PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

The Patient Protections and Transparency Act of 2018

Section-by-Section Summary

Section I. Title: The title of the act shall be "The Patient Protections and Transparency Act of 2018".

Section II. Purpose: This section describes the purpose of the legislation, stating that patients need to be aware of information surrounding their health insurance coverage and their in-network providers. Physicians should give their patients fee information and talk to them about any out-of-network fees in advance of any services, where possible. Health insurance companies should provide a provider directory online and in print, and clearly disclose the scope and limitations of any out-of-network services they provide in a way that is understandable to the patient. In general, patients should be protected from the financial impact that narrower networks and cost-shifting trends within health insurance can create.

Section III. Definitions: This section contains definitions for specific terms found in the bill.

Section IV. Applicability and Scope: The bill applies to all health insurance companies that offer health insurance plans with provider networks in the State.

Section V. Unanticipated Out-of-Network Care: A provider will bill unanticipated out-of-network care to a patient's health insurance company. Unanticipated care is defined as "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."

The provider will be reimbursed by the insurance company at the Minimum Benefit Standard (MBS), defined as "the eightieth (80^{th}) 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."

With reimbursement at the MBS, providers will not bill a patient for any difference between the payment received and payment that would have been received if the payment was based on the provider's charge. In other words, balance billing is prohibited with reimbursement of the MBS.

When unanticipated out-of-network care is provided, the provider cannot bill a patient for more than the cost-sharing requirements of an in-netowrk provider. The patient's insurance company

will inform the provider of its enrollee's cost sharing requirements within ten business days of receiving a bill from the provider.

Finally, cost-sharing payments to the provider will be treated by the insurance company as if they were paid to an in-network health care professional as it relates to a patient's deductibles and out-of-pocket maximums.

Section VI. Effective: The act goes into effect six months from the date of enactment.

Section VII. Severability: This section declares the provisions of the act to be severable, and a court ruling against one section will not invalidate the rest.

Section VIII. Nullification: Any contract provision violating the bill will be considered null and void.