LB997
2020

LEGISLATURE OF NEBRASKA

ONE HUNDRED SIXTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 997

FINAL READING

Introduced by Morfeld, 46; Blood, 3; Groene, 42; Hilgers, 21; Hansen, M., 26; Bolz, 29.

Read first time January 14, 2020

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to insurance; to adopt the Out-of-Network Emergency Medical Care Act; and to provide an operative date.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 17 of this act shall be known and may be cited as the Out-of-Network Emergency Medical Care Act.

Sec. 2. For purposes of the Out-of-Network Emergency Medical Care Act, the definitions found in sections 3 to 13 of this act apply.

Sec. 3. Covered person means a person on whose behalf an insurer is obligated to pay health care expense benefits or provide health care services.

Sec. 4. Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (2) serious impairment to such person's bodily functions, (3) serious impairment of any bodily organ or part of such person, or (4) serious disfigurement of such person.

Sec. 5. Emergency services means health care services medically necessary to screen and stabilize a covered person in connection with an emergency medical condition.

Sec. 6. (1) Health benefits plan means a benefits plan which pays or provides hospital and medical expense benefits for covered services and is delivered or issued for delivery in this state by or through an insurer.

(2) Health benefits plan does not include the medical assistance program, medicare, medicare advantage, accident-only, credit, disability, or long-term care coverage, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance, and hospital confinement indemnity coverage.

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Sec. 7. Health care facility means a general acute hospital, satellite emergency department, or ambulatory surgical center licensed pursuant to the Health Care Facility Licensure Act.

Sec. 8. Health care professional means an individual who is credentialed pursuant to the Uniform Credentialing Act, who is acting within the scope of his or her credential, and who provides a covered service defined by the health benefits plan.

Sec. 9. Health care provider means a health care professional or health care facility.

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. 11. Medical assistance program means the medical assistance program established pursuant to the Medical Assistance Act.

Sec. 12. Medically necessary means a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, an injury, or a disease, or its symptoms, and that is in accordance with the generally accepted standards of medical practice; that is clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; that is not primarily for the convenience of the covered person or the health care provider; and that is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or

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diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

Sec. 13. TRICARE means a health care program of the United States Department of Defense Military Health System.

Sec. 14. If a covered person receives emergency services at any health care facility, the facility shall not bill the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

Sec. 15. If a covered person receives emergency services at an in-network or out-of-network health care facility, the health care provider performing those services shall not bill the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

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 may pay the billed amount. A claim or a payment shall be presumed

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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.

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