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E AND R AMENDMENTS TO LB 997

Introduced by Slama, 1, Chairman Enrollment and Review

1 1. Strike the original sections and all amendments thereto and
2 insert the following new sections:
3 Section 1. Sections 1 to 17 of this act shall be known and may be
4 cited as the Out-of-Network Emergency Medical Care Act.
5 Sec. 2. For purposes of the Out-of-Network Emergency Medical Care
6 Act, the definitions found in sections 3 to 13 of this act apply.
7 Sec. 3. Covered person means a person on whose behalf an insurer is
8 obligated to pay health care expense benefits or provide health care
9 services.
10 Sec. 4. Emergency medical condition means a medical or behavioral
11 condition, the onset of which is sudden, that manifests itself by
12 symptoms of sufficient severity, including, but not limited to, severe
13 pain, that a prudent layperson, possessing an average knowledge of
14 medicine and health, could reasonably expect the absence of immediate
15 medical attention to result in (1) placing the health of the person
16 afflicted with such condition in serious jeopardy or, in the case of a
17 behavioral condition, placing the health of such persons or others in
18 serious jeopardy, (2) serious impairment to such person's bodily
19 functions, (3) serious impairment of any bodily organ or part of such
20 person, or (4) serious disfigurement of such person.
21 Sec. 5. Emergency services means health care services medically
22 necessary to screen and stabilize a covered person in connection with an
23 emergency medical condition.
24 Sec. 6. (1) Health benefits plan means a benefits plan which pays
25 or provides hospital and medical expense benefits for covered services
26 and is delivered or issued for delivery in this state by or through an
27 insurer.

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1 (2) Health benefits plan does not include the medical assistance
2 program, medicare, medicare advantage, accident-only, credit, disability,
3 or long-term care coverage, TRICARE supplement coverage, coverage arising
4 out of a workers' compensation or similar law, automobile medical payment
5 insurance, personal injury protection insurance, and hospital confinement
6 indemnity coverage.
7 Sec. 7. Health care facility means a general acute hospital,
8 satellite emergency department, or ambulatory surgical center licensed
9 pursuant to the Health Care Facility Licensure Act.
10 Sec. 8. Health care professional means an individual who is
11 credentialed pursuant to the Uniform Credentialing Act, who is acting
12 within the scope of his or her credential, and who provides a covered
13 service defined by the health benefits plan.
14 Sec. 9. Health care provider means a health care professional or
15 health care facility.
16 Sec. 10. Insurer means an entity that contracts to provide,
17 deliver, arrange for, pay for, or reimburse any of the costs of health
18 care services under a health benefits plan, including (1) any individual
19 or group sickness and accident insurance policy or subscriber contract
20 delivered, issued for delivery, or renewed in this state and any
21 hospital, medical, or surgical expense-incurred policy, except for a
22 policy that provides coverage for a specified disease or other limited-
23 benefit coverage, and (2) any self-funded employee benefit plan to the
24 extent not preempted by federal law.
25 Sec. 11. Medical assistance program means the medical assistance
26 program established pursuant to the Medical Assistance Act.
27 Sec. 12. Medically necessary means a health care service that a
28 health care provider, exercising his or her prudent clinical judgment,
29 would provide to a covered person for the purpose of evaluating,
30 diagnosing, or treating an illness, an injury, or a disease, or its
31 symptoms, and that is in accordance with the generally accepted standards

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1 of medical practice; that is clinically appropriate, in terms of type,
2 frequency, extent, site, and duration, and considered effective for the
3 covered person's illness, injury, or disease; that is not primarily for
4 the convenience of the covered person or the health care provider; and
5 that is not more costly than an alternative service or sequence of
6 services at least as likely to produce equivalent therapeutic or
7 diagnostic results as to the diagnosis or treatment of that covered
8 person's illness, injury, or disease.
9 Sec. 13. TRICARE means a health care program of the United States
10 Department of Defense Military Health System.
11 Sec. 14. If a covered person receives emergency services at any
12 health care facility, the facility shall not bill the covered person in
13 excess of any deductible, copayment, or coinsurance amount applicable to
14 in-network services pursuant to the covered person's health benefits
15 plan.
16 Sec. 15. If a covered person receives emergency services at an in-
17 network or out-of-network health care facility, the health care provider
18 performing those services shall not bill the covered person in excess of
19 any deductible, copayment, or coinsurance amount applicable to in-network
20 services pursuant to the covered person's health benefits plan.
21 Sec. 16. (1) If a covered person receives emergency services at an
22 in-network or out-of-network health care facility, the insurer shall
23 ensure that the covered person incurs no greater out-of-pocket costs than
24 the covered person would have incurred with an in-network health care
25 provider for covered services.
26 (2) With respect to emergency services at an in-network or out-of-
27 network health care facility, if the out-of-network health care provider
28 bills an insurer directly, any reimbursement paid by the insurer shall be
29 paid directly to the out-of-network health care provider. The insurer
30 shall provide the out-of-network health care provider with a written
31 remittance of payment that specifies the proposed reimbursement and the

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1 applicable deductible, copayment, or coinsurance amounts owed by the
2 covered person.
3 (3) If emergency services provided at an in-network or out-of-
4 network health care facility are performed, the out-of-network health
5 care provider may bill the insurer for the services rendered. The insurer
6 may pay the billed amount. A claim or a payment shall be presumed
7 reasonable if it is based on the higher of (a) the contracted rate under
8 any then-existing in-network contractual relationship between the insurer
9 and the out-of-network health care provider for the same or similar
10 services or (b) one hundred seventy-five percent of the payment rate for
11 medicare services received from the federal Centers for Medicare and
12 Medicaid Services for the same or similar services in the same geographic
13 area. If the out-of-network health care provider deems the payment made
14 by the insurer unreasonable, the out-of-network health care provider
15 shall return payment to the insurer and utilize the dispute resolution
16 procedure under section 17 of this act.
17 Sec. 17. (1) If an insurer or an out-of-network health care
18 provider provides notification that it considers a claim or payment to be
19 not reasonable, the insurer and the health care provider shall have
20 thirty days after the date of such notification to negotiate a
21 settlement. If a settlement has not been reached after such thirty-day
22 period, the insurer and the health care provider shall engage in
23 mediation in accordance with the Uniform Mediation Act. The insurer may
24 attempt to negotiate a final reimbursement amount with the out-of-network
25 health care provider which differs from the amount paid by the insurer
26 pursuant to this section.
27 (2) Following completion of the mediation process, the cost of
28 mediation shall be split evenly and paid by the insurer and the health
29 care provider.
30 (3) Mediation shall not be used when the insurer and the health care
31 provider agree to a separate payment arrangement.

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1 Sec. 18. This act becomes operative on January 1, 2021.