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2019

LEGISLATURE OF NEBRASKA

ONE HUNDRED SIXTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 569

Introduced by Morfeld, 46.

Read first time January 22, 2019

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to health care benefits; to adopt the Out-of-Network Consumer Protection, Transparency, and Accountability Act.

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

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Section 1. Sections 1 to 19 of this act shall be known and may be cited as the Out-of-Network Consumer Protection, Transparency, and Accountability Act.

Sec. 2. For purposes of the Out-of-Network Consumer Protection, Transparency, and Accountability Act, the definitions found in sections 3 to 13 of this act apply.

Sec. 3. Carrier 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.

Sec. 4. Covered person means a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services.

Sec. 5. (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 a carrier.

(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.

Sec. 6. 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. 7. 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. 8. Health care provider means a health care professional or health care facility.

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Sec. 9. (1) Inadvertent out-of-network services means health care services that are covered under a health benefits plan which provides a network and that are provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility.

(2) Inadvertent out-of-network services includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

Sec. 10. Knowingly, voluntarily, and specifically selected an out-of-network health care provider means that a covered person chose the services of a specific health care provider, with full knowledge that the health care provider is out-of-network with respect to the covered person’s health benefits plan, under circumstances that indicate that the covered person had the opportunity to obtain covered services by an in-network health care provider, but instead selected the out-of-network health care provider.

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 diagnostic results as to the diagnosis or treatment of that covered

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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. Prior to scheduling an appointment with a covered person for a nonemergency procedure, a health care facility shall:

(1) Disclose to the covered person whether the health care facility is in-network or out-of-network with respect to the covered person’s health benefits plan;

(2) Advise the covered person to check with the health care provider arranging the facility services to determine whether or not that health care provider and any health care provider reasonably anticipated to provide services to the covered person is in-network or out-of-network with respect to the covered person's health benefits plan;

(3) Advise the covered person that, at an in-network health care facility with respect to the person's health benefits plan:

(a) The covered person will have a financial responsibility applicable to an in-network procedure and not in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan;

(b) Unless the covered person, at the time of the disclosure required pursuant to this subdivision, has knowingly, voluntarily, and specifically selected an out-of-network health care provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(c) Any bills, charges, or attempts to collect by the health care facility or any health care provider involved in the procedure, in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan in violation of subdivision (b) of this subdivision, should be reported to the covered person's carrier; and

(4) Advise the covered person that, at an out-of-network health care

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facility with respect to the covered person's health benefits plan:

(a) The covered person may have a financial responsibility applicable to health care services provided at an out-of-network facility, in excess of the covered person’s copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by the health benefits plan; and

(b) The covered person should contact the covered person's carrier for further consultation on those costs.

Sec. 15. A health care facility shall post on the facility's web site:

(1) The health benefits plans in which the health care facility is a participating health care provider;

(2) A statement that physician services provided in the health care facility are not included in the facility's charges; and

(3) A statement that health care providers who provide services in the health care facility may or may not participate with the same health benefits plans as the health care facility.

Sec. 16. (1) Prior to scheduling a nonemergency procedure, a health care provider shall disclose to a covered person the following:

(a) The health benefits plans in which the provider is a participating provider and facilities with which the provider is affiliated; and

(b) If the provider is out-of-network for the covered person, that the covered person will have a financial responsibility applicable to health care services provided by an out-of-network provider, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by the health benefits plan.

(2) A health care provider who is a physician shall provide, to the extent the information is available:

(a) The name, practice name, and telephone number of any provider

scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office for the covered person or coordinated or referred by the physician for the covered person at the time of referral to, or coordination of, services with that provider to the covered person; and

(b) For a covered person's scheduled facility admission or scheduled outpatient facility services, the name, practice name, and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the preadmission, testing, registration, or admission at the time the nonemergency services are scheduled to the covered person and the facility.

Sec. 17. If a covered person receives medically necessary services at any health care facility on an emergency or urgent basis as defined by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd et seq., 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. 18. If a covered person receives inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis as defined by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd et seq., the health care provider performing those services shall:

(1) In the case of inadvertent out-of-network services, not bill the covered person in excess of any deductible, copayment, or coinsurance amount; and

(2) In the case of emergency and urgent services, 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. 19. (1) If a covered person receives inadvertent out-of-network services or receives services at an in-network or out-of-network

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health care facility on an emergency or urgent basis, the carrier 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 inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, benefits provided by a carrier that the covered person receives for health care services shall be assigned to the out-of-network health care provider, which shall require no action on the part of the covered person.

(3) Once the benefit is assigned, any reimbursement paid by the carrier shall be paid directly to the out-of-network health care provider. The carrier 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.

(4) If inadvertent out-of-network services or services provided at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network health care provider may bill the carrier for the services rendered. The carrier may pay the billed amount or notify the health care provider within twenty days after the date of the receipt of the claim that the carrier considers the claim to be excessive.

(5) If the carrier provides this notification, the carrier and the health care provider shall have thirty days after the date of this notification to negotiate a settlement. The carrier may attempt to negotiate a final reimbursement amount with the out-of-network health care provider which differs from the amount paid by the carrier pursuant to this section.