STOP Surprise Medical Bills

Bipartisan Senate Working Group

U.S. Senators Bill Cassidy, M.D. (R-LA), Michael Bennet (D-CO), Todd Young (R-IN), Maggie Hassan (D-NH), Lisa Murkowski (R-AK), and Tom Carper (D-DE)

Section by Section
STOP Surprise Bills Act of 2019

Section 1:
"Stopping the Outrageous Practice (STOP) of Surprise Bills Act of 2019"

Section 2:
Prohibition on Surprise Balance Billing
Patients are protected from surprise balance bills in the following scenarios:

- When receiving emergency care at an out-of-network facility or by an out-of-network provider;
- When elective health care services are provided by out-of-network providers at in-network facilities;
- When receiving additional health care services at an out-of-network facility following emergency care when the patient is not able to travel without medical transport to a different facility.

Additionally, patients that receive out-of-network laboratory or imaging services ordered by an in-network provider at their office, are held harmless and protected from those surprise bills.

In these scenarios, patients are only liable for the in-network cost-sharing, and patient-cost sharing for these services shall accrue toward the in-network deductible and out-of-pocket maximum.

Providers or plans/issuers who violate the ban on surprise billing will be subject to civil monetary penalties.

Automatic Payment
For any service where the surprise bill ban applies, providers will automatically be paid the median in-network rate. Should the provider or plan like to adjust this payment amount, they would have 30 days to initiate the independent dispute process.

Establishment of Independent Dispute Resolution (IDR) Process
The Secretary of HHS in consultation with the Secretary of Labor shall certify entities to perform the independent dispute resolution. Eligible entities shall be unbiased and unaffiliated with health plans/issuers and providers and free of conflicts of interest.

Patients will be totally removed from the IDR process, which takes place exclusively between the plan and the provider. The IDR process will be baseball style, meaning each party submits one final offer, and loser-pays, such that the non-prevailing party will pay the costs of the IDR process for the prevailing party. These aspects will ensure that parties submit reasonable offers to the IDR entity and do not frivolously pursue arbitration.

Claims may be batched by the plan/issuer or the provider for the IDR process so long as such claims involve the identical plan and professional or facility parties, involve claims with the same or related current procedural terminology (CPT) codes relevant to a particular procedure and occur within 30 days of each other.

The IDR entity shall consider commercially reasonable rates (which must be based on in-network rates and not charges) for that geographic area when making its award determinations.

Providers and plans/issuers may submit additional information to the IDR entity such as:

- The level of training, education, experience, and quality and outcomes measurements of The out-of-network health care provider;
- The circumstances and complexity of the particular dispute, including the time and place of the service;
- The market share held by the out-of-network health care provider or that of the plan or issuer;
- Demonstration of good faith efforts (or lack of good faith efforts) made by the out-of-network provider or the plan to contract and prior negotiated rates, if applicable; and
- Other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.

Decisions made by the IDR entity shall be binding and not subject to judicial review, except if it has been determined that fraudulent or corrupt actions have been taken on the part of the IDR entity or by one the parties involved in the IDR process. The IDR entity has thirty days to perform its review and make its determination.

Section 3:

Notification of New Insurance Products

If a provider has a contract with a health plan/issuer to provide in-network services to enrollees, the health plan/issuer shall notify contracted providers of any new insurance products for which the provider would be eligible within seven days of offering the new product.

Section 4:

Transparency Regarding Deductibles

A health plan/issuer shall clearly list on any insurance card issued to enrollees in its plan the amount of the in-network and out-of-network deductibles.

Section 5:

Ensuring Patient Access to Price Transparency

Providers and plans/issuers are required to tell patients or enrollees the expected cost sharing for

the provision of a specific health care service, including services reasonably expected to be provided in conjunction with it (e.g. laboratory work) within 48 hours of request.

Plans/issuers shall make available price information available online for services provided at different sites of care within its network to enable patients to know prices up front.

Section 6:

Medical Loss Ratio

Group health plans may include the costs of arbitration as part of medical care costs in their medical loss ratio calculations.

Section 7:

Transparency Requirements on Hospitals

Each hospital shall disclose on its internet website and in printed materials, any financial relationship or profit-sharing agreement that the hospital has with a physician group.

Hospitals are required to include ancillary services provided by individuals such as phlebotomists, laboratory technicians and echocardiogram technicians within the hospital bill sent to patients.

The Secretary of HHS shall perform a study regarding the feasibility of hospitals and providers giving patients a single, unified bill for all services provided within an episode of care, include services that may have been outsourced to a different facility, no later than one year after enactment.

Section 8:

Transparency Requirements for Group Health Plans

Each group health plan and issuer shall annually report to the Secretary of HHS and Secretary of Labor with respect to the applicable plan for the applicable year the following information:

- The total claims that were submitted by both in-network and out-of-network health care providers with respect to enrollees under the plan or coverage, and the number of such claims that were paid and the number of such claims that were denied;
- With respect to out-of-network claims, the out-of-pocket costs to enrollees for such services, and the difference between billed charges and the amount the plan/issuer pays, adjusted by any balance billing limitations; and
- The number of out-of-network claims reported for emergency care and the number of out-of-network claims for care performed at in-network facilities.

Section 9:

Applicability to States with Surprise Billing Laws

This procedures and methodology outlined in 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 have not enacted surprise billing protections through law or regulations. States are free to choose their own methodology (i.e. in no way must states adopt an IDR framework) to determine provider compensation for surprise medical bills so long as the patient protections outlined in section two are in place.

Section 10:

Balance Billing Study

The HHS Secretary in consultation with the DOL Secretary shall study the effects of this act and submit to Congress a report on its findings with analysis of the following:

- The financial impact on patient responsibility for health care spending and overall health care spending;
- The incidence and prevalence of the delivery of out-of-network health care service;
- The adequacy of provider networks offered by health plans/issuers;
- The impact of connecting reimbursement to different claims databases;
- The number of bills that go to the independent dispute resolution process; and
- The administrative cost of the independent dispute resolution process and estimated impact on insurance premiums and deductibles.