§1718-D. Prohibition on balance billing for surprise bills and bills for out-of-network emergency services; disputes of bills for uninsured patients and persons covered under self-insured health benefit plans; disclosure related to referrals

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. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection 7. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B-1. "Knowingly elected to obtain the services from an out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this paragraph. [PL 2019, c. 668, §1 (NEW).]

C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection 1. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

E. "Visit" means any interaction between an enrollee and one or more providers for the purpose of assessing the health status of an enrollee or providing one or more health care services between the time an enrollee enters a facility and the time an enrollee is discharged. [PL 2019, c. 668, §1 (NEW).]

[PL 2019, c. 668, §1 (AMD).]

2. Prohibition on balance billing. An out-of-network provider reimbursed for a surprise bill or a bill for covered emergency services under Title 24-A, section 4303-C or, if there is a dispute, under Title 24-A, section 4303-E or a bill for COVID-19 screening and testing under Title 24-A, section 4320-P 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. For an enrollee subject to coinsurance, the out-of-network provider shall calculate the coinsurance amount based on the median network rate for that health care service under the enrollee's health plan. An out-of-network provider is also subject to the following with respect to any overpayment made by an enrollee.

A. If an out-of-network provider provides health care services covered under an enrollee's health plan and the out-of-network provider receives payment from the enrollee for health care services for which the enrollee is not responsible pursuant to this subsection, the out-of-network provider shall reimburse the enrollee within 30 calendar days after the earlier of the date that the provider received notice of the overpayment and the date the provider became aware of the overpayment. [PL 2019, c. 668, §1 (NEW).]

B. An out-of-network provider that fails to reimburse an enrollee for an overpayment as required by paragraph A shall pay interest on the overpayment at the rate of 10% per annum beginning on the earlier of the date the provider received notice of the overpayment and the date the provider became aware of the overpayment. An enrollee is not required to request the accrued interest from

the out-of-network provider in order to receive interest with the reimbursement amount. [PL 2019, c. 668, §1 (NEW).]

[PL 2021, c. 28, Pt. A, §1 (AMD).]

3. Uninsured patients; disputes of bills. An uninsured patient who has received a bill for emergency services from a provider for one or more emergency health care services rendered during a single visit totaling $750 or more may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E. The independent dispute resolution entity contracted to resolve the dispute over the surprise bill shall select either the out-of-network provider's fee or the uninsured patient's proposed payment amount in accordance with Title 24-A, section 4303-E. An uninsured patient may not be charged by a provider more than the amounts generally billed to a patient who has insurance covering emergency services as determined using the method described in 26 Code of Federal Regulations, Section 1.501(r)-5, paragraph (b)(3) or (b)(4). A provider shall hold the uninsured patient harmless for the duration of the independent dispute resolution process and may not seek payment until the independent dispute resolution process is completed. Notwithstanding Title 24-A, section 4303-E, subsection 1, paragraph F, payment for the independent dispute resolution process is the responsibility of the provider. In the event a claim includes more than one emergency health care service rendered during a single visit, the independent dispute resolution entity may allocate the prorated independent dispute resolution costs at its discretion among providers.

[PL 2019, c. 668, §1 (NEW).]

REVISOR'S NOTE: (Subsection 3 as enacted by PL 2019, c. 670, §1 is REALLOCATED TO TITLE 22, SECTION 1718-D, SUBSECTION 5)

4. Person covered under self-insured health benefit plan; disputes of surprise bills or bills for covered emergency services rendered by an out-of-network provider. A person covered under a self-insured health benefit plan that is not subject to the provisions of Title 24-A, section 4303-E pursuant to Title 24-A, section 4303-E, subsection 2 and who has received a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E, subsection 1. The independent dispute resolution entity contracted to resolve the dispute over the bill shall select either the out-of-network provider's fee or the covered person's proposed payment amount in accordance with Title 24-A, section 4303-E, subsection 1. This subsection does not apply to a person covered under a self-insured health benefit plan who knowingly elected to obtain the services from an out-of-network provider.

[PL 2019, c. 668, §1 (NEW).]

5. (REALLOCATED FROM T. 22, §1718-D, sub-§3) Referral to an out-of-network provider. A provider receiving a nonemergency referral or self-referral for any in-person health care service or procedure shall disclose to the enrollee whether that provider to whom the enrollee is being referred is a member of the provider network under the enrollee's health plan before the enrollee schedules the appointment for that service or procedure.

[RR 2019, c. 2, Pt. A, §25 (RAL).]

SECTION HISTORY

PL 2017, c. 218, §1 (NEW). PL 2017, c. 218, §3 (AFF). PL 2019, c. 668, §1 (AMD). RR 2019, c. 2, Pt. A, §§24, 25 (COR). PL 2019, c. 670, §1 (AMD). PL 2021, c. 28, Pt. A, §1 (AMD).