

ONE HUNDRED SIXTH LEGISLATURE - SECOND SESSION - 2020
COMMITTEE STATEMENT
LB997

Hearing Date: Tuesday February 11, 2020
Committee On: Banking, Commerce and Insurance
Introducer: Morfeld
One Liner: Adopt the Out-of-Network Emergency Medical Care Act

Roll Call Vote - Final Committee Action:
Advanced to General File with amendment(s)

Vote Results:
Aye: 8 Senators Gragert, Howard, Kolterman, La Grone, Lindstrom,
McCollister, Quick, Williams
Nay:
Absent:
Present Not Voting:

Oral Testimony:

Proponents:

Senator Adam Morfeld
Eric Dunning
Molly McCleery

Representing:

Introducer
Blue Cross and Blue Shield of Nebraska
Nebraska Appleseed

Opponents:

Andy Hale

Representing:

Nebraska Hospital Association

Neutral:

Robert Bell
Dexter Schrodt
Coleen Nielsen

Representing:

Nebraska Insurance Federation
Nebraska Medical Association
American Health Insurance Plans

Summary of purpose and/or changes:

This bill would enact 17 new sections to be known as the Out-of-Network Emergency Medical Care Act. The bill would provide, section by section, as follows:

Section 1 would provide for a named act - the Out-of-Network Emergency Medical Care Act.

Section 2 would provide for definitions found in sections 3 to 13 of the bill.

Section 3 would provide for a definition of "carrier."

Section 4 would provide for a definition of "covered person."

Section 5 would provide for a definition of "emergency medical condition" - a medical condition, the onset of which is sudden, that manifests itself by 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 a 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.

Section 6 would provide for a definition of "emergency services" - health care services medically necessary to screen and stabilize a covered person in connection with an emergency medical condition.

Section 7 would provide for a definition of "health benefit plan."

Section 8 would provide for a definition of "health care facility" - a general acute hospital, satellite emergency department, or ambulatory surgical center.

Section 9 would provide for a definition of "health care professional" - a credentialed individual, who is acting within the scope of his or her credential, and who provides a covered service defined by the health benefit plan.

Section 10 would provide for a definition of "health care provider."

Section 11 would provide for a definition of "medical assistance program."

Section 12 would provide for a definition of "medically necessary" - a health care service that a healthcare 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 person's illness, injury, or disease.

Section 13 would provide for a definition of "TRICARE."

Section 14 would provide that 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.

Section 15 would provide that if a covered person receives emergency services at an in-network or out-of-network health care facility, the health care provider 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.

Section 16 would provide that if a covered person receives emergency services at an in-network or out-of-network health care facility, the carrier shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with in-network healthcare provider for covered services.

With respect to emergency services at an in-network or out-of-network health care facility, benefits provided by a carrier that the covered person receives shall be assigned to the out-of-network health care provider.

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 carrier for the services. The carrier may pay the billed amount or notify the health care provider within twenty days that the center considers the claim to be excessive. A claim is presumed reasonable if it is based on the higher of the carrier's contracted rate or one hundred twenty-five percent of the payment rate received from the Federal Centers for Medicare and Medicaid Services for the same or similar service in the same geographic area.

Section 17 would provide that if the carrier provides notification that it considers a claim to be excessive, the carrier and the health care provider shall have thirty days to negotiate a settlement or engage in mediation. The carrier and the

health care provider shall reach agreement through the mediation process. The cost of mediation shall be split evenly and paid by the carrier and the health care provider.

Section 18 would provide that the bill becomes operative on January 1, 2021.

Explanation of amendments:

The committee amendments would make various changes throughout the bill.

The committee amendments would convert the defined term "carrier" to "insurer."

The committee amendments would eliminate requirements for benefits provided by a carrier for emergency services provided by an out-of-network health care provider to be assigned to the out-of-network healthcare provider.

The committee amendments would provide that 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) 175 percent of the payment rate "for Medicare services" for the same or similar services in the same geographic area. As introduced, the bill would provide that a claim shall be presumed reasonable if it is based on the higher of the carrier's contracted rate or 125 percent of the payment rate received from the federal Centers for Medicare and Medicaid Services for the same or similar services in the same geographic area.

The committee amendments would provide that if an 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 set out in the bill.

The committee amendments would provide that if an insurer "or an out-of-network health care provider" provides notification that it considers a claim or payment to be unreasonable, the insurer and the health care provider shall have 30 days after the notification to negotiate a settlement. The committee amendments would provide that if a settlement is not reached, the insurer and the health care provider shall engage in mediation. The committee amendments would eliminate provisions that would provide that the carrier and the health care provider shall reach agreement through the mediation process.

Matt Williams, Chairperson