers or provider groups contracted to provide surgical or ancillary services.

Health carriers must update their website and provider directory no later than 30 days after the addition or termination of a facility or provider.

Further, when determining the adequacy of a proposed provider network or the ongoing adequacy of an in-force provider network, the Insurance Commissioner must consider whether the carrier's proposed provider network or in-force provider network includes a sufficient number of contracted providers of emergency and surgical or ancillary services at or for the carrier's contracted in-network hospitals or ambulatory surgical facilities to reasonably ensure enrollees have in-network access to covered benefits delivered at that facility.

This measure exempts a patient from balance-billing protection if they voluntarily chose an out-of-network surgeon for a procedure scheduled at least 72 hours prior to the procedure and if an in-network provider was also available.

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# West Virginia

**West Virginia HB 4061 - A Bill to amend the Code of West Virginia, 1931, as amended, by adding thereto two new sections, designated §33-15-4u and §33-15-22; to amend said code by adding thereto two new sections, designated §33-16-3ff and §33-16-18, to amend said code by adding thereto two new sections, designated §33-24-7u and §33-24-45; to amend said code by adding thereto two new sections, designated §33-25-8r and §33-25-22; to amend said code by adding thereto two new sections, designated §33-25A-8u and §33-25A-36, to amend said code by adding thereto a new article, designated §33-53-1, §33-53-2, §33-53-3, §33-53-4, §33-53-5, §33-53-6, §33-53-7, §33-53-8, §33-53-9, §33-53-10, §33-53-11, §33-53-12, and §33-53-13, all relating to health plan benefits and benefit networks; creating the Health Benefit Plan Network Access and Adequacy Act; incorporating references to the act into the insurance code; requiring honoring of the optional assignment of certain benefits in dental care insurance programs; detailing revocation and reimbursement requirements; and excluding Medicaid, CHIP, and contracts approved by the Department of Health and Human Resources Bureau for Medical Services.**

**Links:**

- 3/25/2020 Version
- 3/3/2020 Version
- 2/28/2020 Version
- 1/15/2020 Version
- 1/8/2020 Version

**Summary For 03/30/2020**
The measure amends the West Virginia code to implement the Health Benefit Network Access and Adequacy Act.

The measure requires a health plan to create a provider directory.

(a)(1)(A) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in subsection 3 (b) of this section.

(B) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)(A) The health carrier shall update each network plan provider directory at least monthly.

(B) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy, and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information of a current provider directory with the information described in subsection (b) of this section upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language, in both the electronic and print directory, the following general information:

(A) In plain language, a description of the criteria the carrier has used to build its provider network;

(B) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(C) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(D) If applicable, note that authorization or referral may be required to access some providers.

(5)(A) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(B) The health carrier shall include in both its 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 health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to subsections (b), (c), and (d) of this section in a provider directory pertaining to a health care professional, a hospital, or a facility than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) 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.

(b) The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(A) Name;

(B) Gender;

(C) Participating office location(s);

(D) Specialty, if applicable;

(E) Medical group affiliations, if applicable;

(F) Facility affiliations, if applicable;

(G) Participating facility affiliations, if applicable;

(H) Languages spoken other than English, if applicable; and

(I) Whether accepting new patients.

(2) For hospitals:

(A) Hospital name;

(B) Hospital type (i. e., acute, rehabilitation, children's, cancer);

(C) Participating hospital location;

(D) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility location(s).

(c) For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under subsection (b) of this section:

(1) For health care professionals:

(A) Contact information;

(B) Board certification(s); and

(C) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

(d)(1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(A) For health care professionals:

(i) Name;

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, (i. e., acute, rehabilitation, children's, cancer); and

(iii) Participating hospital location and telephone number; and

(C) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in 90 subdivision (1) of this subsection, included in the directory, is accurate as of the date of printing, and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.