

**February 7, 2020
(Updated February 13)**

House Committees Release Legislation to Address Surprise Medical Bills

House Ways and Means Committee Chairman Richard Neal, D-Mass., and Ranking Member Kevin Brady, R-Texas, this morning released [legislative text](#) of the Consumer Protections Against Surprise Medical Bills Act of 2020, the committee's proposal to address surprise medical bills. The legislation prohibits providers from balance billing patients for emergency services or medical care the patient reasonably could have expected to be in-network, and does not allow patients to be charged more than the in-network cost-sharing amount. The proposal does not rely on a benchmark payment rate to determine out-of-network reimbursement, but instead includes a period for health plans and providers to negotiate reimbursement, to be followed by a mediated dispute resolution process should it be necessary. The proposal also includes several other consumer protection and transparency provisions. The committee is expected to mark up the legislation on Wednesday, Feb. 12. **A summary of the legislation is below.**

In addition, House Committee on Education and Labor Chairman Robert C. "Bobby" Scott, D-Va. and Ranking Member Virginia Foxx, R-N.C., this morning unveiled the Ban Surprise Billing Act. The legislation is similar to the bills passed last year by the House Energy and Commerce Committee and Senate Health, Education, Labor and Pensions Committee in that it relies on a median in-network rate to resolve out-of-network payments. For amounts paid above \$750 (or \$25,000 for air ambulance services), the legislation allows for an independent dispute resolution process to determine the final payment. A summary of the legislation is [here](#) and [legislative text](#) was released late this afternoon. The committee is scheduled to mark up the legislation on Tuesday, Feb. 11.

SUMMARY OF WAYS AND MEANS COMMITTEE'S CONSUMER PROTECTIONS AGAINST SURPRISE MEDICAL BILLS ACT OF 2020 (REVISED TO REFLECT BILL AS PASSED OUT OF COMMITTEE)

Section 2: Consumer Protections through Requirements on Health Plans to Prevent Surprise Medical Bills for Emergency Services.

Beginning in 2022, patients who receive emergency care at an out-of-network facility, including an emergency department of a hospital, as well as a freestanding emergency department, would be responsible for only their in-network cost sharing responsibilities.

The copayment or coinsurance rate would be based on either the reimbursement rate established under state law (for state-regulated products in states with surprise medical billing protections in place) or the health plan's median in-network rate developed using a methodology established by the secretaries of the Departments of Health and Human Services, Treasury and Labor. The legislation also contemplates several unique arrangements in certain states, e.g., states that have an all-payer model agreement. Any deductibles or out-of-pocket maximums would apply as if the services were provided by a participating provider. The provider would be paid the difference between the patient's cost-sharing obligation and the out-of-network rate for those services (described below).

Hospitals would be permitted to offer patients the option of transferring to an in-network facility or paying a higher out-of-network rate. The hospital also would be responsible for alerting patients if any providers practicing in its facility could be out-of-network with the patient's health plan and provide an estimate of the cost of the services from non-participating providers.

Health plans would be required to allow enrollees with children to designate a participating pediatrician as the child's primary care provider. Health plans also would be prohibited from requiring an authorization or referral for an enrollee seeking coverage of obstetrical or gynecological care provided by a participating health care professional specializing in obstetric and gynecology.

Section 3: Consumer Protections through Requirements on Health Plans to Prevent Surprise Medical Bills for Non-Emergency Services Performed by Non-Participating Providers at Certain Participating Facilities.

Patients who receive out-of-network services at a facility that is in-network with their health plan would be responsible for only their in-network cost-sharing responsibilities. The copayment or coinsurance rate would be based on the same options described above. Any deductibles or out-of-pocket maximums would apply as if the services were provided by a participating provider. The provider would be paid the difference between the patient's cost-sharing obligation and the out-of-network rate for those services (described below). The provider would be responsible for notifying the patient about whether or not they contract with the patient's health plan.

Section 4: Consumer Protections through Application of Health Plan External Review in Cases of Certain Surprise Medical Bills.

Consumers would be able to use an appeals process to dispute decisions made by their health plans with respect to surprise medical bills.

Section 5: Consumer Protections through Health Plan Transparency Requirements.

Health plans would be required keep accurate provider directories. The information would have to be verified at least every 90 days with a sample size of at least 10% of

health care providers. Updates to the database would have to be made within two business days of the receipt of information from a provider or facility. Plans would have to respond to enrollee inquiries about whether a provider was in or out-of-network within one business day and also maintain a database on a public website. Plans also would have to disclose “information in plain language” regarding the prohibitions of balance billing in certain circumstances, information on patient cost-sharing obligations for out-of-network providers and how an individual can contact state and local authorities if they believe the health plan violated these requirements. Patient cost sharing would be limited to in-network amounts if the information provided by the plan was inaccurate.

Section 6: Consumer Protections through Health Plan Requirement for Fair and Honest Advance Cost Estimate.

Health plans would be required to provide an Advanced Explanation of Benefits to enrollees for services they expect to receive from a provider or facility, including information on whether the provider or facility participates in the health plan network, the contracted rate if the provider or facility is in-network, and if the provider or facility is not in-network, how information on participating providers can be obtained.

In addition, the plan must provide a “good faith estimate” of the amount the provider or facility would charge for the item or service, the amount the plan expects to pay, the enrollee’s anticipated cost sharing responsibilities, and any amount the enrollee has already paid in terms of meeting annual deductibles and out-of-pocket cost sharing limits.

If an enrollee uses an out-of-network provider based on inaccurate information provided by the health plan, the cost-sharing obligations are limited to what the enrollee would have paid in-network, and the out-of-network provider would be paid at the most recent contracted rate or if no recent rate is available, the out-of-network rate (described below).

Section 7: Determination through Open Negotiation and Mediation of Out-of-Network Rates to be Paid by Health Plans.

Out-of-network reimbursement would be determined either through a provider’s acceptance of a health plans’ initial payment, through a period of “open negotiation” or, ultimately, through a mediated dispute resolution process. Either health plans or providers could trigger a 30-day period of negotiation during which the parties would seek to agree upon a payment amount. The health plan would be required to share the median amount it has paid for such items or services in the last year, and the provider would be required to share the median of the amount of reimbursement received for the most recent year under contracted arrangements (in other words, not including out-of-network payments). If this information were not available, the HHS Secretary would determine which information should be specified.

Should the two parties not be able to reach an agreement during the open negotiation process, either party can initiate a Mediated Dispute Process. The process would be

established by the Secretaries of HHS, Treasury and Labor and include the selection of an independent entity to moderate the dispute. Multiple similar dispute items could be “bundled” for purposes of consideration.

Within 30 days, the mediator would be required to select either the offer made by the health plan or the provider/facility. In selecting an offer, the mediator only would be permitted to consider any information put forth by the health plan and the provider, as well as the median contracted rate for the service or item. The mediator would be prohibited from taking into consideration usual and customary charges or billed charges.

The Secretaries of HHS, Treasury and Labor would make available a summary of the Mediated Dispute Process on a quarterly basis starting in 2023.

Section 8: Prohibiting Balance Billing Practices by Providers for Emergency Services, for Services Furnished by Non-Participating Providers at Participating facility, and in Certain Cases of Misinformation.

Starting in 2022, hospitals and other providers no longer will be able to send balance bills for out-of-network emergency services or for out-of-network services provided at a facility that is in-network with a patient’s health plan. For scheduled services, the out-of-network provider would be required to give written notice within 48 hours that the provider does not have a relationship with the patient’s plan, the estimated amount the provider may charge the individual, and information that the patient can seek services from a contracted provider, or else it will be considered a “surprise bill” for cost sharing purposes and the bill could be subject to mediation.

Providers and facilities would be required to submit to insurers in a timely fashion any changes in contact information for use in the health plans’ provider directories.

For scheduled procedures, providers and facilities must provide “good faith estimates” of expected charges for items or services at least three business days before the date such item is to be provided. These estimates would be shared with the patient’s health plan and bundled with other information the health plan would be required to provide under Section 6 above. The text also would require continuity of coverage for patients involved in a course of treatment for whom their health plan no longer contracts with a provider or facility, with the plan to pay at the previously contracted rate.

Providers would be required to bill the patient within one year after the date on which the services were provided.

Uninsured patients would be provided with a dispute resolution process should they be billed “substantially in excess” of the good faith estimate they were given by a provider or facility.

Section 9: Additional Consumer Protections.

For continuity of coverage, consumers would be granted up to 90 days of in-network cost sharing rates if their provider is no longer in network during a course of treatment. Health plan membership cards would be required to include information on the closest in-network hospital, phone and internet resources for customer information, deductibles, out-of-pocket cost sharing maximums, and emergency and urgent care services cost-sharing obligations.

Health plans would be required to make available price comparison tools for their enrollees that also take into consideration an individual's cost-sharing requirements for each item or provider listed.

Rather than relying on the enrollee to pay for out-of-network bills, health plans would be required to make payments directly to providers and facilities (assignment of benefits).

Section 10: Air Ambulance Cost Data Reporting Program.

The HHS Secretary would be required to publish information from air ambulances on claims and cost data within one year of the enactment of the legislation and will submit a report to Congress.

Section 11: GAO Report on Effects of Legislation.

Within two years of enactment of the legislation, the Comptroller General of the U.S. would be required to submit a report to Congress on the impact of the legislation at the state and federal level, as well as the impact on network adequacy standards and provider and facility participation in networks.