

December 12, 2020

Text of Bipartisan, Bicameral Surprise Medical Billing Legislation Released

AHA summary of provisions included in the bill

Last night, House and Senate Committee leaders announced a bipartisan agreement to address surprise medical bills, the “No Surprises Act.” The bill is supported by House Ways and Means Committee Chairman Richard E. Neal (D-MA) and Ranking Member Kevin Brady (R-TX), House Energy and Commerce Committee Chairman Frank Pallone, Jr. (D-NJ) and Ranking Member Greg Walden (R-OR), House Education and Labor Committee Chairman Robert C. “Bobby” Scott (D-VA) and Ranking Member Virginia Foxx (R-NC), and Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA).

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 bill also includes several other provisions to help patients access certain types of care and better understand their provider networks and costs.

The legislation may be voted on before the end of the year. The bill would use the savings generated from the surprise medical billing provisions to fund certain expiring public health programs, including Community Health Centers, National Health Service Corps, Teaching Health Centers, and the Special Diabetes Programs.

The Congressional Budget Office has not yet released publicly a score. The legislative text is available [here](#) and a summary follows.

HIGHLIGHTS OF THE LEGISLATION

Surprise Medical Billing Patient Protections (Sections 102 and 104). Beginning Jan. 1, 2022, patients would be protected from surprise medical bills that could arise from out-of-network emergency care, certain ancillary service provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient’s informed consent. Patients would be required to only pay the in-network cost-sharing amount, which would be determined through a formula

established by the Secretary of Health and Human Services (HHS) and would count toward the patient's health plan deductible and out-of-pocket cost-sharing limits. Providers would not be permitted to balance bill patients beyond this cost-sharing amount. Both providers and health plans would be required to inform patients about these protections. Violations could result in state enforcement action or federal civil monetary penalties of up to \$10,000.

In certain instances, an out-of-network provider would still be permitted to bill a patient more than the in-network cost-sharing amount for care. However, the provider would need to give the patient notice of their network status and an estimate of charges, as well as obtain the patient's written consent, prior to the delivery of care.

Provider Reimbursement and Independent Dispute Resolution (IDR) Process (Section 103). Health plans would be required to reimburse out-of-network providers for the services subject to surprise medical billing protections, and patients would be shielded from any payment disputes that arose between plans and providers. The rate may be determined by state law or policy in certain circumstances, including when the state has a statute that addresses reimbursement for certain out-of-network claims or uses an all-payer model.

If a provider is dissatisfied with a payment made by a health plan, it could initiate a structured process to resolve the dispute. First, the health plan and provider would have 30 days to attempt to resolve the dispute through negotiation. If a settlement could not be reached during that period, the involved parties would be able to access an IDR process conducted by an unbiased entity approved by the federal government. Each party would submit a final offer for consideration by the arbiter (also known as "baseball-style arbitration), along with supporting information.

The arbiter would be directed to consider a wide range of relevant information, including: the median contracted in-network rate; the provider's training and experience; the patient's acuity and the complexity of care provided; the facility's teaching status, case mix and scope of services; any demonstration of good faith effort or lack thereof to resolve the dispute; prior year contracted rates; and other information brought forward by the involved parties. The arbiter would not be able to consider provider charges.

There would be no minimum disputed payment threshold to enter the IDR process, and similar claims within a certain timeframe could be batched together to ease administrative burden. The arbitration process would need to be concluded within 30 days, and the losing entity would pay the fees to participate in the process. However, if the dispute is resolved by the parties before the arbiter makes a decision, the parties share in the cost. Following the determination by the IDR arbiter, the parties involved could not initiate another IDR process for the same item or service for a 90-day period.

Application of Protections to Ambulance Services (Sections 105, 106, and 118). Patients using air (but not ground) ambulance services would be accorded similar protections against surprise medical billing as previously described, and providers of air

ambulance services and health plans would be accorded a similar process for resolving disputed claims as outlined above. Air ambulance providers also would be subject to new cost and claims reporting requirements to both HHS and the Department of Transportation. An advisory committee would be established to review and make recommendations on policy related to air ambulance quality and patient safety. In addition a separate advisory committee would be established to review ground ambulance billing practices and recommend consumer protections regarding balance billing.

Provider Price Transparency (Section 112). Health care providers (both individual practitioners and facilities) would be required to share “good faith estimates” of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured). The language is unclear whether these estimates must be provided upon patient request or for every scheduled service. The estimate would need to include the expected billing and diagnostic codes for all items and services included in the estimate. The provider would need to determine the patient’s health coverage status and develop the good faith estimate at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider would need to furnish the information within three business days of a patient requesting a service or scheduling a service. This requirement would go into effect Jan. 1, 2022.

In addition, the HHS Secretary would be required to establish a “patient-provider dispute resolution process” to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the good faith estimate provided prior to service.

Health Plan Price Transparency (Sections 111 and 114). Health plans would be required to send patients an “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients looking for more information prior to scheduling. The Advanced EOB requirement is triggered by the provider sending the “good faith estimate” required in Section 112 to the plan. The Advanced EOB would need to include:

- Whether the provider and facility are in-network and either the contracted rate for the item or service (if in-network) or information on finding in-network providers for the item or service (if out-of-network);
- The “good faith estimate” provided by the provider (see Section 112 above), with a delineation by the health plan of the portion the patient should expect to pay and the portion the health plan is expected to pay;
- An estimate of the amount the patient has incurred toward their deductible and cost-sharing limits;
- Information on any medical management (i.e., prior authorization) required for the item or service;
- A disclaimer that all information included in the notice is an estimate and subject to change; and
- A list of all in-network providers able to furnish the item or service.

Health plans would need to share this information within three business days of receiving a request or notice that a service had been scheduled, as long as the service was scheduled for at least 10 business days after the notice. If scheduled for less than 10 days after the notice, the health plan would need to provide this information within one business day. The HHS Secretary would have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs. This requirement would go into effect Jan. 1, 2022.

In addition, health plans would need to maintain online price comparison tools that would allow patients to compare expected out-of-pocket costs for particular items and services across multiple providers. Health plans also would need to provide price comparisons over the phone. Health plans would need to offer such price comparisons for plan years beginning on or after Jan. 1, 2022.

Timely Billing (Section 117). Health care providers (both individual practitioners and facilities) would be required to share with patients a list of items and services rendered during a visit, including the names of any providers seen for particular services, within 15 days of discharge or the date of the visit. For facility-based services, the facility is responsible for consolidating information on all services into a single itemized list, regardless of whether the practitioner of a particular service is an employee of the facility. Providers then would have 30 days following discharge or the date of a visit to submit bills to patients' health plans. While the language is not explicit, it appears that facilities would be responsible for consolidating and submitting to the health plan a single bill accounting for all services, regardless of whether a particular practitioner is employed by the facility. Health plans would then have 30 days to adjudicate the bills. Upon receiving the adjudicated bill, the provider would need to bill the patient their cost-sharing obligation within 30 days. Providers would be required to allow patients at least 45 days to pay their bills. Patients receiving bills after 90 days would not be obligated to pay the bill; if the patient paid such a bill, the provider would be required to refund the payment with interest.

If a patient or their provider appeals an adverse coverage determination, or if an out-of-network provider disputes a payment through open negotiation or the IDR process, this timeline may be paused or extended. In addition, providers that could not reasonably send the bill within the allotted timeframe due to an incorrect address or extenuating circumstances (e.g., hurricane, cyberattack) also may be exempt.

These requirements would go into effect six months after enactment. Within one year of enactment, HHS would issue regulations defining "extenuating circumstances," as well as "date of service" for providers that submit global packages for services provided over the course of multiple visits.

Other Provisions to Help Patient Access Care (Section 102 and 113). The draft legislation includes certain other provisions to help patients access care, including requirements around access to obstetrical or gynecological care, as well as the ability of

a patient to select a pediatrician as the child's primary care provider. In addition, the legislation would protect continuity of care for patients' when health plans change provider networks particularly for individuals with complex care needs.

Provider Directories (Section 116). Health plans would be required to ensure their in-network providers are up-to-date. This requirement would entail a verification process that patients could access on-line or within one business day of an inquiry. A patient that relied on a health plan's inaccurate provider directory would be only responsible for the in-network cost-sharing amount if the patient provides documentation they received incorrect information.

Disclosure of Cost-sharing (Section 107). The bill would require that health plans include on any physical or electronic health plan or insurance identification card issued to an enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations. Plans also would be required to include information on how consumers can seek further assistance.

All-payer Claims Databases (APCDs) (Section 115). The draft legislation would provide grants to states to build or improve APCDs and direct the federal government to develop a standard for voluntary self-insured plan reporting to state APCDs. States that get grants would be required to provide access to data for researchers, employers, health insurance issuer, health care provider, or other stakeholder for the purpose of quality improvement or cost containment, although states could apply for waivers of those requirements.

Reporting and Audits (Throughout). The draft legislation includes a number of instances where the government would be directed to audit health plans and providers for compliance, conduct evaluations of the impact of certain provisions, and publicly release data. For example, the legislation directs an evaluation of network adequacy and whether plans have a history of routine denials, low payment, down-coding or other abuses. Other evaluations would focus on the impact of these provisions on health care costs and consolidation, among other areas of focus.

FURTHER QUESTIONS

If you have questions, please contact AHA at 800-424-4301.