TAM19C38 S.L.C.

Bill Cassidy, M.D.

AMENDMENT NO. 4 Calendar No._____

Purpose: To establish a process for resolving payment disputes between group health plans, or health insurance issuers offering health insurance coverage in the group market, and out-of-network health care providers in surprise medical bill situations.

IN THE SENATE OF THE UNITED STATES—116th Cong., 1st Sess.

S. 1895

To lower health care costs.

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. CASSIDY

Hassan Murkowski

Viz:

Strike section 303, and insert the following:

SEC. 103. BENCHMARK FOR PAYMENT.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

"SEC. 2729A. BENCHMARK FOR PAYMENT.

"(a) ESTABLISHMENT OF BENCHMARK.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall pay providers, including facilities and practitioners, furnishing services

for which such facilities and practitioners are prohibited under section 2719A(g) from billing enrollees for amounts beyond the cost-sharing amount that would apply under subsection (b)(1)(C)(ii)(II), (e), or (f) of section 2719A,the median in-network rate for such services provided to enrollees, using a methodology determined under subsection (b) for the same or similar services offered by the group health plan or health insurance issuer in that geographic region. Such payment shall be made in a timely fashion in order to ensure compliance with sections 399V–7 and 2729D.

"(b) MEDIAN IN-NETWORK RATE.—

"(1) IN GENERAL.—For purposes of this section, the term 'median in-network rate' means, with respect to health care services covered by a group health plan or group or individual health insurance coverage, the median contracted rate under the applicable plan or coverage recognized under the plan or coverage as the total maximum payment for the service minus the in-network cost-sharing for such service under the plan or coverage, for the same or a similar service that is provided by a provider in the same or similar specialty and in the geographic region in which the service is furnished. This number shall be calculated by the plan based on informa-

tion from 2018 and then grown by the rate of inflation for each subsequent year.

"(2) RULEMAKING.—

"(A) IN GENERAL.—Not later than 1 year after the date of enactment of the Lower Health Care Costs Act, the Secretary shall, through rulemaking, determine the methodology a group health plan or health insurance issuer is required to use to determine the median in-network rate described in paragraph (1), differentiating by business line, the information the plan or issuer shall share with the out-of-network provider involved when making such a determination, and the geographic regions applied for purposes of this subsection. Such rulemaking shall take into account payments that are made by health insurance issuers that are not on a fee-for-service basis.

"(B) GEOGRAPHIC REGIONS.—In establishing geographic regions under subparagraph (A), the Secretary shall consider adequate access to services in rural areas and health professional shortage areas, as defined in section 332. The Secretary shall consult with the National Association of Insurance Commissioners

in establishing the geographic regions. The Secretary shall update the geographic regions periodically, as appropriate, taking into account the findings of the report under section 106 of the Lower Health Care Costs Act.

"(3) CERTAIN INSURERS.—If a group health plan or health insurance issuer offering group or individual health insurance coverage does not have sufficient information to calculate a median in-network rate for this service or provider type, or amount of, claims for services (as determined by the applicable State authority, in the case of health insurance coverage, or by the Secretary of Labor, in the case of a self-insured group health plan) covered under the list of out-of-network services set by the State authority or Secretary of Labor, as applicable, in a particular geographic area, such plan or issuer shall demonstrate that it will use a database free of conflicts of interest that has sufficient information reflecting allowed amounts paid to individual health care providers for relevant services provided in the applicable geographic region, and that such plan or issuer will use that database to determine a median in-network rate. The group health plan or health in-

surance issuer shall cover the cost of accessing the database.

"(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall prevent a group health plan or health insurance issuer from establishing separate calculations of a median in-network rate under paragraph (1) for services delivered in nonhospital facilities, including freestanding emergency rooms.

"(e) FACILITY.—For purposes of this section, the term 'health care facility' or 'facility' includes hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgery centers, laboratories, radiology clinics, freestanding emergency rooms, and any other facility that provides services that are covered under a group health plan or health insurance coverage, including settings of care subject to section 2719A(b).

"(d) ESTABLISHMENT OF IDR PROCESS; CERTIFICATION OF ENTITIES.—

"(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this section, the Secretary, in consultation with the Secretary of Labor, shall establish a process for resolving payment disputes between group health plans, or health insurance issuers offering health insurance coverage in the group market, and out-of-network health care

providers in surprise medical bill situations in accordance with this section (referred to in this section as the 'IDR process').

"(2) CERTIFICATION OF ENTITIES.—An entity wishing to participate in the IDR process under this subsection shall request certification from the Secretary. The Secretary, in consultation with the Secretary of Labor, shall determine eligibility of applicant entities, ensuring that the entity is unbiased and unaffiliated with health plans and providers and free of conflicts of interest, in accordance with the Secretary's rulemaking on determining criteria for conflicts of interest.

"(3) IDR ENTITY.—Under the process established under paragraph (1), the parties in the independent dispute resolution process shall jointly agree upon an independent dispute resolution entity. In the event that parties cannot agree, one will be selected at random jointly by the Department of Health and Human Services and the Department of Labor.

"(4) APPLICABLE CLAIMS.—

"(A) IN GENERAL.—The IDR process shall be with respect to one or more Current Procedural Terminology ('CPT') codes.

"(B) BATCHING OF CLAIMS.—Health care facilities and providers and group health plans or health insurance issuers may batch claims if such claims—

"(i) involve identical plan or issuer and provider or facility parties;

"(ii) involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

"(iii) involve claims that occur within 90 days of each other.

"(5) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(A) TIMING.—An independent dispute resolution entity that receives a request under this section shall, not later than 30 days after receiving such request, determine the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, is required to pay the out-of-network health care provider. Such amount shall be—

"(i) the amount determined by the parties through a settlement under subparagraph (B); or

"(ii) the amount determined reasonable by the entity in accordance with subparagraph (C).

"(B) SETTLEMENT.—

"(i) IN GENERAL.—If the independent dispute resolution entity determines, based on the amounts indicated in the request under this section, that a settlement between the group health plan, or health insurance issuer offering health insurance coverage in the group market, and the out-of-network health care provider is likely, the independent dispute resolution entity may direct the parties to attempt, for a period not to exceed 10 days, a good faith negotiation for a settlement.

"(ii) TIMING.—The period for a settlement described in clause (i) shall accrue towards the 30-day period required under subparagraph (A).

"(C) DETERMINATION OF AMOUNT.—

"(i) FINAL OFFERS.—In the absence of a settlement under subparagraph (B), the group health plan, or health insurance issuer offering health insurance coverage in the group market, and the out-of-network health care provider shall each submit to the independent dispute resolution entity their final offer. Such entity shall determine which of the 2 amounts is more reasonable based on the factors described in clause (iv).

"(ii) FINAL DECISIONS.—The amount that is determined to be the more reasonable amount under clause (i) shall be the final decision of the independent dispute resolution entity as to the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, is required to pay the out-of-network health care provider.

"(iii) SERVICE UNITS.—A final determination under clause (ii) may include the resolution of disputes for multiple items or services, if such determination is in regard to items or services that are eligible for

independent dispute resolution under paragraph (3)(B).

"(iv) FACTORS.—In determining which final offer to select as the more reasonable amount under clause (i), the independent dispute resolution entity shall consider relevant factors including—

"(I) commercially reasonable rates for comparable services or items in the same geographic area; and

"(II) other factors that may be submitted at the discretion of either party, which may include—

"(aa) the level of training, education, experience, and quality and outcomes measurements of the out-of-network health care provider;

"(bb) the circumstances and complexity of the particular dispute, including the time and place of the service;

"(cc) the market share held by the out-of-network health care

provider or that of the plan or issuer;

"(dd) 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

"(ee) other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.

"(v) EFFECT OF DETERMINATION.—A final determination of an independent dispute resolution entity under clause (ii)—

"(I) shall be binding; and

"(II) shall not be subject to judicial review, except in cases comparable to those described in section 10(a) of title 9, United States Code, as determined by the Secretary in consultation with the Secretary of Labor, and cases in which information submitted by one party was determined to be fraudulent.

"(D) PRIVACY LAWS.—An independent dispute resolution entity shall, in conducting an independent dispute resolution process under this subsection, comply with all applicable Federal and State privacy laws.

"(E) DATA AVAILABILITY.—Information submitted to the independent dispute entity shall be kept confidential. Independent dispute entities may consider past decisions awarded by independent dispute entities during the independent dispute resolution process.

"(F) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The nonprevailing party shall be responsible for paying all fees charged by the independent dispute resolution entity. If the parties reach a settlement prior to completion of the independent dispute resolution process, the costs of the independent dispute resolution process shall be divided equally between the parties when past decisions relate to disputes between the same 2 parties.

"(G) PAYMENT.—Group health plans and health insurance issuers with respect to group health coverage shall pay directly to the health care provider amounts determined by the inde-

pendent dispute resolution entity within 30 days of the date on which the entity makes a determination with respect to such amount.".

(b) NON-FEDERAL GOVERNMENTAL PLANS.—Section 2722(a)(2)(E) of the Public Health Service Act (42 U.S.C. 300gg–21(a)(2)(E)) is amended by inserting ", except that such election shall be available with respect to section 2729A" before the period.

(c) EMERGENCY SERVICES.—Section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act (42 U.S.C. 300gg–19a(b)(1)(C)(ii)(II)) is amended by inserting ", deductible amount," after "copayment amount".

(d) DEFINITION.—In this section (and the amendments made by this section), the term "commercially reasonable" means commercial network rates for the geographic area involved, and does not include charges, Medicare, or Medicaid rates.