LEGISLATIVE GENERAL COUNSEL
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EMERGENCY SERVICES BALANCE BILLING AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Brady Brammer

Senate Sponsor: _____

LONG TITLE

General Description:

This bill enacts requirements related to billing and provider networks for certain health insurance plans.

Highlighted Provisions:

This bill:

- defines terms;
- requires a managed care organization to provide adequate coverage of certain health care services in the managed care organization's network;
- requires a managed care organization to publish and maintain a provider directory of health care providers that are in the managed care organization's network; and
- enacts procedures that a managed care organization and a non-network physician must follow if there is a dispute regarding payment for certain emergency services.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

31A-22-653, Utah Code Annotated 1953

31A-22-654, Utah Code Annotated 1953

H.B. 379

31A-22-655, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-653** is enacted to read:

31A-22-653. Access to managed care organization health care providers.

(1) As used in this section:

(a) (i) "Balance billing" means the practice of a physician billing a managed care organization enrollee for the difference between a physician's charge and the managed care organization's allowed amount.

(ii) "Balance billing" does not include billing an enrollee for cost sharing required by the enrollee's health benefit plan, including copayments, coinsurance, and deductibles.

(b) "Covered benefit" means a health care service covered under the terms of a health benefit plan.

(c) "Emergency medical condition" means the same as that term is defined in Section 31A-22-627.

(d) "Emergency services" means, with respect to an emergency medical condition, services rendered by a physician billable by or on behalf of the physician for:

(i) a medical or mental health screening examination that is within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(ii) any further medical or mental health examination and treatment, to the extent the treatment or examination is within the capabilities of the emergency department and is necessary to stabilize the patient.

(e) "Licensed provider" means an individual who is licensed under Title 58, Occupations and Professions, to provide health care.

(f) "Managed care organization" means:

(i) a managed care organization as defined in Section 31A-27a-403; and

(ii) a third-party administrator.

(g) "Physician" means the same as that term is defined in Section 58-67-102.

(h) (i) "Post stabilization care" means services related to emergency services that:

(A) are provided by the physician who performed the emergency services;

(B) are provided after an enrollee's condition is no longer considered an emergency medical condition;

(C) maintain a stabilized condition or improve or resolve the enrollee's condition; and

(D) are provided within 90 days after the day on which the enrollee's condition is no longer considered an emergency medical condition.

(ii) "Post stabilization care" does not include health care facility charges or laboratory charges.

(i) "Stabilize" means to stabilize as defined in 42 U.S.C. Sec. 1395dd(e)(3).

(2) A managed care organization that offers or administers a network plan shall maintain a network that is sufficient in number and appropriate types of licensed providers, including those that serve predominantly low-income, medically underserved individuals, to ensure that all services to enrollees, including children and adults, will be accessible without unreasonable travel or delay.

(3) An enrollee under a managed care organization's network plan shall have access to emergency services 24 hours per day, seven days per week.

(4) (a) At least one time each year, a managed care organization that provides a network plan shall demonstrate to the commissioner that the managed care organization is able to provide adequate access to current and potential enrollees through a contracted network of health care providers, including health care facilities, for each county within the managed care organization's filed service area.

(b) Adequate access under Subsection (4)(a) is demonstrated if the managed care organization:

(i) has a network of health care providers that meets the maximum travel time and distance standards in, and has sufficient numbers of, health care providers to meet the minimum number of requirements set forth by:

(A) the Centers for Medicare and Medicaid Services for Medicare Advantage plans; and

(B) modifications to and extensions of the standards in Subsection (4)(b)(i)(A) adopted by the commissioner by administrative rule based on nationally recognized standards and as necessary to reflect the age and demographics of the enrollees in the network plan and the availability of rural health care providers; and

(ii) meets adequacy and sufficiency standards established by the commissioner by administrative rule made in accordance with this Subsection (4) and Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(c) The commissioner shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish reasonable standards under Subsection (4)(b)(ii) regarding:

(i) the ratio of enrollees to licensed providers, by specialty;

(ii) the ratio of enrollees to primary care licensed providers;

(iii) the geographic accessibility of health care providers;

(iv) geographic variation and population dispersion;

(v) waiting times for an appointment with participating health care providers;

(vi) hours of operation;

(vii) the availability of the network to meet the needs of enrollees, which may include low-income individuals, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities, or individuals with limited English proficiency;

(viii) other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering health care;

(ix) the volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services;

(x) the extent to which participating health care providers are accepting new patients;

(xi) the regionalization of specialty care, which may require some children and adults to cross state lines for care;

(xii) the number of health care providers within a specified area, including rural or urban areas, that takes into consideration an insured's travel time and distance to health care providers; and

(xiii) the manner in which a managed care organization demonstrates compliance with the criteria established under this Subsection (4).

Section 2. Section **31A-22-654** is enacted to read:

31A-22-654. Managed care organization provider directories.

(1) As used in this section:

(a) "Licensed provider" means the same as that term is defined in Section 31A-22-653.

(b) "Managed care organization" means the same as that term is defined in Section 31A-22-653.

(2) (a) A managed care organization shall post electronically a current and accurate directory of licensed providers for each of the organization's network plans.

(b) In making the directory available electronically, the managed care organization shall ensure the general public is able to view all of the current licensed providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(c) The managed care organization shall update each network plan provider directory at least monthly.

(d) A managed care organization does not violate the requirement of Subsection (2)(c) if the managed care organization fails to update the directory because a licensed provider has failed to notify the managed care organization of a change to the licensed provider's information.

(3) A managed care organization shall make available through a searchable electronic directory, for each network plan, the following information about each licensed provider in the managed care organization's network plan:

(a) the licensed provider's name;

(b) the licensed provider's gender;

(c) participating office locations;

(d) specialty and board certifications;

(e) medical group affiliations, if applicable;

(f) participating facility affiliations, if applicable;

(g) languages spoken other than English, if applicable;

(h) whether the licensed provider is accepting new patients; and

(i) contact information.

(4) The provider directory under this section shall accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for individuals with limited English proficiency.

Section 3. Section **31A-22-655** is enacted to read:

31A-22-655. Managed care organization out-of-network services -- Emergency

services -- Post stabilization care -- Balance billing.

(1) As used in this section:

(a) "Balance billing" means the same as that term is defined in Section 31A-22-653.

(b) "Covered benefit" means the same as that term is defined in Section 31A-22-653.

(c) "Emergency medical condition" means the same as that term is defined in Section 31A-22-627.

(d) "Emergency services" means the same as that term is defined in Section 31A-22-653.

(e) "Managed care organization" means the same as that term is defined in Section 31A-22-653.

(f) "Physician" means the same as that term is defined in Section 58-67-102.

(g) "Post stabilization care" means the same as that term is defined in Section 31A-22-653.

(h) "Stabilize" means to stabilize as defined in 42 U.S.C. Sec. 1395dd(e)(3).

(2) A managed care organization shall have a process to ensure that an enrollee is able to obtain health care for a covered benefit from a non-network physician:

(a) at an in-network level of benefit, including an in-network level of cost sharing, or under an arrangement approved by the commissioner;

(b) in accordance with Section 31A-22-653; and

(c) (i) when an enrollee is diagnosed with a condition or disease that requires specialized health care services; and

(ii) when the managed care organization does not have an in-network physician of the required specialty with the professional training and expertise to treat or provide health care for the condition or disease, or cannot provide reasonable access to an in-network physician with the required training or expertise to treat or provide health care services for the condition or disease.

(3) A managed care organization shall:

(a) reimburse a non-network physician for emergency services and post stabilization care in accordance with this section;

(b) (i) pay a non-network physician directly for emergency services and post stabilization care provided to an enrollee; and

(ii) send an explanation of benefits to the non-network physician with the information required under Subsection (3)(f);

(c) pay a non-network physician for emergency services in accordance with Subsection (6);

(d) pay a non-network physician for post stabilization care at the in-network allowed amount for the patient's managed care organization plan if the patient and the provider agree to post stabilization care;

(e) count toward any deductible or out-of-pocket maximum applied under the enrollee's plan any cost sharing payments made by the enrollee with respect to emergency services or post stabilization care reimbursed under this section in the same manner as if such cost sharing payments were paid for services or care furnished by an in-network physician; and

(f) provide to an enrollee who has received emergency services and to the non-network physician an explanation of benefits that includes:

(i) whether payment for the emergency services and post stabilization care is subject to any regulation under state or federal law;

(ii) the amount the non-network physician may attempt to collect from the enrollee for the enrollee's cost sharing, including unmet deductibles, copayments, and coinsurance; and

(iii) the managed care organization's allowed amount under Subsection (3)(c) for the emergency services or Subsection (3)(d) for post stabilization care.

(4) If a non-network physician sends a bill directly to an enrollee for emergency services or post stabilization care, the bill shall notify the enrollee:

(a) that the emergency services or post stabilization care were performed by a physician who is not a network physician for the enrollee's health benefit plan; and

(b) that the enrollee is responsible for paying the enrollee's applicable in-network cost sharing amount.

(5) A non-network physician who receives payment from the managed care organization under Subsection (3)(c) or (d):

(a) may rely on the explanation of benefits provided by the managed care organization to the enrollee and the non-network physician under Subsection (3)(f);

(b) shall accept the payment from the enrollee under Subsection (4)(b) as payment in full for the emergency services and post stabilization care from the enrollee; and

(c) may not attempt to collect payment from an enrollee for emergency services or post stabilization care in excess of the amount under Subsection (5)(b).

(6) (a) When a managed care organization receives a bill for emergency services from a non-network physician, the managed care organization shall:

(i) ensure that the enrollee shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network physician; and

(ii) may elect to pay a non-network physician for emergency services:

(A) as submitted by the provider;

(B) in accordance with Subsection (6)(b); or

(C) in an amount mutually agreed upon by the managed care organization and the physician.

(b) This section does not preclude a managed care organization and a non-network physician from agreeing to a different payment arrangement if:

(i) the enrollee is responsible for no more than the applicable in-network cost sharing amount; and

(ii) the enrollee has no legal obligation to pay the balance for emergency services remaining after the payments under Subsection (5).

(c) A managed care organization that does not pay in accordance with Subsection (6)(a)(ii)(A) or (B) shall pay a commercially reasonable amount for the emergency services rendered by the non-network physician, based on the criteria described in Subsection (8), except for the enrollee's copayment, coinsurance, or deductible, if applicable.

(d) If the managed care organization pays the non-network physician under Subsection (6)(c), the physician and the managed care organization may, no later than 30 days after the day on which the payment is made, negotiate an amount of payment for the emergency services, other than the amount paid by the managed care organization.

(e) If the managed care organization and the non-network physician have not agreed to a negotiated amount under Subsection (6)(d), the managed care organization or the non-network physician may initiate an independent dispute resolution process under Subsection (7) to determine the amount of payment.

(7) (a) An arbitrator's determination under this Subsection (7) shall be to select, based on an evaluation of what is a commercially reasonable fee for the services rendered, either:

(i) the managed care organization's payment; or

(ii) the non-network physician's reimbursement request.

(b) The arbitrator shall determine which amount to select based upon the conditions and factors set forth in Subsection (8).

(c) The determination of the arbitrator shall be binding on the managed care organization, physician, and patient, and is admissible in:

(i) a court proceeding between the managed care organization, physician, or patient; and

(ii) an administrative proceeding between the state and the physician.

(d) The arbitrator shall make a determination within 30 days after the day on which the arbitrator receives the dispute for review.

(e) (i) For disputes involving an insured, when the arbitrator determines the managed care organization's payment is commercially reasonable, payment for the dispute resolution process shall be the responsibility of the non-network physician.

(ii) When the arbitrator determines the non-network physician's reimbursement request is commercially reasonable, payment for the dispute resolution process shall be the responsibility of the managed care organization.

(iii) When a good faith negotiation directed by the arbitrator under this Subsection (7) results in a settlement between the managed care organization and non-network physician, the managed care organization and the non-network physician shall evenly divide and share the prorated cost of the dispute resolution under this Subsection (7).

(f) Claims may be grouped under this Subsection (7) if each of the claims that is grouped involves:

(i) the same managed care organization and health care provider group;

(ii) claims with the same or related current procedural terminology codes relevant to a particular procedure for the patient; and

(iii) claims that occur within 90 days of each other.

(8) (a) In determining what is a commercially reasonable fee to pay for a health care service, an arbitrator shall consider all relevant factors, including:

(i) the usual and customary reimbursement for the service; and

(ii) other factors that may be submitted at the discretion of either party, which may

include:

(A) the physician's usual payment for comparable services with regard to patients in health care plans in which the physician is in-network and patients in health care plans in which the physician is not in-network;

(B) the circumstances and complexity of the particular case, including time and place of the service;

(C) individual patient characteristics; and

(D) other relevant clinical and economic factors, including payment by third-party private payors.

(b) (i) The usual and customary reimbursement for a health care service under Subsection (8)(a) means the 80th percentile of all total amounts paid for the particular health care service performed by a physician in the same or similar specialty and provided in the same geographical area of the state as reported in a benchmarking database maintained by a nonprofit or government organization specified by the Department of Health by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with:

(A) a state physician association representing all physician specialties; and

(B) a state association representing health insurers in the state.

(ii) The database described in Subsection (8)(b)(i) may be the all payer claims database maintained by the Department of Health if the database can produce the necessary data in a form approved by the department in consultation with:

(A) the Department of Health;

(B) a state physician association representing all physician specialties; and

(C) a state association representing health insurers in the state.

(iii) If the benchmarking database described in Subsection (8)(b)(i) is maintained by a nonprofit organization, the nonprofit organization may not be affiliated with a managed care organization or health insurer.