AM2431
LB997
MMM - 02/13/2020

AMENDMENTS TO LB997

Introduced by Banking, Commerce and Insurance.

1. Strike original sections 3, 16, and 17 and insert the following new sections:

Sec. 10. Insurer means an entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including (1) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for a policy that provides coverage for a specified disease or other limited-benefit coverage, and (2) any self-funded employee benefit plan to the extent not preempted by federal law.

Sec. 16. (1) If a covered person receives emergency services at an in-network or out-of-network health care facility, the insurer shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services.

(2) With respect to emergency services at an in-network or out-of-network health care facility, if the out-of-network health care provider bills an insurer directly, any reimbursement paid by the insurer shall be paid directly to the out-of-network health care provider. The insurer shall provide the out-of-network health care provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

(3) If emergency services provided at an in-network or out-of-network health care facility are performed, the out-of-network health care provider may bill the insurer for the services rendered. The insurer

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may pay the billed amount. A claim or a payment shall be presumed reasonable if it is based on the higher of (a) the contracted rate under any then-existing in-network contractual relationship between the insurer and the out-of-network health care provider for the same or similar services or (b) one hundred seventy-five percent of the payment rate for medicare services received from the federal Centers for Medicare and Medicaid Services for the same or similar services in the same geographic area. If the out-of-network health care provider deems the payment made by the insurer unreasonable, the out-of-network health care provider shall return payment to the insurer and utilize the dispute resolution procedure under section 17 of this act.

Sec. 17. (1) If an insurer or an out-of-network health care provider provides notification that it considers a claim or payment to be not reasonable, the insurer and the health care provider shall have thirty days after the date of such notification to negotiate a settlement. If a settlement has not been reached after such thirty-day period, the insurer and the health care provider shall engage in mediation in accordance with the Uniform Mediation Act. The insurer may attempt to negotiate a final reimbursement amount with the out-of-network health care provider which differs from the amount paid by the insurer pursuant to this section.

(2) Following completion of the mediation process, the cost of mediation shall be split evenly and paid by the insurer and the health care provider.

(3) Mediation shall not be used when the insurer and the health care provider agree to a separate payment arrangement.

2. On page 2, lines 8 and 27 and 28, strike "a carrier" and insert "an insurer".

3. Renumber the remaining sections accordingly.