



The Patient Protections and Transparency Act of 2019

An Act

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

Section 1. Title. This act shall be known as and may be cited as “The Patient Protections and Transparency Act of 2019.”

Section 2. Purpose. Congress hereby finds and declares that:

- A. Health Insurance Plans are increasingly offering narrow network plans, regularly reducing the number of Clinicians available to beneficiaries in these plans.
- B. Patients should be able to access In-Network primary care Clinicians and specialists in a timely manner, including Facility-Based Clinicians;
- C. Patients must be supplied with full knowledge of the facts to make informed decisions concerning the health insurance coverage they purchase and where and from which Clinicians they seek health care services;
- D. Clinicians shall give fee information to patients and discuss their OON fees in advance of services, whenever possible, except for Emergency Services or in Unanticipated OON Care situations;
- E. A Health Insurance Plan (The Plan) shall provide a Clinician directory online and in print. The Plan shall annually audit at least a reasonable sample size of its directories for accuracy; The online directory shall be updated at least monthly, the Plan shall ensure the public can view all current In-Network Clinicians, and the directory shall have a searchable format; the Health Insurance Company shall disclose that the directory was accurate at the time of printing and that an Enrollee should consult the electronic Clinician directory to ensure that information is current;
- F. A Health Insurance Plan shall clearly disclose the scope and limitations of any OON benefit they purport to provide, in language that is meaningful to the consumer; and the methodology for reimbursement for OON services shall be transparent to Enrollees, consumers, Clinicians, hospitals and regulatory authorities via an on-line non-profit benchmarking database that is not affiliated or financially connected to a Health Insurance Plan or its affiliates;
- G. Patients shall be assured that any higher premiums paid for affordable access to OON Clinicians reasonably reflects the actuarial value of the OON benefit provided;
- H. Patients shall be protected from the financial impact that can result from narrow networks, retroactive denials and cost-shifting trends within Health Insurance Plans; and,
- I. Solutions to OON issues for unanticipated care including Emergency Services and EMTALA mandated care shall ensure universal access to high quality emergency care.

Section 3. Definitions.

- A. **Allowed Amount:** The amount negotiated between a Health Insurance Company and the

Clinician participating in the Company's Health Insurance Plan's Clinical Network. This allowed amount reflects the total contracted fee to include both the Enrollee's Cost-Sharing and the Company's Health Insurance Plan's reimbursement for specific healthcare services.

- B. **Alternative Dispute Resolution (ADR) Exempt Claims:** Clinician charges where the difference between the charge and the Health Insurance Plan's First Offer of Reimbursement (as defined herein and including Patient Cost-Sharing) is less than \$750 unless the Exempt Claim amount is bundled with other Exempt Claims for more than \$750.
- C. **Balance Bill:** After the provision of health care services, a bill from a Clinician to a Patient that reflects the difference (if any) between the Clinician's charge and the Health Insurance Plan's First Offer of Reimbursement.
- D. **Clinician:** See Facility-Based Health Care Professional or Health Care Professional.
- E. **Clinical Network:** all the Clinicians contracted to provide services to a specified group of Enrollees under a Health Insurance Plan.
- F. **Cost-Sharing:** Any expenditure required by or on behalf of an Enrollee with respect to health benefits, including co-insurance, deductibles, and/or co-pays. Cost-sharing does not include premiums, balance billing amounts for OON Clinicians and spending for non-covered services.
- G. **Days:** Days shall mean calendar days unless otherwise specified.
- H. **Emergency Medical Condition:** "Emergency Medical Condition" means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:
 - 1. Placing the patient's mental or behavioral health or, with respect to a pregnant woman, the woman's or her fetus' health in serious jeopardy;
 - 2. Serious impairment to a bodily function;
 - 3. Serious impairment of any bodily organ or part; or
 - 4. With respect to a pregnant woman who is having contractions: (a) That there is inadequate time to affect a safe transfer to another hospital before delivery; or (b) That transfer to another hospital may pose a threat to the health or safety of the woman or fetus; or a threat to the individual's safety or the safety of others.
- I. **Emergency Services:** A physical, mental or behavioral health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to determine the presence of and evaluate the emergency medical condition; and (2) any further physical, mental or behavioral health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient, and as required by the federal Emergency Medical Treatment Active Labor Act (EMTALA).
- J. **Enrollee:** a patient eligible for services covered by a specific Health Insurance Plan.
- K. **Facility-Based Health Care Professional or Clinician:** a health care professional who provides services to patients in a facility, and typically includes anesthesiologists, radiologists, pathologists, emergency physicians, and hospitalists, but may also include other specialists such as those that provide on-call services, as well as non-physician health care professionals such as nurses, nurse practitioners, physician assistants, anesthesia assistants, advanced practice providers (APPs), physical therapists, and nutritionists.
- L. **First Offer of Reimbursement:** The initial offer of reimbursement by the Health Insurance Plan to the Clinician for the services provided to the Patient.
- M. **Health Care Facility or Facility:** institutions, including mobile facilities which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. "Health care facility" includes hospitals, chronic disease facilities, birthing centers, psychiatric facilities, nursing homes, free standing emergency

centers, home health agencies, outpatient or independent surgical, diagnostic or therapeutic centers or facilities, including, but not limited to, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories (including independent imaging facilities), cardiac catheterization laboratories and radiation therapy facilities.

- N. **Health Care Professional or Clinician:** a health care professional, a physician, APP, anesthesia assistant, surgical assistant or other health care practitioner licensed, accredited or certified to perform specified physical, mental or behavioral health care services consistent with their scope of practice under state law.
- O. **Health Care Services or Services:** services for the diagnosis, prevention, treatment or cure of a health condition, illness, injury or disease.
- P. **Health Insurance Company or Company:** a company that sells and/or provides a Health Insurance Plan.
- Q. **Health Insurance Plan or Plan:** any hospital and medical expense incurred policy, non-profit health care service plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.
- R. **In-Network Clinician:** a health care provider who/that, through a contract with the Plan, has agreed to provide health care services to Enrollees with an expectation of receiving reimbursement, including coinsurance, copayments or deductibles, directly or indirectly from the health insurance company.
- S. **In-Network Level of Coverage:** the portion of the cost for a health care service a Plan agrees to reimburse to a health care provider who/that participates in the Plan's network. An Enrollee is generally responsible for the In-Network Cost-Sharing.
- T. **Out-Of-Network (OON) Care:** care provided to a Patient by a Clinician or in a Facility who/that does not participate in the Patient's Plan's network.
- U. **Out-Of-Network (OON) Clinician:** a Health Care Professional or Clinician who does not have a contract with a Plan to provide care to Enrollees of that Plan.
- V. **Out-Of-Network (OON) Level of Coverage:** the portion of the cost for a Health Care Service a Plan is obligated to reimburse a Clinician who does not participate in the Plan's network for Health Care Services provided to an Enrollee under an Enrollee's Plan. An Enrollee is generally responsible for the difference between the Clinician's charges and the OON allowable, and OON Cost-Sharing as determined by the Plan.
- W. **Patient:** participant, beneficiary, Enrollee, guarantor or authorized representative (collectively "the Patient").
- X. **Secretary:** The Secretary of the United States Department of Health and Human Services or the Secretary of the United States Department of Labor where applicable.
- Y. **Unanticipated Out-Of-Network (OON) Care:** Services received by a Patient in a Facility from an OON Health Care Professional or Clinician when the Patient did not have the ability or control to select such services from an In-Network Clinician, or when emergency services are provided to a Patient by an OON Clinician. Unanticipated OON care does not include non-emergency services received by a Patient when the Patient *voluntarily selects in writing* an OON Clinician prior to the provision of the care.

Section 4. Establishment of the Alternative Dispute Resolution (ADR), ADR Entity

Requirements and Certification of the Entities. This Act applies to all Plans that are doing business in a State. The amount the Plan is required to pay under this Section shall be an amount determined and payable in such manner in accordance with the law of the applicable State, county, parish or tribal government. In the case of a State in which the law does not provide for such payment, the Secretary, in consultation with other applicable regulators, shall establish an ADR process through a certified

ADR entity or administrator for resolving reimbursement disputes between Clinicians and Plans regarding Unanticipated OON Care claims by Facility-Based Clinicians. The ADR may include mediation, upon agreement of both parties, and/or arbitration, by the request of either party.

- A. The ADR entity shall request certification from the Secretary and the Secretary shall determine eligibility in accordance with the following standards.
- B. Conflict of Interest Standards for ADR: The Secretary shall select and contract with an ADR entity or administrator (Administrator or Adjudicator). The Administrator shall meet the following requirements:
 - 1. determined to be independent of plans and clinicians;
 - 2. not be an affiliate, subsidiary or in any way controlled by plans or clinicians or their trade associations;
 - 3. submit upon application for contract and annually or upon any change thereafter
 - i. names of all stockholders over 5%,
 - ii. names of all holders of bonds or notes over \$100,000,
 - iii. names of all corporations and organizations administrator controls or is affiliated with,
 - iv. names and bios of all directors, officers and executives and description of any past or present relationships directors, officers and executives have with plans or clinician groups,
 - v. how it will ensure the secretary's standards are met;
 - 4. administrator, experts, officers, directors or employees shall have no material, familial or financial relationship with plans or Clinician groups.
- C. The Secretary may impose additional requirements in accordance with the Secretary's rule making.
- D. The Secretary shall assess the sufficiency of the state reimbursement and ADR process, if any, (including the state's determination of interim and final reimbursement and standards therefore) in which the services were rendered to determine whether the state process is meaningfully accessible to both Facility-Based Clinicians and Plans to adjudicate reimbursement disputes. Either Clinicians or Plans may petition the Secretary for access to ADR under federal law if they reasonably believe that the state dispute resolution process is not sufficient.
- E. If the Secretary determines that the state reimbursement and ADR process, if any, is sufficiently available to both Plans and Clinicians, then the reimbursements and disputes shall be determined in accordance with state law;
- F. Non-proprietary application information shall be available to the public.

Section 5. OON Ban and ADR Procedure.

- A. OON Facility-Based Clinicians shall not send, transmit, communicate or mail a demand for payment to balance bill a Patient for Unanticipated OON care and services delivered after the effective date of this law and subject to the terms and conditions herein;
- B. If the Plan does not reimburse the Clinician for the Clinician's full charge within timely claim adjudication requirements in that state, the Plan shall make a First Offer of Reimbursement to the Clinician;
- C. With respect to the ADR specified above in Section 4, if the Clinician and Plan have not agreed on a reimbursement amount within 30 days of the submission of the claim—
 - 1. The Plan shall reimburse the OON Clinician at least the "Interim Direct Reimbursement" (IDR) specified below within 45 days of submission of the claim;
 - 2. Either party may request mediation and if the other party accepts mediation, the

mediation costs and filing fees will be equally shared by the parties unless otherwise agreed.

- D. Penalty for non-reimbursement of the IDR: If the Plan does not reimburse the Clinician for at least the IDR as specified above, then the Plan shall not have access to the ADR as specified herein and shall be subject to \$250 per claim per day penalties for each day that such violation occurs, and such penalties shall be reimbursed to the Clinician. In addition to the penalty, the Plan shall reimburse the Clinician charges and the Patient Cost-Sharing directly to the Clinician for ADR Exempt Claims. Penalties shall continue to accumulate until the charge and penalty has been paid.
- E. The Clinician may initiate court proceedings to enforce the provisions herein.
- F. The ADR decision shall be no later than 60 days from the notice by either party for the initiation of the ADR, absent exceptional circumstances as determined by the ADR adjudicator.
- G. Bundling of Similar Claims: The presumption in law shall be for similarly situated claims to be bundled into one ADR, regardless of the number of Patient encounters. The Clinician may bundle claims for one year prior to the initiation of ADR. Certain ADR Exempt Claims below the dollar threshold stated below (as defined herein) may be bundled together and eligible for ADR.
- H. Exception for ADR Exempt Claims: Where the reimbursements in dispute are less than \$750 (the difference between the Clinician charges and the First Offer of Reimbursement by the Plan for Unanticipated OON Care, adjusted for inflation each year, these Claims shall not be eligible for ADR (ADR Exempt Claims).
 - 1. Plans shall reimburse the Clinician's charges and the Patient Cost-Sharing directly to the Clinician for ADR Exempt Claims provided that the Clinician's charges do not exceed the 80th percentile of charges for the particular health care service performed by a health care professional in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Secretary.
 - 2. The nonprofit organization shall not be affiliated with or receive funding from a health insurance company.
 - 3. Multiple Exempt Claims less than \$750, adjusted for inflation, may be bundled together and shall be eligible for ADR.
- I. Interim Direct Reimbursement (IDR): The IDR shall be reimbursed as defined above and the amount determined on the following criteria _____. (Provisions for referencing the IDR to a database of charges if the IDR is so defined) The IDR shall be indexed to _____ for the particular health care service performed by a health care professional in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Secretary. The nonprofit organization shall not be affiliated with or receive funding from a health insurance company and shall be increased each year on the annual Consumer Price Index (CPI) for Medical Care.)
- J. ADR Determination of Final Reimbursement: The ADR adjudicator shall not consider the amount of the IDR reimbursed by the Plan in the ADR for the determination of final reimbursement to the Clinician (Final Reimbursement). The ADR adjudicator shall conduct a "baseball-style" ADR where the Clinician charges and the First Offer of Reimbursement shall be selected, one or the other. The ADR process shall be "per CPT code" and not "per patient visit" or "per procedure." The final ADR decision shall be binding and enforceable in court and the ADR decision shall be a matter of public record.
- K. Factors in the ADR Adjudicator Determining Final Reimbursement: When determining the Final Reimbursement in the ADR, the ADR adjudicator shall consider the following factors

but shall not consider the IDR, indigent programs, Medicare, Tricare, nor Medicaid rates in its decision on the Final Reimbursement:

1. The OON Clinician's level of training, education, experience, specialization or sub-specialization, the acuity level of patients seen by the OON Clinician and the Clinician's quality and outcome metrics;
 2. Contracted rates for the Clinicians by Health Plans in the same geographic area including the value received for contracting;
 3. If terminated by either party within one year prior to the filing of the ADR, the prior contract between the Plan and the Clinicians under dispute including value received for contracting;
 4. Past compliance with the prior contract terms between the Plan and Clinicians under dispute;
 5. The 80th percentile of charges for comparable services in the same geographical area, as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health),
 6. The circumstances and complexity of the case under dispute, including the place of service as defined by the Centers for Medicare and Medicaid Services (CMS);
 7. The OON Clinician's charges for the relevant services;
 8. Other relevant economic aspects of Clinician payment for the same specialty within the same geographic area;
- L. Final Reimbursement shall be received by the Clinician no later than 10 days after the ADR adjudicator's decision and shall accrue interest in accordance with the provisions below until paid in full;
- M. Costs and filing fees for the ADR shall be awarded to the prevailing party in the ADR.
- N. The ADR decision shall be subject to statutory interest from the date of the award until full payment in accordance with state law where the Clinician's services were provided.
- O. The ADR decision may be considered by other ADR adjudicators for precedent if similar issues of fact and/or law are presented in subsequent cases.

Section 6. Communications by the Health Insurance Plans or Plan and Clinicians to Patients Regarding Unanticipated Out-of-Network (OON) Care and Patient Cost-Sharing.

- A. The Company shall provide the Clinician with an explanation of benefits (EOB) describing the charges, reimbursements and other relevant information from the claim adjudication, in similar form and fashion as the Company would if the Clinician was In-Network.
- B. When Unanticipated OON care is provided at a Facility, and the Final Reimbursement and Patient Cost-Sharing is received from the Plan, the Clinician shall provide the Patient with information regarding the adjudication of the his/her claim to demonstrate the charges filed and reimbursements received by the Plan on behalf of the Patient. The Patient's Cost-Sharing obligation to the Plan shall be for no more than the Cost-Sharing requirements that would have been applicable if the care had been provided by a Health Care Professional at In-Network rates applicable to the Patient's Plan.
- C. Cost-Sharing reimbursements to the Clinician shall be treated by the Company as though they were paid to an In-Network Clinician for purposes related to the Enrollee's deductibles and out-of-pocket maximums. The Plans shall apply the OON charges to the Patient's In-Network out of pocket maximums.
- D. The Plan shall remit all reimbursements directly to the Clinician and the Plan shall be barred from remitting reimbursements directly to the Patient, regardless of whether the Clinician is OON.
- E. The Plan shall bill the Patient for the Cost-Sharing but shall not delay reimbursements to

the Clinician in accordance with State prompt payment laws based on delayed or non-payment of the Cost-Sharing by the Patient.

Section 7. Transparency of Network Directories.

- A. The Plans shall provide a Clinician directory on both the Plan's website and in print format.
 - a. The Plan shall annually audit at least a reasonable sample size of its clinical directories for accuracy and retain documentation of such an audit to be made available to the Commissioner upon request.
 - b. The directory on the Plan's website and in print format shall contain the following general information in plain language for each network plan:
 - i. a description of the criteria the Plan has used to build its network;
 - ii. if applicable, a description of the criteria the Plan has used to tier Clinicians;
 - iii. if applicable, how the Plan designates the different Clinician tiers or levels in the network and identifies for each specific Clinician, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, for a covered person or a prospective covered person to be able to identify the Clinician tier;
 - iv. if applicable, a statement that authorization or referral may be required to access certain Clinicians;
 - v. what Clinician directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state;
 - vi. a customer service email address and telephone number or electronic link that Enrollees or the public may use to notify the Plan of inaccurate Clinician directory information.
- B. Regarding the directory posted online, the Plan shall:
 - a. update the Clinician directory at least monthly;
 - b. ensure that the public may view all the current Clinicians for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;
 - c. make available in a searchable format the following information for each network plan:
 - i. For health care professionals: name; gender; participating office location(s); specialty, if applicable; medical group affiliations, if applicable; facility affiliations; if applicable; participating facility affiliations, if applicable; languages spoken other than English, if applicable; and whether the Clinician is accepting new patients.
 - ii. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; and,
 - iii. For Facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).
 - d. make available the following information in addition to the information available under Subsection B 3:
 - i. for Health Care Professionals: contact information; board certification(s); and languages spoken other than English by clinical staff, if applicable;
 - ii. for Hospitals: telephone number; and
 - iii. for Facilities other than Hospitals: telephone number.
- C. Regarding the clinical directory in print format, the Plan shall include a disclosure that the directory is accurate as of the date of printing and that Enrollees and prospective Enrollees

should consult the Plan's electronic Clinician directory on its website or call [insert appropriate customer service phone number] to obtain current Clinician directory information.

- D. Upon request of an Enrollee or a prospective Enrollee, the Plan shall make available in print format, the following Clinician directory information for the applicable network plan:
 - a. for Health Care Professionals: name; contact information; participating office location(s); specialty, if applicable; languages spoken other than English, if applicable; and whether the Clinician is accepting new patients;
 - b. for Hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and
 - c. for Facilities, other than Hospitals, by type: facility name; facility type; types of services performed; and participating facility.

Section 8. Effective. This Act shall become effective six months from the date of enactment.

Section 9. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

Section 10. Nullification. Any contract provision violating this Act shall be considered null and void.