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54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019

INTRODUCED BY

DISCUSSION DRAFT

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING THE SURPRISE BILLING PROTECTION ACT; PROVIDING FOR PROTECTION OF COVERED PERSONS FROM UNEXPECTED BILLING FROM PROVIDERS THAT DO NOT PARTICIPATE IN THE COVERED PERSON'S HEALTH BENEFITS PLAN; ENACTING A NEW SECTION OF CHAPTER 59A, ARTICLE 16 NMSA 1978 TO PROHIBIT SURPRISE BILLING AS AN UNFAIR PRACTICE; ESTABLISHING PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--Sections 1 through 13 of this act may be cited as the "Surprise Billing Protection Act"."

SECTION 2. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in the Surprise Billing Protection Act:

A. "ambulance service" means any government or private ground transportation service designated and used, or intended to be used, for the transportation of sick or injured persons;

B. "balance billing" means a provider's practice of billing a covered person for the difference between the provider's billed charges and the health insurance carrier's limit for reimbursement of provider charges;

C. "claim" means a request from a provider for payment for health care services rendered;

D. "co-insurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that co-insurance rates may differ for different types of services under the same health benefits plan;

E. "copayment" means a cost-sharing provision that requires a covered person to pay a fixed dollar amount when health care services are received or when purchasing medicine after subtraction of any deductible, with the health insurance carrier paying the balance allowable amount; provided that there may be different copayment requirements for different types of services and a copayment may be subject to a maximum out-of-pocket limit;

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F. "cost sharing" means a copayment, co-insurance, deductible or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of a health benefits plan;

G. "covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan;

H. "covered person" means:

(1) an enrollee, policyholder or subscriber;

(2) the enrolled dependent of an enrollee, policyholder or subscriber; or

(3) another individual participating in a health benefits plan;

I. "deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

J. "emergency medical condition" means a physical or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson in that circumstance, possessing an average knowledge of medicine and health, to reasonably

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expect, in the absence of immediate medical attention, to result in:

(1) placing the individual's physical or behavioral health or, with respect to a pregnant woman, the woman or a fetus' health in serious jeopardy;

(2) serious impairment of bodily function;

(3) serious impairment of any bodily organ or part; or

(4) with respect to a pregnant woman who is having contractions:

(a) providing inadequate time to effect a safe transfer to another hospital before or after delivery; or

(b) the transfer to another hospital may pose a threat to the health or safety of the woman or a fetus;

K. "emergency service" means, with respect to an emergency medical condition:

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

(2) any further medical or mental health examination and treatment to the extent that they are within the capabilities of the staff and facilities available at the

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emergency medical facility to stabilize the patient; and

(3) any transportation provided by ambulance to a hospital for emergency medical, mental or behavioral health treatment;

L. "facility" means an entity providing a health care service, including:

(1) a general, special, psychiatric or rehabilitation hospital;

(2) an ambulatory surgical center;

(3) a cancer treatment center;

(4) a birth center;

(5) an inpatient, outpatient or residential drug and alcohol treatment center;

(6) a laboratory, diagnostic or other outpatient medical service or testing center;

(7) a health care provider's office or clinic;

(8) an urgent care center; or

(9) any other therapeutic health care setting;

M. "health benefits plan" means a policy or agreement entered into or offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(1) an accident-only policy;

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(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(7) a fixed indemnity policy;

(8) a dental-only policy;

(9) a vision-only policy;

(10) a workers' compensation policy;

(11) an automobile medical payment policy; or

(12) any other policy specified in rules of the superintendent;

N. "health care services" means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan;

O. "health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a

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nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services or that provides, offers or administers a health benefit policy or managed health care plan in the state;

P. "hospital" means a facility offering inpatient health care services, nursing care and overnight care for three or more individuals on a twenty-four-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions;

Q. "inducement" means the act or process of enticing or persuading another person to take a certain course of action;

R. "network" means the group or groups of participating providers that have been contracted to provide health care services under a network plan;

S. "network plan" means a health benefits plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers and facilities managed, owned, under contract with or employed by the health insurance carrier offering the health benefits plan;

T. "nonparticipating provider" means a provider who is not a participating provider;

U. "participating provider" means a provider or

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facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing;

V. "prior authorization" or "pre-certification" means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of a health benefits plan that the health insurance carrier offers;

W. "provider" means a health care professional, hospital or other facility licensed to furnish health care services;

X. "stabilize" means to provide medical or behavioral health treatment of a patient's emergency medical condition as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient to a facility or, with respect to emergency labor, to deliver, including the delivery of a placenta; and

Y. "surprise bill":

(1) means a bill that a nonparticipating provider issues to a covered person for health care services

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rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

(a) emergency services or emergency ground transportation provided by the nonparticipating provider; or

(b) non-emergency services rendered by a nonparticipating provider at a participating facility where: 1) a participating provider is unavailable; 2) a nonparticipating provider renders unforeseen services; or 3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered; and

(2) does not mean a bill:

(a) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating health care provider without prior authorization; or

(b) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider

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plan; provided that the health care services are not provided as emergency services."

SECTION 3. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] EMERGENCY SERVICES--REIMBURSEMENT--LIMITATION ON CHARGES.--

A. A health insurance carrier shall reimburse a nonparticipating provider for emergency services necessary to evaluate and stabilize a covered person at a nonparticipating hospital emergency department if a prudent layperson would reasonably believe that:

(1) emergency services are necessary; and

(2) use of a participating hospital emergency department would result in a delay that would worsen the covered person's condition.

B. A health insurance carrier shall not require that prior authorization for emergency services be obtained by, or on behalf of, a covered person prior to the point of stabilization of that covered person if a prudent layperson would reasonably believe that an emergency medical condition exists.

C. A health insurance carrier may impose a copayment, co-insurance or limitation of benefits requirement for emergency services performed by a nonparticipating provider only to the same extent that the copayment, co-insurance or

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limitation of benefits requirement applies for participating providers and is documented in the policy.

D. A health insurance carrier may require an emergency services provider to notify a health insurance carrier of a covered person's admission to the hospital within a reasonable time period after stabilization of the emergency medical condition."

SECTION 4. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] NON-EMERGENCY SERVICES--LIMITATION ON CHARGES.--

A. Other than applicable cost sharing that would apply if a participating provider had rendered the same services, a health insurance carrier shall provide reimbursement for and a covered person shall not be liable for charges and fees for covered non-emergency services rendered by a nonparticipating provider that are delivered when:

(1) the covered person at an in-network facility does not have the ability or opportunity to choose a participating provider who is available to provide the covered services; or

(2) medically necessary care is unavailable within a health benefits plan's network; provided that "medical necessity" shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan.

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B. Except as set forth in Subsection A of this section, nothing in this section shall preclude a provider from balance billing for non-emergency health care services provided by a nonparticipating provider to an individual with coverage through a health maintenance organization contract."

SECTION 5. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] CREDIT AGAINST MAXIMUM OUT-OF-POCKET COST-SHARING AMOUNT--SURPRISE BILL COMPLAINT FORM--COMMUNICATION BY HOSPITALS--ADVANCE NOTIFICATION OF CHARGES FOR HEALTH CARE SERVICES.--

A. If a covered person receives a health care service from a nonparticipating provider under the conditions set forth in Section 3 or 4 of the Surprise Billing Protection Act, that provider shall not knowingly submit a surprise bill to the covered person. Upon request, the covered person's health insurance carrier shall submit to the nonparticipating provider a statement of the applicable in-network cost-sharing amounts owed by the covered person to the nonparticipating provider.

B. If a covered person receives a surprise bill, the covered person may submit a surprise bill complaint form to the covered person's health insurance carrier in accordance with the provisions of this section.

C. The superintendent shall:

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(1) develop a standardized surprise bill complaint form to permit a covered person to plead that a bill is a surprise bill; and

(2) post the form on the superintendent's website and distribute written copies to the public.

D. A health insurance carrier to which a covered person submits a surprise bill complaint form shall review the surprise bill complaint form in accordance with its grievance procedures established pursuant to the Patient Protection Act.

E. In accordance with the hearing procedures established pursuant to the Patient Protection Act, a covered person or a nonparticipating provider may appeal a health insurance carrier's determination made pursuant to the filing of a surprise bill complaint form.

F. A health insurance carrier may require a covered person who files a surprise bill complaint form to submit a statement and reasonable documentation attesting that the claim in question is a surprise bill that meets the definition under Subsection Y of Section 2 of the Surprise Billing Protection Act.

G. By December 31, 2019, the department of health shall require each health facility licensed pursuant to the Public Health Act to post the following on the health facility's website in a publicly accessible manner:

(1) the names and hyperlinks for direct access

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to the websites of all health benefits plans for which the hospital has a contract for services;

(2) a statement that sets forth the following:

(a) services may be performed in the hospital by participating providers as well as nonparticipating providers who may separately bill the patient;

(b) providers that perform health care services in the hospital may or may not participate in the same health benefits plans as the hospital; and

(c) prospective patients should contact their health insurance carriers in advance of receiving services at that hospital to determine whether the scheduled health care services provided in that hospital will be covered at in-network rates;

(3) the rights of covered persons under the Surprise Billing Protection Act; and

(4) instructions for contacting the superintendent.

H. Any communication pertaining to services provided under circumstances giving rise to a surprise bill shall clearly state that the covered person is responsible only for payment of applicable in-network cost-sharing amounts under the covered person's health benefits plan."

SECTION 6. A new section of the New Mexico Insurance Code is enacted to read:

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"[NEW MATERIAL] COVERED PERSONS--PROVIDERS--OVERPAYMENT.--

A. If a covered person pays a nonparticipating provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the nonparticipating provider shall refund to the covered person within thirty calendar days of receipt any amount paid in excess of the in-network cost-sharing amount.

B. If a nonparticipating provider has not made a full refund to the covered person of any amount paid in excess of the in-network cost-sharing amount to the covered person within thirty calendar days of receipt, interest shall accrue at the rate of ten percent per year beginning with the first calendar day following the thirty-calendar-day period.

C. A covered person may seek recovery of the refund of the amount the covered person has paid in excess of the in-network cost-sharing amount that a nonparticipating provider owes, plus interest, pursuant to Subsection B of this section by bringing an action in district court to recover that overpayment amount and interest owed and reasonable costs and attorney fees, if approved by the court."

SECTION 7. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] NONPARTICIPATING PROVIDERS--REBATES AND INDUCEMENTS--PROHIBITION.--A nonparticipating provider shall not, either directly or indirectly, knowingly waive, rebate,

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give, pay or offer to waive, rebate, give or pay all or part of a cost-sharing amount owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek a health care service from that nonparticipating provider. The superintendent may impose fines on providers for unlawful rebates and inducements; provided that a provider on which the superintendent intends to impose a fine shall be entitled to a hearing in accordance with the provisions of Section 59A-4-15 NMSA 1978."

SECTION 8. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROVIDERS--REIMBURSEMENT FOR A SURPRISE BILL.--

A. For services provided under circumstances giving rise to a surprise bill, a health insurance carrier shall reimburse a nonparticipating provider for emergency health care services rendered, the greatest of the following amounts:

(1) the median reimbursement rate the health benefits plan would cover for emergency services if rendered by a participating provider; or

(2) the usual, customary and reasonable rate for emergency services. As used in this paragraph, "usual, customary and reasonable rate" means **[xxx]** for the particular health care service performed by a provider in the same or similar specialty in the same geographic area, as reported in a

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benchmarking database maintained by a nonprofit organization specified by the superintendent. The nonprofit organization shall be conflict-free and unaffiliated with any stakeholder in the health care sector. Benchmarks for the usual, customary and reasonable rate shall be reviewed by the superintendent every two years to ensure fairness to providers and to evaluate the impact on health insurance premiums. The superintendent shall establish the benchmark threshold by rule.

B. Calculation of the date of health insurance carrier receipt of the bill shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

C. A health insurance carrier shall reimburse a nonparticipating provider for non-emergency health care services rendered under circumstances giving rise to a surprise bill in the following manner:

(1) the health insurance carrier and nonparticipating provider may reach an agreement as to an amount to be paid for the nonparticipating provider's services, payment of which, in addition to the applicable in-network cost-sharing amount owed by the covered person, shall constitute payment in full to the nonparticipating provider for the health care service rendered, and the health insurance carrier shall pay the provider in accordance with requirements for prompt payment established pursuant to Section 59A-16-21.1

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NMSA 1978;

(2) if a nonparticipating provider and health insurance carrier do not reach agreement on a payment amount through the negotiation process outlined in this section within forty-five calendar days after the health insurance carrier receives the bill for the health care service, either party may submit a formal dispute resolution request to the superintendent and include all of the claims pertaining to a covered person from a single episode of illness;

(3) calculation of the date of health insurance carrier receipt of the bill shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978; and

(4) a health insurance carrier's failure to respond within forty-five days to a nonparticipating provider's request for prompt payment of a surprise bill shall constitute acceptance of the provider's charges. Payment of accepted charges shall be made in accordance with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

D. A health insurance carrier shall make available to providers access to claims status information."

SECTION 9. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] HEALTH INSURANCE CARRIERS--

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NONPARTICIPATING PROVIDERS--INDEPENDENT DISPUTE RESOLUTION FOR NON-EMERGENCY SERVICES CLAIMS--COSTS.--

A. A health insurance carrier or nonparticipating provider may initiate binding arbitration to determine reimbursement for non-emergency services provided by a nonparticipating provider. Failure to respond within fifteen business days to a request for arbitration constitutes an acceptance of the final claims settlement offer of the party requesting arbitration. Payment of accepted charges shall align with requirements for prompt payment established pursuant to Section 59A-16-21.1 NMSA 1978.

B. Arbitration shall be initiated by filing a request with the superintendent. The parties may agree to resolve disputes over additional reimbursement services for multiple covered persons during the arbitration process.

C. The superintendent shall publish a list of resolution organizations or arbitrators that provide binding arbitration.

D. Both parties shall agree on an arbitrator from the list within five business days of submission of a request for arbitration.

E. If no agreement can be reached, a list of five arbitrators will be provided. From the list of five arbitrators, the party initiating arbitration shall first veto two arbitrators and then the other party shall veto two

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arbitrators from the remaining list. The remaining arbitrator shall be the chosen arbitrator.

F. The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer to resolve the dispute over reimbursement for services provided before arbitration occurs. In response to this notice, the non-requesting party shall inform the requesting party of its final offer before arbitration occurs.

G. The arbitrator's review shall consist of a review of both parties' final offers submitted to resolve the dispute over reimbursement for services. The arbitrator's decision may be one of the two amounts submitted by the parties as their final offers or another amount determined to be reasonable by the arbitrator. If the arbitrator finds that, given the final offers, a settlement between the health insurance carrier and the nonparticipating provider is reasonably likely or that the final offers represent unreasonable extremes, the arbitrator may direct both parties to attempt a good faith negotiation for settlement. The health insurance carrier and nonparticipating provider may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty-day period for dispute resolution.

H. In making a determination pursuant to this section, the arbitrator may consider, and the parties shall provide at the resolution organization's request, documentation

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of the following:

(1) the individual covered person's characteristics;

(2) the level of training, education and experience of the nonparticipating provider;

(3) the nonparticipating provider's usual charge for comparable services provided out-of-network with respect to any health benefits plan;

(4) the participating provider contracted rate of payment for comparable services;

(5) the usual and customary provider charges, as defined by a public independent database of charges, for the same or similar services in the same geographic area;

(6) the amount that would be paid under health coverage pursuant to health coverage under part A or part B of Title 18 of the federal Social Security Act, as amended, or federal-state medical assistance provided pursuant to Title 19 or 21 of the federal Social Security Act for the service;

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

(8) the availability of the health care service for the covered person from participating providers;

(9) any payments made in prior surprise bill disputes between the provider and the health insurance carrier;

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and

(10) the propensity of the provider to be included in health insurance carrier networks.

I. The arbitrator shall issue a written decision within thirty business days after assignment of a matter for dispute for resolution. Copies of any written findings of fact shall be provided to both parties and the superintendent by the same means, whether electronic or hard copy.

J. The determination obtained through the resolution process pursuant to this section shall be binding on both parties and not appealable.

K. A final determination as to a claim code of a service shall be binding on the health insurance carrier and the provider for any disputes between them involving the same claim code for a period of one year from the date of the determination.

L. An arbitrator's expenses and fees, together with other expenses, excluding attorney fees, incurred in the conduct of arbitration shall be shared equally by the parties to the arbitration.

M. A party that fails to pay all amounts due to the other party and to the resolution organization within thirty business days of receiving the final determination shall:

(1) pay interest to the resolution organization and to the prevailing party at one and one-half

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percent per month; and

(2) be subject to a penalty of one hundred dollars ($100) per day, payable to the current school fund, until all payments are made in full.

N. Nothing in this section shall preclude the parties from reaching a resolution of their dispute before the arbitrator issues its decision.

O. A resolution organization shall:

(1) protect from disclosure, including in the information provided to the superintendent, any information specifically identifying the covered person who received the health care services that were the subject of an arbitration decision. The information shall be protected and remain confidential in compliance with all applicable state and federal law and shall be confidential as a record pursuant to applicable state and federal law; and

(2) report to the superintendent any change in its status that would cause it to cease performing or being qualified to perform arbitrations pursuant to the Surprise Billing Protection Act."

SECTION 10. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] REASONABLE HEALTH CARE COST MANAGEMENT PERMITTED.--Nothing in the Surprise Billing Protection Act shall be construed to prohibit a health insurance carrier from

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appropriately using reasonable health care cost management techniques."

SECTION 11. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PRIVATE CAUSE OF ACTION.--Except as provided in Subsection C of Section 6 of the Surprise Billing Protection Act, nothing in that act shall be construed to create or imply a private cause of action for a violation of that act."

SECTION 12. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] RULEMAKING.--The superintendent:

A. shall promulgate rules as may be necessary to appropriately implement the provisions of the Surprise Billing Protection Act, including creation of a surprise billing complaint form; and

B. may require by rule that carriers report the annual percentage of claims and expenditures paid to nonparticipating providers for health care services."

SECTION 13. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] APPLICABILITY.--The provisions of the Surprise Billing Protection Act apply to the following types of health coverage delivered or issued for delivery in this state:

A. group health coverage governed by the provisions

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of the Health Care Purchasing Act;

B. individual health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

C. group and blanket health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

D. individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; and

E. individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law."

SECTION 14. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--SURPRISE BILLING PROHIBITED.--

A. A health care provider shall not knowingly submit to a covered person a surprise bill for health care services, which surprise bill demands payment for any amount in excess of the cost-sharing amounts that would have been imposed by the covered person's health benefits plan if the health care service from which the surprise bill arises had been rendered by a participating provider.

B. It shall be an unfair practice for a health care

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provider to submit a surprise bill to a collection agency.

C. As used in this section:

(1) "co-insurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided that co-insurance rates may differ for different types of services under the same health benefits plan;

(2) "copayment" means a cost-sharing provision that requires a covered person to pay a fixed dollar amount when health care services are received or when purchasing medicine after subtraction of any deductible, with the health insurance carrier paying the balance allowable amount; provided that there may be different copayment requirements for different types of services and a copayment may be subject to a maximum out-of-pocket limit;

(3) "cost sharing" means a copayment, co-insurance, deductible or any other form of financial obligation of a covered person other than a premium or share of a premium, or any combination of any of these financial obligations as defined by the terms of a health benefits plan;

(4) "covered person" means:

(a) an enrollee, policyholder or subscriber;

(b) the enrolled dependent of an enrollee, policyholder or subscriber; or

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(c) another individual participating in a health benefits plan;

(5) "deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

(6) "emergency medical condition" means a physical or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson in that circumstance, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(a) placing the individual's physical or behavioral health or, with respect to a pregnant woman, the woman or a fetus' health in serious jeopardy;

(b) serious impairment of bodily function;

(c) serious impairment of any bodily organ or part; or

(d) with respect to a pregnant woman who is having contractions: 1) that there is inadequate time to effect a safe transfer to another hospital before or after

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delivery; or 2) the transfer to another hospital may pose a threat to the health or safety of the woman or a fetus;

(7) "emergency services" means, with respect to an emergency medical condition:

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

(b) any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the emergency medical facility to stabilize the patient; and

(c) any transportation provided by ambulance to a hospital for emergency medical, mental or behavioral health treatment;

(8) "facility" means an entity providing a health care service, including:

(a) a general, special, psychiatric or rehabilitation hospital;

(b) an ambulatory surgical center;

(c) a cancer treatment center;

(d) a birth center;

(e) an inpatient, outpatient or residential drug and alcohol treatment center;

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(f) a laboratory, diagnostic or other outpatient medical service or testing center;

(g) a health care provider's office or clinic;

(h) an urgent care center; or

(i) any other therapeutic health care setting;

(9) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(a) an accident-only policy;

(b) a credit-only policy;

(c) a long- or short-term care or disability income policy;

(d) a specified disease policy;

(e) coverage provided pursuant to Title 18 of the federal Social Security Amendments of 1965, as then constituted or later amended;

(f) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(g) a fixed indemnity policy;

(h) a dental-only policy;

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(i) a vision-only policy;

(j) a workers' compensation policy;

(k) an automobile medical payment policy; or

(l) any other policy specified in rules of the superintendent;

(10) "health care provider" means a health care professional, hospital or other facility licensed to furnish health care services;

(11) "health care services" means any service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or other disease, including physical or behavioral health care services, to the extent they are offered by a health benefits plan;

(12) "nonparticipating provider" means a provider who is not a participating provider;

(13) "participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing; and

(14) "surprise bill":

(a) means a bill that a nonparticipating

underscored material = new
[bracketed material] = delete

provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider: 1) emergency services or emergency ground transportation provided by the nonparticipating provider; or 2) non-emergency services rendered by a nonparticipating provider at a participating facility, where a participating provider is unavailable or a nonparticipating provider renders unforeseen services or services without the consent of the covered person; and

(b) does not mean a bill: 1) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating health care provider without prior authorization; or 2) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided that the health care services are not provided as emergency services."

SECTION 15. EFFECTIVE DATE.--The effective date of the provisions of this act is October 1, 2019.