

## The Patient Protections and Transparency Act of 2018

### An Act

Be it enacted by the People of the State of \_\_\_\_\_

**Section 1. Title.** This act shall be known as and may be cited as “The Patient Protections and Transparency Act of 2018.”

**Section 2. Purpose.** The Legislature hereby finds and declares that:

(A) Health insurance companies are increasingly offering narrow network plans and regularly removing providers from networks;

(B) Patients should be able to access in-network primary care physicians and specialists in a timely manner, including facility-based physicians;

(C) Patients must be supplied with full knowledge of the facts to make informed decisions concerning the health insurance coverage they purchase and where, and from which providers, they seek health care services;

(D) Physicians should give fee information to patients and discuss their out-of-network fees in advance of services, whenever possible;

(E) A health insurance company shall provide a provider directory online and in print. The company shall annually audit at least a reasonable sample size of its directories for accuracy. The online directory shall be updated at least monthly, the company shall ensure the public can view all current providers, and the directory shall have a searchable format. The company shall disclose that the directory was accurate at the time of printing and that an enrollee should consult the electronic provider directory to ensure that information is current.

(F) Health insurance plans should clearly disclose the scope and limitations of any out-of-network benefit they purport to provide, in language that is meaningful to the consumer; the methodology for reimbursement for out-of-network services should be transparent to enrollees, consumers, clinicians, hospitals and regulatory authorities via an on-line non-profit benchmarking database that is not affiliated or financially connected to a health insurance company or its affiliates;

(G) Patients should be assured that the higher premiums they pay to make affordable access to out-of-network providers reasonably reflect the actuarial value of the out-of-network benefit provided; and

(H) It is imperative that patients be protected from the financial impact that can result from narrow networks and cost-shifting trends within health insurance.

### **Section 3. Definitions.**

1. **Commissioner:** The insurance commissioner of this state.
2. **Cost-sharing:** Any expenditure required by or on behalf of an enrollee with respect to health benefits, including co-insurance, deductibles, and co-pays. Cost-sharing does not include premiums, balance billing amounts for out-of-network providers, and spending for non-covered services.

3. **Emergency Medical Condition:** “Emergency medical condition” means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, which would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:
  - (1) Placing the patient’s mental or behavioral health or, with respect to a pregnant woman, the woman’s or her fetus’ health in serious jeopardy;
  - (2) Serious impairment to a bodily function;
  - (3) Serious impairment of any bodily organ or part; or
  - (4) With respect to a pregnant woman who is having contractions: (a) That there is inadequate time to affect a safe transfer to another hospital before delivery; or (b) That transfer to another hospital may pose a threat to the health or safety of the woman or fetus; or a threat to the individual’s safety or the safety of others.
4. **Emergency Services:** A physical, mental or behavioral health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to determine the presence of and evaluate the emergency medical condition; and (2) any further physical, mental or behavioral health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.
5. **Enrollee:** a patient eligible for services covered by a specific health insurance plan.
6. **Facility-Based Health Care Professional:** a health care professional who provides services to patients in a facility, and typically includes anesthesiologists, radiologists, pathologists, emergency physicians, and hospitalists, but may also include other specialists such as those that provide on-call services, as well as non-physician health care professionals such as nurses, physical therapists, and nutritionists.
7. **Health Care Facility:** institutions, including mobile facilities which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. “Health care facility” includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities, nursing homes, free standing emergency centers, home health agencies, outpatient or independent surgical, diagnostic or therapeutic centers or facilities, including, but not limited to, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories (including independent imaging facilities), cardiac catheterization laboratories and radiation therapy facilities.
8. **Health Care Professional:** a physician or other health care practitioner licensed, accredited or certified to perform specified physical, mental or behavioral health care services consistent with their scope of practice under state law.
9. **Health Care Services:** services for the diagnosis, prevention, treatment or cure of a health condition, illness, injury or disease.
10. **Health Insurance Company:** a company that sells a health insurance plan.
11. **Health Insurance Plan:** any hospital and medical expense incurred policy, non-profit health care service plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
12. **Health Care Provider:** a health care professional, clinician (including APPs, CRNAs and surgical assistants) hospital, health care facility or other provider who/that is accredited, licensed or certified where required in the state of practice and performing within the scope of that accreditation, license or certification.
13. **Health Plan Allowable:** the maximum amount the health plan will pay for a covered service.
14. **In-Network Level of Coverage:** the portion of the cost for a health care service a health insurance plan agrees to pay to a health care provider who/that participates in the health

insurance plan's network. An enrollee is generally responsible for the remaining portion of the cost of care.

15. **In-Network Provider:** a health care provider who/that, through a contract with the health insurance plan, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health insurance company.
16. **Out-Of-Network Level of Coverage:** the portion of the cost for a health care service a health insurance plan is obligated to pay a health care provider who does not participate in the health insurance plan's network for health care services provided to an enrollee under an enrollee's health insurance plan. An enrollee is generally responsible for the remaining portion of the cost of care.
17. **Out-Of-Network Care:** care provided to a patient by a health care provider who/that does not participate in the patient's health insurance plan's network.
18. **Out-Of-Network Provider:** a health care provider who does not have a contract with a health insurance plan to provide care to enrollees of that health insurance plan.
19. **Patient:** participant, beneficiary, enrollee or authorized representative.
20. **Primary Care Physician:** a physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care.
21. **Provider Network:** all the providers contracted to provide services to a specified group of enrollees under a health insurance plan.
22. **Specialist:** a physician who focuses on a specific area of physical, mental or behavioral health or a group of patients and has successfully completed required training and certification. "Specialist" includes a subspecialist who has additional training and certification above and beyond his or her specialty training.
23. **Tier:** to structure a network that identifies and groups some or all types of providers into specific groups to which different provider payment, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.
24. **Unanticipated Out-Of-Network Care:** Services received by a patient in a facility from an out-of-network health care professional when the patient did not have the ability or control to select such services from an in-network health care professional, or emergency services provided to a patient by an out-of-network health care professional. Unanticipated out-of-network care does not include non-emergency services received by a patient when the patient *voluntarily selects in writing* an out-of-network health care professional prior to the provision of the care.
25. **Minimum Benefit Standard (MBS):** The MBS is the usual and customary rate defined as the eightieth (80th) percentile of all charges for the particular health care service performed by a health care professional in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be affiliated with a health insurance company.

**Section 4. Applicability and Scope:** This Act applies to all health insurance companies that offer health insurance plans with provider networks in the State.

#### **Section 5. Unanticipated Out-of-Network Care:**

(A) A health care professional shall send a bill for his or her charges for unanticipated out-of-network care to the patient's health insurance company. The health insurance company shall reimburse the health care professional directly pursuant to Section 5 of this Act.

(1) The health insurance company shall reimburse the health care professional at the Minimum Benefit Standard (MBS);

(2) Under Part (A) (1) of this section, if the provider's reimbursement is at the MBS, a health care professional shall not send a bill to the patient for any difference between the payment received and payment that would have been received if payment was based on the health care professional's charge, (e.g. balance billing is prohibited upon reimbursement of the MBS).

(B) When unanticipated out-of-network care is provided, the providing health care professional may bill a patient for no more than the cost-sharing requirements that would be applicable if the care had been provided by a health care professional in the patient's provider network.

(C) The patient's health insurance company shall inform the health care professional of its enrollee's cost sharing requirements within ten (10) business days of receiving a bill from the health care professional for services provided.

(D) Cost-sharing payments to the health care professional shall be treated by the health insurance company as though they were paid to an in-network health care professional for purposes related to the enrollee's deductibles and out-of-pocket maximums.

**Section 6. Effective.** This Act shall become effective six months from the date of enactment.

**Section 7. Severability.** If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

**Section 8. Nullification.** Any contract provision violating this Act shall be considered null and void.