

Protecting People From Surprise Medical Bills Act
Section by Section

Section 1:

Title

“Protecting People From Surprise Medical Bills Act”

Section 2:

Prohibition on Surprise Balance Billing

Out-of-network (OON) providers will no longer be permitted to balance bill a patient for unanticipated out-of-network care, which includes the following situations:

- Emergency care in both in-network and out-of-network facilities
- Scheduled anticipated care with unanticipated out-of-network providers
- Out-of-network after-emergency care when a patient cannot travel without medical transport
- Out-of-network imaging or lab services when ordered by an in-network provider

The patient shall not be liable to pay the insurer any amount in excess of the applicable in-network cost-sharing amount and deductible, and the insurer or provider shall not bill any such excess payment.

Entities who violate the ban and balance bill a patient will be subject to civil monetary damages if the patient has not been reimbursed the amount that they were balanced billed within 30 days of the entity being made aware of the error.

Initial payment

The plan/issuer will pay the provider a commercially reasonable rate within 30 days.

Direct Negotiation

If either party is dissatisfied with that amount, they will have 30 days to privately settle on a payment amount.

Establishment of Independent Dispute Resolution (IDR) Process

If no agreement between the parties is met, either party may trigger the independent dispute resolution (IDR) process described below.

The Secretaries of HHS and Labor shall establish an IDR process for resolving disputes between health plans and out-of-network providers for emergency services or unanticipated care rendered to enrollees.

The patient will be completely out of the process and will only be billed for their in-network cost-sharing rates.

The IDR is “baseball style” – the arbiter will select either the initial provider charge or the payment that the plan initially paid the provider, whichever they deem to be more reasonable.

If the parties reach a settlement prior to completion of the arbitration process, then they split the costs of the process. Any payment owed by one party to the other must be made within 15 calendar days.

HHS shall maintain a database of arbitrators (which responsibility may be delegated to the American Arbitration Association or to a state that already undertakes a similar function) who are qualified to resolve billing disputes of this nature and are unbiased and free from actual or potential conflicts of interest.

Providers shall be permitted to submit multiple claims of identical code(s) from a single site of service for simultaneous consideration under the arbitration process. The dates of service for these claims shall occur within 60 days of each other.

Once arbitration is requested, the arbitration process shall be completed within sixty (60) days; this timeframe includes 30 days for both parties to submit information and data and 30 days for the arbiter to render a decision.

Providers/issuers may submit supporting documents, and the IDR entity shall consider:

- The usual and customary cost of the service, which is defined as 80th percentile of charges for comparable services for that specialty in the geographical area in which the services were rendered, determined through reference to an independent medical claims database;
- If previously contracted, the history of commercial network contracting between the plan and the provider, including the prior in-network rates;
- The training and specialization of the provider, as well as the characteristics of the practice setting (including the acuity level and cost intensity);
- The provider’s quality and outcome metrics;
- The circumstances and complexity of the case, including time of the service;
- The physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;
- If there is a wide discrepancy between what the plan is attempting to pay this OON provider vs. other OON providers and between what the provider is charging for this OON patient vs. other OON patients;
- Individual patient characteristics; and
- Other economic and clinical circumstances relevant to the case.

The final judgment of the arbitrator on the reasonable amount shall be binding and enforceable in any court with subject matter jurisdiction, and not subject to appeal unless it is determined that fraudulent or corrupt actions have been taken by any of the parties involved in the IDR process.

Section 3:

Deductible transparency

A health plan/issuer shall clearly print in-network and out-of-network deductible amounts on insurance cards distributed to the beneficiaries.

Section 4:

Transparency for In-Network Patients

The Secretary shall establish transparency standards to provide better information to covered patients about which providers are in-network of the covered plan. Such standards shall include at a minimum a requirement that plans offer provider directories online and in print; annual audits of provider directories; monthly updates of the online directory; and disclosures on accuracy of the print directories.

A patient cannot be held responsible for out-of-network costs if the patient could not have reasonably known they were out-of-network because insurers are not compliant. For example, if a patient checks the website and verifies with the plan that they are in-network, they cannot be balance billed if that turns out not to be true.

Section 5:

Reporting Requirements

Each group health plan and issuer must submit the following information annually to the Secretary of HHS and Secretary of Labor:

- The number of claims submitted by in-network providers, including how many of those claims were paid and how many were denied;
- The number of claims submitted by out-of-network providers, including how many of those claims were paid and how many were denied;
- Patient out-of-pocket costs for out-of-network services; and
- For unanticipated care out-of-pocket claims, how many of the claims are for emergency care and how many are for out-of-network care in an in-network facility.

Section 6:

Impact Study

No later than 3 years after enactment, the Secretary of HHS shall report to Congress an analysis of the following effects of this statute:

- Financial impact on cost-sharing and overall health care spending;
- The incidence and prevalence of unanticipated out-of-network care broken down by type – emergency care vs. out-of-network care in an in-network facility;
- Network adequacy;
- Comparison of claims databases used and the impact on reimbursement rates;
- Number of bills that are settled in direct negotiation and the number that go to IDR;
- Administrative cost of IDR; and
- Impact of IDR on premiums and deductibles

Section 7:

Billing feasibility study

The Secretary of HHS will conduct a feasibility study on the provision of a single bill for all services provided for a single episode of care.

Section 8:

Scope and Applicability to States with Surprise Billing Laws

This act shall apply to all self-funded plans and Federal Employees Health Benefits Program plans, and to all fully-insured plans in states that do not have balanced billing laws or regulations. States do not have to use the IDR framework but must include the patient protections included in section 2 of this legislation regarding cost to patients.

Section 9:

Billing Statute of Limitation

A patient cannot be billed for the first time for any services after one year of services rendered by either the provider or the payer.

Section 10:

Effective Date

The Secretary of Labor and Secretary of Health and Human Services shall promulgate regulations pertaining to this law within one year of enactment. The provisions of this bill shall be effective for plans and providers starting on the January 1st that occurs after one year after enactment.

Section 11:

Publication

HHS shall publish results of arbitration by geographic region in order to give more guidance to providers and plans.