HOUSE COMMITTEE ON WAYS & MEANS

Consumer Protections Against Surprise Medical Bills Act of 2020
Section-by-Section

Section 1: Short Title.

This act may be cited as Consumer Protections Against Surprise Medical Bills Act of 2020.

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

Beginning in 2022, consumers receiving emergency medical services at a non-participating facility will be limited to in-network cost-sharing and protected against surprise medical bills.

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.

Beginning in 2022, consumers receiving medical services by non-participating providers at a participating facility will be limited to in-network cost-sharing and protected against surprise medical bills.

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

Ensures patients can access the current law independent appeal process.

Section 5: Consumer Protections through Health Plan Transparency Requirements.

Health plans will be required to provide accurate and up-to-date information to consumers regarding provider participation in the health plan. Providers will be required to update information to a health plan in a timely manner. If inaccurate information is provided, consumers' cost-sharing will be limited to in-network cost-sharing.

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

Health plans will be required to provide an Advance Explanation of Benefits for services scheduled at least three days in advance. This will give patients new access to important information about their scheduled care and an understanding of which providers are expected to provide treatment, the expected cost, and the network status of the providers.

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

For instances when health plans and providers are unable to come to agreement on their own about reimbursement, the Secretary will establish an independent, unbiased process for resolving payment disputes for out-of-network emergency services and for services furnished by non-participating providers at a participating facility.

If the provider and health plan cannot agree on a payment amount after a service is provided to a patient, the parties may enter a 30-day open negotiation process with the goal of reducing the information asymmetry to encourage resolution of disagreements. Both parties are required to share specified information with each other at this stage to facilitate an agreement. The use, or potential for use, of this process does not absolve a health plan from any existing requirements to render payment to a provider when a service is provided.

If no resolution is reached during the open negotiation, either party can initiate a mediated process to resolve the dispute that must end within 30 days. This process is administered by independent entities with no affiliation to providers or payers, either mutually agreed on or randomly assigned. The Secretary shall ensure the selection process is unbiased.

During mediation, the parties will present best and final offers to the mediator, along with other relevant and supporting information. The dispute resolution entity will consider a median contracted rate specific to the type of plan or provider, type of service, and geographic location. Independent entities are prohibited from considering usual and customary charges or billed charges. There is no minimum dollar threshold to bring cases, and the Secretary is permitted to develop a process that would allow batching of similar claims if it would promote efficiency.

The Secretaries will have to periodically publish a publicly accessible report on outcomes from the process and its impact on consumers, payers, and providers. The Secretaries shall also promulgate through rulemaking the process for determining the median contracted rate and shall ensure such rates used by health plans are audited.

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.

Beginning in 2022, providers will be prohibited from sending a balance bill to consumers that received emergency medical services at a non-participating facility or medical services by non-participating providers at a participating facility. In addition, if patients receive incorrect information from their insurer about the network status of the provider, the patients will be protected any balance bill.

For those who are uninsured, electing to pay cash, or are uncovered for a particular item or service by their health plan, providers will be required to provide a good faith cost estimate in advance of a scheduled treatment. In instances where an eventual charge substantially exceeds the advance cost estimate, patients will have the ability to appeal to the independent mediator.

Section 9: Additional Consumer Protections.

Continuity of Care. For patients undergoing care for complex conditions, if their provider changes network status during treatment, the patient would have up to a 90-day period of continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider.

Better Information on Health Insurance Cards. This provision requires insurance cards to provide consumer information regarding the nearest participating hospital, consumer assistance contact information, deductibles, and other cost-sharing information.

Maintenance of Price Comparison Tool. Health plans will be required to offer a price comparison tool for consumers.

Assignment of Benefits. In order to ensure patients are kept out of the middle, health plans will directly reimburse providers rather than the patient, for out-of-network surprise bills.

Section 10: Air Ambulance Cost Data Reporting Program.

Within one year of the date of enactment, air ambulance providers are required to report cost data, and insurers are required to submit claims data related to air ambulance services to the Secretary of the Department of Health and Human Services (HHS). The Secretary must make these data publicly available within 180 days after HHS receives it.

Section 11: GAO Report on Effects of Legislation.

No later than two years after the date of enactment, the Government Accountability Office (GAO) shall issue a report on the impact of this act and state laws, including network adequacy standards and provider/facility network participation.