CS FOR HOUSE BILL NO. 193(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered: 3/30/18
Referred: Labor and Commerce

Sponsor(s): REPRESENTATIVES GRENN, Tarr

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance trade practices and frauds; relating to services rendered by and payments made to non-network health care providers in certain circumstances; relating to the duty of health care insurers to hold covered persons harmless for covered services provided by non-network health care providers in certain circumstances; relating to group health insurance policies covering employees of a participating governmental unit; relating to balance billing by a health care provider or health care facility; and making certain acts violations of the Alaska Unfair Trade Practices and Consumer Protection Act."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.36 is amended by adding new sections to read:

Sec. 21.36.512. Services rendered by non-network health care providers; payment. (a) Except as provided in (d) of this section, a health care insurer that offers,

issues for delivery, delivers, or renews in this state a health care insurance plan shall pay a non-network health care provider in accordance with (b) of this section if the non-network health care provider renders to a covered person

(1) emergency services or treats an emergency medical condition;

(2) services at an in-network hospital or ambulatory surgical center; or

(3) services for which a referral was made by an in-network health care provider to the non-network health care provider without explicit written consent of the covered person acknowledging that the in-network health care provider is referring the covered person to a non-network health care provider and that the referral may result in costs not covered by the health care insurance plan.

(b) If a non-network health care provider renders services to a covered person under (a) of this section,

(1) the covered person may only be required to pay the copayment, deductible, or coinsurance amounts or other out-of-pocket expenses that would be imposed under the health care insurance plan of the covered person for those services if those services were rendered by an in-network health care provider;

(2) the health care insurer shall apply the amount paid by the covered person under (1) of this subsection toward the in-network deductible of the covered person; and

(3) the health care insurer shall pay the non-network health care provider, based on a calculation that excludes the in-network copayment, deductible, or coinsurance amount imposed on the covered person, the greater of the amount

(A) of the median negotiated contract rate generated using the in-network health care providers for the service provided;

(B) that is equal to the 80th percentile of charges for the service calculated using a method that establishes a statistically credible profile that reflects the general cost differences between the geographical area where the service was performed and the other geographical areas when performed by a health care provider in the same or similar specialty; or

(C) that is at least 350 percent of the amount reimbursed by Medicare for the service provided.

(c) A non-network health care provider that renders services to a covered person under (a) of this section shall submit all bills or invoices for covered services to the covered person's health care insurer to be paid in accordance with (b) of this section. A non-network health care provider that renders services to a covered person under (a) of this section may not send a bill or invoice to the covered person for covered services, except for a copayment, deductible, or coinsurance amount owed under (b) of this section.

(d) A health care insurer is not required to pay a non-network health care provider under (a) or (b) of this section if an in-network health care provider is available to render services to a covered person and the covered person knowingly elects to obtain those services from the non-network health care provider.

(e) In this section,

(1) "ambulatory surgical center" has the meaning given in AS 47.32.900;

(2) "emergency medical condition" has the meaning given in AS 21.07.250;

(3) "emergency services" has the meaning given in AS 21.07.250;

(4) "health care insurance plan" has the meaning given in AS 21.54.500;

(5) "health care insurer" has the meaning given in AS 21.54.500;

(6) "health care provider" has the meaning given in AS 21.07.250.

Sec. 21.36.513. Health care insurers; hold harmless. (a) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall hold a covered person harmless for any covered services provided by a non-network health care provider under AS 21.36.512(a) and ensure that the covered person does not incur greater out-of-pocket costs, including copayment, deductible, or coinsurance amounts, for services rendered from a non-network health care provider under AS 21.36.512(a) than the covered person would have incurred from a health care provider that furnishes those services through a network of health care providers that have entered into a contract with the health care insurer.

(b) In this section,

(1) "health care insurance plan" has the meaning given in AS 21.54.500;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 21.07.250.

*** Sec. 2.** AS 39.30 is amended by adding a new section to read:

Sec. 39.30.093. Services rendered by non-network health care providers. Notwithstanding the definition of health care insurer in AS 21.36.512, 21.36.513, and AS 21.54.500, or its application to the state, a health care insurance plan obtained under AS 39.30.090 or provided under AS 39.30.091 is subject to the requirements of AS 21.36.512 and 21.36.513 for services rendered by a non-network health care provider, as that term is defined in AS 21.07.250.

*** Sec. 3.** AS 45.45 is amended by adding a new section to read:

Sec. 45.45.915. Balance billing by health care provider or health care facility. (a) A health care provider or health care facility that provides services under the circumstances described in AS 21.36.512(a)

(1) may not balance bill a covered person for those services in a manner that results in the covered person's incurring greater out-of-pocket costs, including copayment, deductible, or coinsurance amounts, from a non-network health care provider than would be imposed for those services if those services were rendered by an in-network health care provider; and

(2) shall be paid in accordance with AS 21.36.512(b).

(b) In this section,

(1) "health care facility" includes a hospital emergency room or stand-alone emergency service facility;

(2) "health care insurer" has the meaning given in AS 21.54.500;

(3) "health care provider" has the meaning given in AS 21.07.250.

*** Sec. 4.** AS 45.50.471(b) is amended by adding a new paragraph to read:

(58) violating AS 45.45.915 (balance billing by health care provider or health care facility).