SMcK

L.D. 2111

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

129TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 756, L.D. 2111, Bill, "An Act To Establish Patient Protections in Billing for Health Care"

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

'**Sec. 1. 22 MRSA §1718-D,** as enacted by PL 2017, c. 218, §1 and affected by §3, is amended to read:

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

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.

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.

Sec. 2. 22 MRSA §1718-E is enacted to read:

§1718-E. Prohibition on fees for transferring a patient or a patient's medical records

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, may not require any fee or other payment from any patient for the transfer of a patient between health care entities or for the transfer of any medical records related to a patient between health care entities unless the fee or other payment is disclosed to the patient and is directly related to the costs associated with establishing the patient as a patient of the health care entity or transferring that patient's medical records. This section does not prohibit the use of current procedural technology codes used by the American Medical Association for new office visits that include the cost of care.

Sec. 3. 22 MRSA §1718-F is enacted to read:

§1718-F. Disclosure related to observation status for Medicare patients

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall disclose to a patient who is covered by the federal Medicare program and who is on observation status and not an admitted patient at the health care entity the following information in a single notice:

1. Medicare outpatient observation notice. The Medicare outpatient observation notice required under 42 Code of Federal Regulations, Section 489.20(y);

2. Impact on patient's financial liability. Notification that observation status may have an impact on the patient's financial liability; and

3. Opportunity to discuss potential financial liability. Notification that the patient may meet with a representative from the health care entity's financial office to discuss the patient's potential financial liability.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment replaces the bill and makes the following changes.

1. It requires a health care entity to disclose to a federal Medicare patient who is on observation status in a single notice the required disclosure of that status required by federal Medicare rules, that the patient's observation status may have an impact on the patient's financial liability and that the patient may meet with a representative from the health care entity's financial office to discuss the patient's potential financial liability.

2. It requires that a provider receiving a nonemergency referral to disclose to the patient whether the provider is an out-of-network provider.

3. It prohibits a health care entity from charging any fee for the transfer of a patient between providers or for the transfer of patient records between providers unless the fee

is disclosed and directly related to the costs associated with making that transfer of the patient or the patient's medical records.