# Ending Surprise Medical Billing Legislative Outline

*Rep. Joseph D. Morelle and Rep. Van Taylor*

**Patients Out of the Middle**

- Out-of-network providers may not balance bill a patient for unanticipated out-of-network care – the entire dispute resolution will occur between the provider and the health insurance plan
- Patients are "held harmless" and are responsible only for their usual in-network copays, coinsurance, or deductibles
- Claims are resolved in no more than 90 days

**Direct Negotiation**

- Out-of-network providers and health insurers have 30 days to privately negotiate and settle on a payment amount for the out-of-network services
- If they do not reach an agreement, the insurer must pay the provider a temporary payment, the Interim Direct Reimbursement (IDR)

**Interim Direct Reimbursement (IDR)**

- The IDR is set at the median in-network rate for the service in that geographic region
- This reimbursement allows prompt payment for physicians and other health care providers while the dispute is resolved
- If both parties believe the IDR is relatively fair, it can be accepted as final payment
- If either party believes the IDR to be unacceptable, they may request a resolution through Alternative Dispute Resolution, i.e. arbitration

**Binding "Baseball-Style" Arbitration**

- The Secretaries of HHS and Labor shall establish an Independent Dispute Resolution process for arbitrating between health plans and out-of-network providers
- This process is available to enrollees in self-funded plans covered under ERISA, as well as enrollees in other plans regulated by states for which there has not been a state dispute resolution established
- The Alternative Dispute Resolution Entity (ADRE) will be unbiased and unaffiliated with both health plans and providers
- The out-of-network provider and plan shall each submit their final offers to the arbitration entity, along with any supporting documentation explaining their offer within 30 days
- The ADRE then has 30 days to review the documentation and make a determination as to which party's amount is more reasonable
- The amount that is determined to be more reasonable shall be the final decision, binding and enforceable

**Determining A Reasonable Fee**

- In judging the appropriate amount to pay for a health care service, the ADRE will take into account:
    - The usual and customary cost of the service
        - 80th percentile of all charges for the service performed by providers in the same geographic region
        - These rates must be reported in a benchmarking database that is independent, non-profit, and non-conflicted
    - The disparity between the out-of-network charge from the provider and their in-network reimbursement
    - Level of training, education and experience of the provider, including the provider's quality and outcome metrics
    - Provider's usual out-of-network charge for comparable services
    - Circumstances and complexity of the particular case, including time and place of the service

**Cost of Arbitration**

- The party whose requested payment amount is determined not to be reasonable must pay the cost of arbitration
- If the parties reach a settlement during arbitration, they split the cost of arbitration evenly

**Informed Consent**

- The arranging physician is required to advise the patient as to the network status of any physicians who will be reasonably anticipated for the planned services
- Direct HHS Secretary to establish transparency standards for health plans, including at minimum:
    - Online and print directories of in-network providers
    - Annual audits of provider directories
    - Monthly updates of the online directory
- For scheduled anticipated care, providers are responsible for notifying the patient of all other providers anticipated to be participating in the scheduled care
    - Scheduled care is defined as non-emergency services received by a patient scheduled with a provider at least twelve hours prior to the care being provided

**Roll-Out**

- Secretaries of HHS and Labor have one year to promulgate rules from date of enactment
- Provisions are to go into effect for plans and providers starting on the January 1st following one year after enactment