

115TH CONGRESS
1ST SESSION

H. R. 3877

To amend title XVIII of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 28, 2017

Ms. MICHELLE LUJAN GRISHAM of New Mexico introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Fair Billing Act of
5 2017”.

1 **SEC. 2. PROTECTING HEALTH CARE CONSUMERS FROM**
2 **SURPRISE BILLING PRACTICES.**

3 (a) PROVIDERS.—Section 1866 of the Social Security
4 Act (42 U.S.C. 1395cc) is amended—

5 (1) in subsection (a)(1)—

6 (A) in subparagraph (X), by striking
7 “and” at the end;

8 (B) in subparagraph (Y), by striking the
9 period at the end and inserting “, and”; and

10 (C) by inserting after subparagraph (Y)
11 the following new subparagraph:

12 “(Z) in the case of a hospital or critical access
13 hospital, to meet the requirements of paragraphs
14 (1), (2), and (3) of subsection (l).”; and

15 (2) by adding at the end the following new sub-
16 section:

17 “(1) NO SURPRISE BILLING AT IN-NETWORK FACILI-
18 TIES; EMERGENCY SERVICES; EXTERNAL REVIEW OF
19 CERTAIN PAYMENTS.—

20 “(1) NO SURPRISE BILLING AT IN-NETWORK
21 FACILITIES.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), in the case of an individual with
24 benefits under a health care plan who is fur-
25 nished items or services at a relevant facility
26 (including items or services furnished by a pro-

1 vider of services or supplier at such facility)
2 that is within the health care provider network
3 or otherwise a participating provider of services
4 or supplier with respect to the health care plan
5 of such individual, the relevant facility (or the
6 provider of services or supplier) may not hold
7 the individual liable for more than the amount
8 that the individual would have been required to
9 pay in cost sharing if such items or services had
10 been furnished by a relevant facility (or, as ap-
11 plicable, by a provider of services or supplier)
12 that is within the health care provider network
13 or otherwise a participating provider of services
14 or supplier with respect to the health care plan
15 of such individual.

16 “(B) EXCEPTION FOR NOTIFICATION AND
17 WRITTEN CONSENT.—Subparagraph (A) shall
18 not apply in the case of a relevant facility (or
19 provider of services or supplier at such facility)
20 that, not later than 72 hours before furnishing
21 items or services to an individual (or, in the
22 case where such items or services are scheduled
23 to be furnished less than 72 hours from the
24 time of scheduling, 24 hours before furnishing
25 such items or services), notifies such individual

1 of an estimate of the individual’s anticipated
2 total out-of-pocket cost of care for such items
3 and services and obtains written consent from
4 such individual.

5 “(2) EMERGENCY SERVICES.—In the case of an
6 individual with benefits under a health care plan
7 who is furnished items or services with respect to an
8 emergency medical condition at a hospital or critical
9 access hospital (including items or services furnished
10 by a provider of services or a supplier at the hospital
11 or critical access hospital), the hospital or critical ac-
12 cess hospital (or the provider of services or supplier)
13 may not charge the individual more than the amount
14 that the individual would have been required to pay
15 in cost sharing if such items or services had been
16 furnished by a hospital or critical access hospital (or
17 by a provider of services or supplier) within such
18 network or otherwise a participating provider of
19 services.

20 “(3) REVIEW PROCESS.—A relevant facility
21 shall participate in any review process requested,
22 and comply with any determination made, under sec-
23 tion 3 of the Fair Billing Act of 2017.

24 “(4) DEFINITIONS.—In this subsection:

1 “(A) EMERGENCY MEDICAL CONDITION.—
2 The term ‘emergency medical condition’ has the
3 meaning given such term in section 1867(e).

4 “(B) HEALTH CARE PLAN.—The term
5 ‘health care plan’ means—

6 “(i) a group health plan;

7 “(ii) group health insurance coverage;

8 “(iii) individual health insurance cov-
9 erage; or

10 “(iv) a Federal health care program
11 (as defined in section 1128B(f)).

12 “(C) PUBLIC HEALTH SERVICE ACT
13 TERMS.—The terms ‘group health plan’, ‘group
14 health insurance coverage’, and ‘individual
15 health insurance coverage’ have the meanings
16 given those terms, respectively, under section
17 2791 of the Public Health Service Act (42
18 U.S.C. 300gg–91).

19 “(D) RELEVANT FACILITY.—The term ‘rel-
20 evant facility’ means a hospital or critical ac-
21 cess hospital.”.

22 (b) INSURERS.—Section 2719A of the Public Health
23 Service Act (42 U.S.C. 300gg–19a) is amended by adding
24 at the end the following new subsection:

1 “(e) PAYMENT REVIEW PROCESS.—A group health
2 plan or a health insurance issuer offering group or indi-
3 vidual health insurance shall participate in any review
4 process requested, and comply with any determination
5 made, under section 3 of the Fair Billing Act of 2017.”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply with respect to items or services
8 furnished on or after the date that is one year after the
9 date of the enactment of this Act.

10 **SEC. 3. REVIEW PROCESS FOR SURPRISE BILLING PRACTICES.**
11

12 (a) STATE ELECTION.—Each State may elect, at
13 such time and in such manner as the Secretary of Health
14 and Human Services (the “Secretary”) shall prescribe, to
15 establish a review process described in subsection (c) to
16 be available at the request of a health care plan or pro-
17 vider of services or supplier.

18 (b) FAILURE TO ESTABLISH AN EXTERNAL REVIEW
19 PROCESS OR IMPLEMENT STANDARDS.—In the case of a
20 State that does not elect under subsection (a) to establish
21 a review process described in subsection (c), the Secretary
22 shall make available within the State such a review process
23 to be available at the request of a health care plan or pro-
24 vider of services or supplier.

1 (c) REVIEW PROCESS.—In the case of payment from
2 a health care plan to a provider of services or supplier
3 for items or services furnished by such provider or supplier
4 to an individual with benefits under such plan in a case
5 in which section 1866(l)(1)(A) or subsection (l)(2) of such
6 section applies and such plan or such provider or supplier
7 requests a review of such payment, a review process de-
8 scribed in this subsection is a process by which an inde-
9 pendent health care expert determines the amount of the
10 payment to be made by such plan to such provider or sup-
11 plier using the methodology described in subsection (d)
12 and notifies the individual furnished such items or services
13 of such determination within 30 days of making such de-
14 termination.

15 (d) METHODOLOGY.—In the case of payment from a
16 health care plan to a provider of services or supplier for
17 items or services furnished by such provider or supplier
18 to an individual with benefits under such plan, the meth-
19 odology described in this subsection consists of an inde-
20 pendent health care expert determining an amount to be
21 paid by the plan to the provider or supplier by selecting
22 one of the following amounts:

23 (1) The lesser of—

1 (A) an amount proposed by the provider of
2 services or supplier that furnished such items or
3 services; and

4 (B) an amount that is equal to the 80th
5 percentile of the amount paid for such items
6 and services, as reported by a national all-payer
7 claims database or, if available, a State or re-
8 gional all-payer claims database, as determined
9 by the independent health care expert.

10 (2) The greater of—

11 (A) an amount proposed by the health plan
12 providing health benefits coverage to such indi-
13 vidual with respect to such items and services;
14 and

15 (B) 1.25 multiplied by the Medicare fee
16 schedule for such items and services (or, if such
17 items and services are not covered under Medi-
18 care, an amount determined by the Secretary).

19 (e) RECONSIDERATION.—An individual furnished
20 items or services by a provider of services or supplier for
21 which payment is determined in accordance with the re-
22 view process described in subsection (c) may, within 30
23 days of receiving notification of such determination, file
24 a written request for a reconsideration of such determina-
25 tion with the independent health care expert making such

1 determination. Such expert shall, within 30 days of receiv-
2 ing such request, determine whether such determination
3 should be revised and notify such individual of any change
4 to such determination.

5 (f) COST-SHARING CLARIFICATION.—Any cost shar-
6 ing (including any copayment or coinsurance) that an indi-
7 vidual may be responsible for after a determination is
8 made under subsection (c) shall count towards such indi-
9 vidual’s annual deductible with respect to the health care
10 plan of such individual.

11 (g) DEFINITIONS.—In this section:

12 (1) HEALTH CARE PLAN.—The term “health
13 care plan” has the meaning given such term in sec-
14 tion 1866(l)(4) of the Social Security Act (42 U.S.C.
15 1395cc(1)(4)).

16 (2) INDEPENDENT HEALTH CARE EXPERT DE-
17 FINED.—The term “independent health care expert”
18 means an individual who is, with respect to a pay-
19 ment for items and services—

20 (A) an expert in health care billing;

21 (B) free of conflicts of interest with respect
22 to such payment; and

23 (C) appointed by a State or the Secretary
24 to make determinations under the external re-
25 view process described in subsection (c).

1 (3) PROVIDER OF SERVICES.—The term “pro-
2 vider of services” has the meaning given such term
3 in section 1861 of the Social Security Act (42
4 U.S.C. 1395x).

5 (4) STATE.—The term “State” has the mean-
6 ing given such term in section 210 of the Social Se-
7 curity Act (42 U.S.C. 410).

8 (5) SUPPLIER.—The term “supplier” has the
9 meaning given such term in section 1861 of the So-
10 cial Security Act (42 U.S.C. 1395x).

11 (h) GRANTS TO STATES.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services shall provide grants, not later than
14 90 days after the date of the enactment of this Act,
15 to eligible States to establish and implement a re-
16 view process described in subsection (a).

17 (2) ELIGIBLE STATE.—For purposes of this
18 subsection, the term “eligible State” means a State
19 that has elected under subsection (a) to establish a
20 review process and that has submitted an application
21 to the Secretary at such time, in such manner, and
22 containing such information as the Secretary may
23 require.

24 (3) AUTHORIZATION OF APPROPRIATIONS.—
25 There is authorized to be appropriated to the Sec-

1 retary of Health and Human Services
2 \$4,000,000,000 to award grants under this sub-
3 section.

4 (i) EFFECTIVE DATE.—This section shall apply with
5 respect to items or services furnished on or after the date
6 that is one year after the date of the enactment of this
7 Act.

○