S.309

Introduced by Senators Lyons, Ingram, McCormack, Pearson and Westman

Referred to Committee on

Date:

Subject: Health; health insurance; health care providers; contract provisions; surprise billing

Statement of purpose of bill as introduced: This bill proposes to prohibit certain provisions in contracts between health insurers and health care providers. It would also limit patients' out-of-pocket exposure for emergency services delivered at out-of-network health care facilities and for nonemergency services delivered by out-of-network providers at in-network facilities.

An act relating to limitations on health care contract provisions and surprise medical bills

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 18 V.S.A. § 9418c is amended to read:

§ 9418c. FAIR CONTRACT STANDARDS

* * *

(c) Provision of information. When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in subdivisions (a)(1)(A) and (B) of this section.

(d) Evaluation and review programs. Upon request, the contracting entity shall identify any utilization management, quality improvement, price or quality transparency program, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program upon request by the participating provider who is subject to or is participating in the program within 14 days after the date of the request.

(e) Confidentiality agreements. The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract.

(f) Prohibited contract provisions. Unless agreed to by both contracting parties, necessary to protect policyholders, or required by law, ~~A~~a health care contract between a health plan or other contracting entity and a health care provider shall not include any of the following:

(1) A provision that transfers to the provider liability related to the cost of care provided by other participating or nonparticipating health care providers. This prohibition shall not apply to an agreed-upon written contract between a health plan and a health care provider or group of health care providers that specifically waiver the provisions of this subdivision for the purposes of bearing risk for the cost of care.

(2) A provision that prohibits, or that provides financial or administrative incentives to forgo~~,~~ providing health care services to an insured or referring an insured for health care services, including services from nonparticipating health care providers.

(3) A provision that imposes responsibility on a health care provider for informing insureds about the contracted or participation status of other health care providers.

Sec. 2. 18 V.S.A. § 9422 is added to read:

§ 9422. SURPRISE MEDICAL BILLS

(a) Definitions. As used in this section:

(1) "Cost-sharing amount" means any co-payment, ~~amount or~~ coinsurance ~~rate~~or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(2) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(A) placing the health of the individual or, with respect to a pregnant individual, the health of the individual or the unborn child, in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(3) "Emergency medical services" means:

(A) a medical screening examination, as required by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; and

(B) any further medical examination and treatment to stabilize the patient that are within the capabilities of the hospital staff and facilities, as required by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd.

(4) "Reasonable and customary value" means the average of the contracted commercial rates paid by the health plan for the same or similar services in Vermont, but in all circumstances shall be within 125 and 200 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in Vermont.

(5) "Nonparticipating provider" means a health care professional who is licensed by this state to deliver or furnish health care services and who is not contracted with the insured's health care service product.

(b) Emergency services; nonparticipating provider. For emergency services delivered to an insured by a nonparticipating health care provider~~, a health plan~~:

(1) a health plan

(A) shall not impose on the insured a cost-sharing amount for the items and services delivered that is greater than the cost-sharing amount that would apply under the plan if the items and services had been delivered by a participating health care provider; ~~and~~

(~~2~~B) shall pay to the provider delivering the items and services the reasonable and customary value for the items and services provided; and~~, except that it~~

(C) shall ~~be~~ have the responsibility ~~of the health insurer~~ to respond to, defend against, and resolve any health care provider request or claim for payment exceeding the amount the health plan paid or reimbursed the health care provider pursuant to this subsection.

(2) An insured shall not owe the nonparticipating provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the nonparticipating provider, the plan shall inform the insured and the nonparticipating provider of the in-network cost-sharing amount owed by the insured.

(3) A nonparticipating provider shall not bill or collect any amount from the insured for services subject to this section except for the in-network cost-sharing amount. Any communication from the nonparticipating provider to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point

bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until he or she is informed by his or her health care service plan of any applicable cost sharing.

(A) If the nonparticipating provider has received more than the in-network cost-sharing amount from the insured for services subject to this section, the nonparticipating provider shall refund any overpayment to the insured within 30 calendar days after receiving payment from the insured.

(B) If the nonparticipating provider does not refund any overpayment to the insured within 30 calendar days after being informed of the insured's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the insured.

(C) A nonparticipating provider shall automatically include in his or her refund to the insured all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(c) Nonemergency services; ~~nonparticipating provider at participating facility.~~ For nonemergency services delivered to an insured by a nonparticipating health care provider at a participating health care facility, ~~including~~ and any imaging services, or laboratory services delivered pursuant to an order from a participating provider~~, a health plan~~:

(1) a health plan

(A) shall not impose on the insured a cost-sharing amount for the items and services delivered that is greater than the cost-sharing amount that would apply under the plan if the items and services had been delivered by a participating health care provider; ~~and~~

(B~~2~~) shall pay to the provider delivering the items and services the reasonable and customary value for the items and services provided;~~, except~~ and ~~that it~~

(C) shall ~~be~~ have the responsibility ~~of the health insurer~~ to respond to, defend against, and resolve any health care provider request or claim for payment exceeding the amount the health plan paid or reimbursed the health care provider pursuant to this subsection.

(2) An insured shall not owe the nonparticipating provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the nonparticipating provider, the plan shall inform the insured and the nonparticipating provider of the in-network cost-sharing amount owed by the insured.

(3) A nonparticipating provider shall not bill or collect any amount from the insured for services subject to this section except for the in-network cost-sharing amount. Any communication from the nonparticipating provider to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until he or she is informed by his or her health care service plan of any applicable cost sharing.

(A) If the nonparticipating provider has received more than the in-network cost-sharing amount from the insured for services subject to this section, the nonparticipating provider shall refund any overpayment to the insured within 30 calendar days after receiving payment from the insured.

(B) If the nonparticipating provider does not refund any overpayment to the insured within 30 calendar days after being informed of the insured's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the insured.

(C) A nonparticipating provider shall automatically include in his or her refund to the insured all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(d) Except for services subject to subdivision (e), the following shall apply:

(1) Any cost sharing paid by the insured for the services subject to this section shall count toward the insured’s in network limit on annual out-of-pocket expenses.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a participating provider.

(3) The cost sharing paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service and shall constitute “applicable cost sharing owed by the insured.”

(e) For services subject to this section, if an insured has a health care service plan that includes coverage for out-of-network benefits, a nonparticipating provider may bill or collect from the insured the out-of-network cost sharing, if applicable, only when the insured consents in writing and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the insured shall consent in writing to receive services from the identified nonparticipating provider.

(2) The consent shall be obtained by the nonparticipating provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the insured is being prepared for surgery or any other procedure.

(3) At the time consent is provided, the nonparticipating provider shall give the insured a written estimate of the insured's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The nonparticipating provider shall not attempt to collect more than the estimated amount without receiving separate written consent from the insured or the insured's authorized

representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise the insured that he or she may elect to seek care from a contracted provider or may contact the insured's health care service plan in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the insured in the language spoken by the insured.

(6) The consent shall also advise the insured that any costs incurred as a result of the insured's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

(f) A nonparticipating provider who fails to comply with the requirements of subdivision (e) has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (b), (c), and (d) shall apply and subdivision (e) shall not apply.

(g) A nonparticipating provider may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivisions (b) and (c) or the out-of-network cost-sharing amount owed pursuant to subdivision (e), that the insured has failed to pay.

(h) A nonparticipating provider, or any entity acting on his or her behalf, including any assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for a minimum of 150 days after the initial billing regarding amounts owed by the insured under subdivisions (b), (c) or (e).

(i) With respect to an insured, the nonparticipating provider, or any entity acting on his or her behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

Sec. 3. EFFECTIVE DATE

This act shall take effect on July 1, 2020.