I

116TH CONGRESS
1ST SESSION

H. R. 3784

To amend title XXVII of the Public Health Service Act and title XI of the Social Security Act to prohibit surprise billing with respect to air ambulance services.

IN THE HOUSE OF REPRESENTATIVES

JULY 16, 2019

Mr. NEGUSE introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XXVII of the Public Health Service Act and title XI of the Social Security Act to prohibit surprise billing with respect to air ambulance services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Air Ambulance Affordability Act of 2019''.

SEC. 2. PROHIBITING SURPRISE BILLING WITH RESPECT TO AIR AMBULANCE SERVICES.

(a) AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsections:

''(e) AIR AMBULANCE SERVICES.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of air ambulance services furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (3)(A)) by a nonparticipating provider (as defined in paragraph (3)(C)), the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such services so furnished that is greater than the cost-sharing amount that would apply under such plan had such services been furnished by a participating provider;

''(B) shall calculate such cost-sharing amount as if the negotiated rate that would have been charged by such participating provider for such services were equal to the amount determined in accordance with subsection (f) for such services (or, in the case of such services furnished in a State described in

paragraph (3)(E)(i), the amount determined by such State for such services in accordance with the method described in such paragraph);

''(C) shall pay to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in paragraph (3)(E)) for such services exceeds the cost-sharing amount imposed for such services (as determined in accordance with subparagraphs (A) and (B)); and

''(D) shall count toward any deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such services so furnished in the same manner as if such cost-sharing payments were with respect to services furnished by a participating provider.

''(2) EXCEPTION FOR CERTAIN SERVICES.—The provisions of paragraph (1) shall not apply in the case of air ambulance services that—

''(A) are not furnished with respect to an individual with an emergency medical condition (as defined in subsection (b)(2)(A)); and

"(B) are furnished by a provider that is in compliance with the requirement of section 1128A(t)(3) of the Social Security Act with respect to such services.

"(3) DEFINITIONS.—In this subsection and subsection (f):

"(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market.

"(B) PROVIDER.—The term 'provider' means a provider of services or a supplier (as such terms are defined in section 1861 of the Social Security Act).

"(C) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to air ambulance services and a group health plan or health insurance coverage offered by a health insurance issuer, a provider or supplier of such services that is licensed by the State involved to furnish such services and that does not have a contractual relationship with the plan or coverage for furnishing such services.

"(D) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to air ambulance services and a group health plan or health insurance coverage offered by a health insurance issuer, a provider or supplier of such services that is licensed by the State involved to furnish such services and that has a contractual relationship with the plan or coverage for services.

"(E) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to air ambulance services—

"(i) in the case of such services furnished in a State that has in effect a State law that provides for a method for determining the amount of payment that is required to be covered by a health plan or health insurance issuer offering group or individual health insurance coverage regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such services from a nonparticipating provider, not more than the amount determined in accordance with such law plus the cost-

sharing amount imposed for such services (as determined in accordance with paragraph (1)); or

''(ii) in the case of such services furnished in a State that does not have in effect such a law, an amount determined in accordance with the independent dispute resolution process established under subsection (f).

''(f) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, in consultation with the Secretary of Labor, shall establish by regulation an independent dispute resolution process (referred to in this subsection as the 'IDR process') under which entities certified under paragraph (2) (in this subsection referred to as 'certified IDR entities') resolve specified claims of nonparticipating providers or health plans, taking into account the factors described in subparagraph (C). Such process shall prohibit such an entity from participating in the resolution of

such a claim if such entity has a conflict of interest with respect to such provider, facility, or the health plan involved.

''(B) SPECIFIED CLAIM.—For purposes of subparagraph (A), the term 'specified claim' means a claim by a nonparticipating provider or health plan that, with respect to air ambulance services furnished by such provider for which a health plan is required to make payment pursuant to subsection (e)(1), is made under the IDR process not later than 30 days after the services are furnished.

''(C) FACTORS.—The factors described in this subparagraph include—

''(i) commercially reasonable rates for comparable services furnished in the same geographic area (which shall take into consideration in-network rates for that geographic area and not charges); and

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

''(I) the level of training, education, experience, and quality and

outcomes measurements of the provider;

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

"(III) the market share held by the provider or that of the plan;

"(IV) demonstration of good faith efforts (or lack of good faith efforts) made by the provider or the plan to contract for negotiated rates, if applicable; and

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

"(2) CERTIFICATION OF ENTITIES.—

"(A) PROCESS OF CERTIFICATION.—As part of the regulation described in paragraph (1), the Secretary, in consultation with the Secretary of Labor, shall establish a certification process under which eligible entities may be certified to carry out the IDR process.

"(B) ELIGIBILITY.—For purposes of subparagraph (A), an eligible entity is an entity that is a nongovernmental entity (such as the American Arbitration Association).

"(3) SELECTION OF CERTIFIED IDR ENTITY FOR A SPECIFIED CLAIM.—With respect to the resolution of a specified claim under the IDR process, the health plan and the nonparticipating provider involved shall agree on a certified IDR entity to resolve such claim. In the case that such plan and such provider cannot so agree, such an entity shall be selected by the Secretary at random.

"(4) PAYMENT DETERMINATION.—

"(A) TIMING.—A certified IDR entity that receives a request from a nonparticipating provider or health plan under this subsection shall, not later than 30 days after receiving such request, determine the amount the health plan is required to pay such provider or facility for services described in paragraph (1), in accordance with subparagraph (C), in the case that a settlement described in subparagraph (B) is not reached.

"(B) SETTLEMENT.—

''(i) IN GENERAL.—If such entity determines that a settlement between the health plan and the provider is likely, the 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) DECISIONS.—The health plan and the nonparticipating provider shall each submit to the certified IDR entity a final offer of payment with respect to services which are the subject of the specified claim. Such entity shall select the offer that such entity determines is the most reasonable based on the factors described in paragraph (1)(C).

''(ii) EFFECT OF DECISION.—A decision of a certified IDR entity under clause (ii)—

''(I) shall be binding; and

"(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code, as determined by the Secretary in consultation with the Secretary of Labor.

"(iii) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The party whose calculation is not chosen under subparagraph (B)(ii) shall be responsible for paying all fees charged by the certified IDR entity. If the parties reach a settlement prior to completion of the IDR process, the costs of such process shall be divided equally between the parties, unless the parties otherwise agree.

"(iv) PAYMENT.—Not later than 30 days after a decision described in clause (i) is made, the health plan shall pay to the provider or supplier of the services with respect to which the specified claim is made the amount determined under this subsection.

''(v) PUBLIC AVAILABILITY.—The certified IDR entity shall make each final offer selected under clause (i) available to the public. Any information submitted to the entity by the health plan, provider, or facility, other than such final offer, may not be disclosed by the entity.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

(b) PREVENTING CERTAIN CASES OF BALANCE BILLING.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsections:

''(t)(1) Subject to paragraph (2), in the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, air ambulance services by a nonparticipating provider (as defined in section 2719A(e)(3) of the Public Health Service Act), if such provider holds the individual liable for a payment amount for such services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with section 2719A(e)(1) of the Public Health Service Act), such provider shall be subject, in ad-

dition to any other penalties that may be prescribed by law, to a civil money penalty of not more than an amount determined appropriate by the Secretary for each specified claim.

''(2) Paragraph (1) shall not apply to a nonparticipating provider, with respect to air ambulance services furnished by the provider to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if—

''(A) such services are not furnished with respect to an individual with an emergency medical condition (as defined in section 2719A(e)(3) of the Public Health Service Act); and

''(B) the provider is in compliance with the requirement of paragraph (3).

''(3)(A) For purposes of paragraph (2) and section 2719A(e)(2) of the Public Health Service Act, a nonparticipating provider is in compliance with this paragraph, with respect to air ambulance services furnished by the provider to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if the provider—

''(i)(I) provides to the participant, beneficiary, or enrollee (or to a representative of the participant, beneficiary, or enrollee), on the date on which the

participant, beneficiary, or enrollee schedules such services, if applicable, and on the date on which the individual is furnished such services—

"(aa) an oral explanation of the written notice described in item (bb) and such documentation of the provision of such explanation, as the Secretary determines appropriate; and

"(bb) a written notice specified, not later than July 1, 2020, by the Secretary through rulemaking that—

"(AA) contains the information required under subparagraph (B); and

"(BB) is signed and dated by the participant, beneficiary, or enrollee; and

"(II) retains, for a period specified through rulemaking by the Secretary, a copy of the documentation described in subclause (I)(aa) and the written notice described in subclause (I)(bb); and

"(ii) obtains from the participant, beneficiary, or enrollee (or representative) the consent described in subparagraph (C).

"(B) For purposes of subparagraph (A)(i), the information described in this subparagraph, with respect to a nonparticipating provider and a participant, beneficiary, or enrollee of a health plan or health insurance coverage

offered by a health insurance issuer, is a notification of each of the following:

''(i) That the health care provider is a nonparticipating provider with respect to the group health plan or health insurance coverage.

''(ii) The estimated amount that such provider will charge the participant, beneficiary, or enrollee for such services involved.

''(C) For purposes of subparagraph (A)(ii), the consent described in this subparagraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer, who is to be furnished air ambulance services by a nonparticipating provider, is a document specified by the Secretary through rulemaking that—

''(i) is signed by the participant, beneficiary, or enrollee (or by a representative of the participant, beneficiary, or enrollee) not less than 24 hours prior to the participant, beneficiary, or enrollee being furnished such services by such provider;

''(ii) acknowledges that the participant, beneficiary, or enrollee has been—

''(I) provided with a written estimate and an oral explanation of the charge that the participant, beneficiary, or enrollee will be assessed

for the services anticipated to be furnished to the participant, beneficiary, or enrollee by such nonparticipating provider; and

''(II) informed that the payment of such charge by the participant, beneficiary, or enrollee will not accrue toward meeting any limitation that the group health plan or health insurance coverage places on cost-sharing; and

''(iii) documents the consent of the participant, beneficiary, or enrollee to—

''(I) be furnished with such services by such nonparticipating provider; and

''(II) in the case that the individual is so furnished such services, be charged an amount that may be greater than the amount that would otherwise be changed the individual if furnished by a participating provider (as defined in section 2719A(e)(3) of the Public Health Service Act) with respect to such services and plan or coverage.

''(4) The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) shall apply to a civil money penalty or assessment under paragraph (1) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a).

''(5) In this subsection, the terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act''.

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