Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'**Sec. 1. 22 MRSA §1718-D** is enacted to read:

§ 1718-D. Prohibition on balance billing for surprise bills

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Enrollee" has the same meaning as in Title 24-A, section 4301-A, subsection 5.

B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection 7.

C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16.

D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection 1.

2. Prohibition on balance billing. An out-of-network provider reimbursed for a surprise bill under Title 24-A, section 4303-C, subsection 2, paragraph B may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan.

Sec. 2. 24-A MRSA §§4303-C and 4303-D are enacted to read:

§ 4303-C. Protection from surprise bills

1. Surprise bill defined. As used in this section, unless the context otherwise indicates, "surprise bill" means a bill for health care services, other than emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.

2. Requirements. With respect to a surprise bill:

A. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider;

B. A carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise; and

C. Notwithstanding paragraph B, if a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent.

§ 4303-D. Provider directories

1. Requirement. A carrier shall make available provider directories in accordance with this section.

A. A carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions described in subsection 2. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current 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.

B. A carrier shall update each provider directory at least monthly. The carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the superintendent upon request.

C. A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection 2 upon request of a covered person or a prospective covered person.

D. For each network plan, a carrier shall include in plain language in both the electronic and print directories the following general information:

(1) A description of the criteria the carrier has used to build its provider network;

(2) If applicable, a description of the criteria the carrier has used to tier providers;

(3) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network the tier in which each is placed, whether by name, symbols, grouping or another designation, so that a covered person or a prospective covered person is able to identify the provider tier; and

(4) If applicable, that authorization or referral may be required to access some providers.

E. A carrier shall make clear in both its electronic and print directories which provider directory applies to which network plan by including the specific name of the network plan as marketed and issued in this State. The carrier shall include in both its electronic and print directories a customer service e-mail address and telephone number or electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information.

F. For the information required pursuant to subsections 2, 3 and 4 in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, a carrier shall make available through the directory the source of the information and any limitations on the information, if applicable.

G. A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency.

2. Information in searchable format. A carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

A. For health care professionals:

(1) The health care professional's name;

(2) The health care professional's gender;

(3) The participating office location or locations;

(4) The health care professional's specialty, if applicable;

(5) Medical group affiliations, if applicable;

(6) Facility affiliations, if applicable;

(7) Participating facility affiliations, if applicable;

(8) Languages other than English spoken by the health care professional, if applicable; and

(9) Whether the health care professional is accepting new patients;

B. For hospitals:

(1) The hospital's name;

(2) The hospital's type;

(3) Participating hospital location; and

(4) The hospital's accreditation status.

This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and

C. For facilities, other than hospitals, by type:

(1) The facility's name;

(2) The facility's type;

(3) Types of services performed; and

(4) Participating facility location or locations.

This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans.

3. Additional information. In the electronic provider directories for each network plan, a carrier shall make available the following information in addition to all of the information available under subsection 2:

A. For health care professionals:

(1) Contact information. This subparagraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans;

(2) Board certifications. This subparagraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and

(3) Languages other than English spoken by clinical staff, if applicable;

B. For hospitals, the telephone number. This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and

C. For facilities other than hospitals, the telephone number. This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans.

4. Information available in printed form. A carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

A. For health care professionals:

(1) The health care professional's name;

(2) The health care professional's contact information;

(3) Participating office location or locations;

(4) The health care professional's specialty, if applicable;

(5) Languages other than English spoken by the health care professional, if applicable; and

(6) Whether the health care professional is accepting new patients;

B. For hospitals:

(1) The hospital's name;

(2) The hospital's type; and

(3) Participating hospital location and telephone number; and

C. For facilities, other than hospitals, by type:

(1) The facility's name;

(2) The facility's type;

(3) Types of services performed; and

(4) Participating facility location and telephone number.

The carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.

5. Rulemaking. The superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 3. Effective date. This Act takes effect January 1, 2018.'

SUMMARY

This amendment replaces the bill. The amendment provides that a carrier shall require an enrollee that receives a surprise bill from an out-of-network provider to pay only the applicable cost-sharing coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for the health care services if the services were rendered by a network provider. The amendment also sets the reimbursement rate for that out-of-network provider at the network rate under the enrollee's health plan unless the carrier and out-of-network provider agree otherwise. If an out-of-network provider is reimbursed by the carrier, the provider may not bill the enrollee for any amount beyond the enrollee's applicable cost sharing. Under the amendment, "surprise bill" means a bill for health care services, other than emergency services, received by an enrollee for services rendered by an out-of-network provider, when the services were rendered by the out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from the out-of-network provider.

Like the bill, the amendment requires health carriers to make available provider directories. The amendment provides discretion to the Superintendent of Insurance to determine if rulemaking is necessary.

The amendment adds an effective date of January 1, 2018.