A "Surprise" Surprise Billing Deal

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Four committees have reached agreement on a surprise billing draft that has been elusive for the last two year. Click here for the discussion draft, here for the committee staff summary and here for the press release.

This draft aligns more closely with the House Ways and Means proposal which was viewed as more agreeable to hospitals and physicians than the other versions. Leaders of the committees (House Ways and Means, House Energy and Commerce, House Education and Labor and the Senate HELP Committee) and Speaker Pelosi want to include the agreement in the year end legislation. It is not yet clear if Senate Majority Leader McConnell will agree. The agreement is written as a discussion draft – additional tweaks are possible.

Major provisions are summarized below, but some highlights include:

- No benchmark rate
- Provider and insurer to negotiate; if no agreement, may go to independent dispute resolution (IDR)
- Billing disputes may be batched together if they occurred within 30 days; no minimum threshold for dispute resolution
- Parties jointly select IDR entity
- Parties each submit best offer – IDR entity picks one after considering the median in-network rate, the complexity of the case, and the relative market power of the insurer versus the doctor or hospital, among other factors
- IDR decision binding, generally not subject to judicial review
- Includes air ambulances
- Balance billing permitted in non-emergency cases when notice and consent are provided
- Amends ERISA
- Does not preempt state law relating to provider directories

Major provisions include:

Sec. 102 – Health insurance requirements – p. 2

- Patients are only required to pay the in-network cost-sharing amount for out-of-network emergency care, for certain ancillary services 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. Definition of emergency services – p. 10; Definition of out-of-network providers at in-network facilities - p. 30

Sec. 103 IDR Process – p. 110

- 30-day open negotiation period for providers and insurers to settle out-of-network claims – p. 110
- If no agreement, either party may access the Independent Dispute Resolution (IDR) process – p. 111
- Items and services may be batched in one proceeding when claims are from the same issuer and occur within 30 days – p. 114
- Certification and selection of IDR entity – p. 116
- Payment determination – IDR entity picks one offer made by either the provider or insurer – p. 121, 122
- IDR entity considers the medial in-network rate, information brought by either party or requested by reviewer, provider's training and experience, patient acuity, complexity; etc. – p. 123
- IDR entity does not consider billed charges or usual and customary – p. 123
- IDR decision binding, generally not subject to judicial review – p. 126
- Party that initiated ADR may not take the same party to IDR for the same item or service for 90 days following the decision, to encourage settlement of similar claims. However, those claims may still be eligible for IDR at the conclusion of the 90-day period. P. 126
- Loser pays costs of IDR – p. 128; if settled, costs are split – p. 129
- Payment to provider within 30 days – p. 129

Sec. 104 Provider Requirements – p. 182

- Beginning 1/1/22 prohibits out-of-network facilities and providers from balance billing more than the in-network cost-sharing amount for out-of-network emergency care, for certain ancillary services 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 – p. 183
- 72-hour written notice and consent for patient to be treated by a non-participating provider or facility – p. 187
- Information to be provided in written notice, includes good faith estimate of charges – p. 190; Participating facilities with non-participating providers required to offer a list of any providers at the facility who are participating.
- Patient's consent is only consent to receipt of information, not a contractual obligation to pay – p. 192
- For appointments made within 72 hours of receiving services, patient must receive notice the day the appointment is made and consent – p. 188
- Regulations to provide further details

Sec. 105 Air Ambulance Bills – p. 203

- Patients held harmless from surprise air ambulance medical bills – pay in-network cost sharing amount; similar IDR procedure.

Sec. 106 – Air Ambulance Reporting Requirements – p. 257

Sec. 107 Transparency Requirements – p. 274

- Insurer ID cards to include the amount of the in-network and out-of-network deductibles and out-of-pocket maximum limitations

Sec. 111 Consumer Protections

- Health plans must provide an Advance Explanation of Benefits for scheduled services at least 3 days in advance – p. 283

Sec. 112 Patient Protections

- Providers/Facilities must verify patient's insurance coverage (if any) and provide notice of good faith estimate – whether or not patient has coverage – within defined timeframes– p. 297
- Uninsured Patient/Provider Dispute Resolution Process - p. 299
    - Uninsured patient may seek dispute resolution when billed charges substantially exceed estimate; regulations to be written

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