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13 Councilmember Anita Bonds


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19 A BILL

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23 IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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28 To prohibit the practice of balance billing in the District, to create procedures for the resolution
29 and payment of balance bills, to create an arbitration process to resolve disputes
30 involving balance bills, to require the Department of Insurance, Securities, and Banking
31 to create a report on the use of arbitration for balance billing, to require the Department
32 of Insurance, Securities, and Banking to create a consumer rights notice regarding
33 balance billing, to require certain disclosures by health care facilities, providers, and
34 insurers, and to authorize the Department of Insurance, Securities, and Banking to
35 enforce the provisions of the act or refer the matter to another enforcement authority.

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37 BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this
38 act may be cited as the "Surprise Billing Patient Protection Act of 2019".

39 Sec. 2. Definitions.

40 For the purposes of this act, the term:

41 (1) "Balance bill" means a bill sent to an enrollee by an out-of-network provider
42 or facility for health care services provided to the enrollee after the provider or facility's billed

43 amount is not reimbursed by the health insurer, excluding any cost-sharing amount due from an
44 enrollee.

45 (2) "Benefits" means the health care services covered by a health insurer under a
46 health benefits plan.

47 (3) "Claim" means a request from a provider for payment for health care services
48 rendered.

49 (4) "Commissioner" means the Commissioner of the Department of Insurance,
50 Securities, and Banking.

51 (5) "Cost-sharing" means a co-payment, co-insurance, deductible, or any other
52 form of financial obligation of an enrollee other than premium or share of premium, or any
53 combination of any of these financial obligations as defined by the terms of a health benefits
54 plan.

55 (6) "Department" means the Department of Insurance Securities, and Banking.

56 (7) "Enrollee" means an individual who is enrolled in a health benefits plan.

57 (8) "Health benefits plan" shall have the same meaning as provided in section
58 2(4) of the Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official
59 Code § 31-3131(4)).

60 (9) "Health care service" means service offered or provided by health care
61 facilities and health care providers relating to the prevention, cure, or treatment of illness, injury,
62 or disease.

63 (10) "Health insurer" shall have the same meaning as provided in section 2(5) of
64 the Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official Code § 31-
65 3131(5)).

66 (11) "In-network" shall have the same meaning as provided in section 2(5) of the
67 Behavioral Health Parity Act of 2018, effective March 3, 2019 (D.C. Law 22-242; D.C. Official
68 Code § 31-3175.01(5)).

69 (12) "Out-of-network" shall have the same meaning as provided in section 2(12)
70 of the Behavioral Health Parity Act of 2018, effective Mar. 3, 2019 (D.C. Law 22-242; D.C.
71 Official Code § 31-3175.01(12)).

72 (13) "Provider" shall have the same meaning as provided in section 2(7) of the
73 Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official Code § 31-
74 3131(7)).

75 (14) "Surgical or ancillary services" means surgery, anesthesiology, pathology,
76 radiology, laboratory, or hospitalist services.

77 Sec. 3. Prohibition against balance billing.

78 (a) An out-of-network provider or facility shall not send a balance bill to an enrollee for
79 the following health care services:

80 (1) Emergency services provided to an enrollee; or

81 (2) Non-emergency health care services provided to an enrollee at an in-network
82 hospital or an in-network ambulatory surgical facility if the services:

83 (A) Involve surgical or ancillary services; and

84 (B) Are provided by an out-of-network provider.

85 (b) Payment for services described in subsection (a) of this section is subject to the
86 provisions of sections (4) and (5) of this act.

87 Section 4. Payment procedures and obligations.

88 (a) If an enrollee receives emergency or nonemergency health care services described in
89 section 3 of this act, the enrollee satisfies the enrollee's obligation to pay for the health care
90 services if the enrollee pays the in-network cost-sharing amount specified in the enrollee's health
91 plan contract. The enrollee's obligation shall be determined using the health insurer's median in-
92 network contracted rate for the same or similar service in the District. The health insurer shall
93 provide an explanation of benefits to the enrollee and the out-of-network provider that reflects
94 the cost-sharing amount determined under this subsection.

95 (b) The health insurer, out-of-network provider, or out-of-network facility, and an agent,
96 trustee, or assignee of the insurer, out-of-network provider, or out-of-network facility shall
97 ensure that the enrollee incurs no greater cost than the amount determined under subsection (a)
98 of this subsection.

99 (c) The out-of-network provider or out-of-network facility, and an agent, trustee, or
100 assignee of the out-of-network provider or out-of-network facility shall not balance bill or
101 otherwise attempt to collect from the enrollee any amount greater than the amount determined
102 under subsection (a) of this subsection. This subsection shall not affect a provider's ability to
103 collect a past due balance for that cost-sharing amount with interest.

104 (d) The health insurer shall treat any cost-sharing amounts determined under subsection
105 (a) of this section paid by the enrollee for an out-of-network provider or facility's services in the
106 same manner as cost-sharing for health care services provided by an in-network provider or
107 facility and shall apply any cost-sharing amounts paid by the enrollee for such services toward
108 the enrollee's maximum out-of-pocket payment obligation.

109 (e) If the enrollee pays the out-of-network provider or out-of-network facility an amount
110 that exceeds the in-network cost-sharing amount determined under subsection (a) of this section,

111 the provider or facility shall refund any amount in excess of the in-network cost-sharing amount
112 to the enrollee within 30 days of receipt. Interest shall be paid to the enrollee for any refunded
113 payments at a rate of 12% beginning on the first calendar day after the 30 days.

114 (f) The allowable amount paid to an out-of-network provider for health care services
115 described in section 3 of this act shall be a commercially reasonable amount, based on payments
116 for the same or similar services provided in the District. Within 30 days after receipt of a claim
117 from an out-of-network provider or facility, the health insurer shall offer to pay the provider or
118 facility a commercially reasonable amount. If the out-of-network provider or facility wants to
119 dispute the health insurer's payment, the provider or facility shall notify the insurer no later than
120 30 days after receipt of payment or payment notification from the insurer. If the out-of-network
121 provider or facility disputes the health insurer's initial offer, the insurer and provider or facility
122 have 30 days after the initial offer to negotiate in good faith. If the insurer and the out-of-network
123 provider or facility do not agree to a commercially reasonable payment amount within 30 days,
124 and the insurer, out-of-network provider, or facility chooses to pursue further action to resolve
125 the dispute, the dispute shall be resolved through arbitration, as provided in section 5 of this act.

126 (g) A health insurer shall make payments for health care services described in section 3
127 of this act provided by out-of-network providers or facilities directly to the provider or facility,
128 rather than the enrollee.

129 (h) A health insurer shall make available through electronic and other methods of
130 communication generally used by the insurer to verify enrollee eligibility and benefits
131 information regarding whether an enrollee's health benefits plan is subject to the requirements of
132 this act.

133 (i) A provider, hospital, or ambulatory surgical facility shall not require a patient, at any
134 time, for any procedure, service, or supply, to sign or execute by electronic means, any document
135 that would attempt to avoid, waive, or alter any provision of this section.

136 (j) This section shall only apply to a provider or facility providing services to members of
137 an entity administering a self-funded group health plan and its plan members if the entity has
138 elected to participate in sections 3, 4, and 5 of this act as provided in section (x) of this act.

139 Sec. 5. Arbitration procedures.

140 (a) If good-faith negotiation, as described in section 4 of this act, does not result in
141 resolution of a claim for payment, and the insurer, out-of-network provider, or facility chooses to
142 pursue further action to resolve the dispute, the insurer, out-of-network provider, or facility shall
143 initiate arbitration to determine a commercially reasonable payment amount.

144 (b) To initiate arbitration, the insurer, out-of-network provider, or facility shall provide
145 written notification to the Commissioner and the non-initiating party no later than 10 calendar
146 days following completion of the period of good-faith negotiation under section 4 of this act. The
147 notification to the non-initiating party shall include the initiating party's final offer. No later than
148 30 calendar days following receipt of the notification, the non-initiating party shall provide its
149 final offer to the initiating party. The parties may reach an agreement on reimbursement during
150 this time and before the arbitration proceeding.

151 (c) Multiple claims may be addressed in a single arbitration proceeding if the claims at
152 issue:

153 (1) Involve identical insurer and provider or facility parties;

154 (2) Involve claims with the same or related current procedural terminology codes

155 relevant to a particular procedure; and

156 (3) Occur within a period of 60 days of one another.

157 (d) Within 7 calendar days of receipt of notification from the initiating party, the
158 Commissioner shall provide the parties with a list of approved arbitrators or entities that provide
159 arbitration. The approved arbitrators shall be trained by the American Arbitration Association or
160 the American Health Lawyers Association and shall have experience in matters related to
161 medical or health care services. The parties may agree on an arbitrator from the list provided by
162 the Commissioner. If the parties do not agree on an arbitrator, they shall notify the
163 Commissioner, who shall provide them with the names of 5 arbitrators from the list. Each party
164 may veto 2 of the 5 named arbitrators. If one arbitrator remains, the remaining arbitrator is the
165 chosen arbitrator. If more than one arbitrator remains, the Commissioner shall choose the
166 arbitrator from the remaining arbitrators. The parties and the Commission shall complete the
167 arbitrator selection process within 20 calendar days of receipt of the original list from the
168 Commissioner.

169 (e) No later than 30 calendar days after the final selection of the arbitrator, each party
170 shall make written submissions to the arbitrator in support of its position. The initiating party
171 shall include in its written submission the evidence and methodology for asserting that the
172 amount proposed to be paid is or is not commercially reasonable. No later than 30 calendar days
173 after receipt of the parties' written submissions, the arbitrator shall:

174 (1) Issue a written decision requiring payment of the final offer amount of either
175 the initiating party or the non-initiating party;

176 (2) Notify the parties of its decision; and

177 (3) Provide the decision and information described in section 6 of this act
178 regarding the decision to the Commissioner.

179 (f) In reviewing the submissions of the parties and making a decision related to whether
180 payment should be made at the final offer amount of the initiating party or the non-initiating
181 party, the arbitrator shall consider the following factors:

182 (1) The evidence and methodology submitted by the parties to assert that their
183 final offer amount is reasonable;

184 (2) Patient characteristics and the circumstances and complexity of the case,
185 including time and place of service, that are not already reflected in the provider's billing code
186 for the service; and

187 (3) Any other information the arbitrator believes is relevant to making a decision.

188 (g) Expenses incurred in the course of arbitration, including the arbitrator's expenses and
189 fees, excluding attorneys' fees, shall be divided equally among the parties to the arbitration. An
190 enrollee shall not be liable for any of the costs of the arbitration and shall not be required to
191 participate in the arbitration proceeding as a witness or otherwise.

192 (h) A party that fails to make timely written submissions under this section without good
193 cause shown shall be considered to be in default, and the arbitrator shall require the defaulting
194 party to pay the final offer amount submitted by the non-defaulting party, and may require the
195 defaulting party to pay expenses incurred to date in the course of arbitration, include the
196 arbitrator's expenses and fees and the reasonable attorneys' fees of the non-defaulting party.

197 (i) Within 10 business days of a party notifying the Commissioner and the non-initiating
198 party of intent to initiate arbitration, both parties shall agree to an execute a nondisclosure
199 agreement. The agreement shall not preclude the arbitrator from submitting the arbitrator's
200 decision to the Commission under subsection (e) of this section or impede the Commissioner's
201 duty to prepare the report described in section 6 of this act.

202 Sec. 6. Commissioner arbitration report.

203 (a) Within one year of the effective date of this act and every year thereafter, the
204 Commissioner shall prepare a report summarizing the dispute resolution information provided by
205 arbitrators under section 5 of this act. The report shall include summary information related to
206 the matters decided through arbitration, as well as the following information for each dispute
207 resolved through arbitration:

208 (1) The name of the health insurer;

209 (2) The name of the provider;

210 (3) The provider's employer or the business entity in which the provider has an
211 ownership interest;

212 (4) The health care facility where the services were provided; and

213 (5) The type of health care services at issue.

214 (b) The Commissioner shall post the report on the Department's website and shall submit
215 the report to the Council.

216 (c) This section shall expire on January 1, 2025.

217 Sec. 7. Consumer rights notice.

218 (a) The Commissioner shall create standard template language for a notice of consumer
219 rights, informing consumers that:

220 (1) The prohibition against balance billing is applicable to health benefits plans
221 issued in the District of Columbia, excluding a self-funded group health benefit plan governed by
222 the provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et
223 seq.);

224 (2) They shall not be balance billed for the health care services described in
225 section 3 of this act and shall receive the protections provided by this act; and

226 (3) They may be balance billed for health care services under circumstances other
227 than those described in section 3 of this act or if they are enrolled in health benefit plan to which
228 this act does not apply, and steps they may take if they are balance billed.

229 (b) The standard template language shall include contact information for the Department
230 to allow consumers to contact the Department if they believe they have received a balance bill in
231 violation of this act.

232 (c) The Commissioner shall determine, by rulemaking, when and in what format health
233 insurers, providers, and health care facilities shall provide consumers with the notice created
234 under this section.

235 Sec. 8. Facility disclosures.

236 (a) A hospital or ambulatory surgical facility shall post the following information on its
237 web site, if one is available:

238 (1) A list of the insurers for which the hospital or ambulatory surgical facility is
239 in-network; and

240 (2) The notice of consumer rights created under section 7 of this act.

241 (b) If the hospital or ambulatory surgical facility does not maintain a website, the
242 information shall be provided to consumers upon oral or written request.

243 (c) Posting or otherwise providing the information required under this section shall not
244 relieve a hospital or ambulatory surgical facility of its obligation to comply with the provisions
245 of this act.

246 (d) Not less than 30 days before executing a contract with an insurer, a hospital or
247 ambulatory surgical facility shall provide the insurer with a list of the nonemployed providers or
248 provider groups contracted to provide surgical or ancillary services at the hospital or ambulatory
249 surgical facility. The hospital or ambulatory surgical facility shall notify the insurer within 30
250 days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory
251 surgical facility shall provide an updated list of these providers within 14 calendar days of a
252 request for an updated list by an insurer.

253 Sec. 9. Provider disclosures.

254 (a) A provider shall post the following information on its website, if one is available:

255 (1) A list of the insurers with which the provider contracts; and

256 (2) The notice of consumer rights created under section 7 of this act.

257 (b) If the provider does not maintain a website, the information shall be provided to
258 consumers upon oral or written request.

259 (c) Posting or otherwise providing the information required under this section shall not
260 relieve a provider of its obligation to comply with the provisions of this act.

261 (d) An in-network provider shall submit accurate information to an insurer regarding the
262 provider's network status in a timely manner, consistent with the terms of the contract between
263 the provider and the insurer.

264 Sec. 10. Insurer disclosures.

265 (a) An insurer shall update its web site and provider directory no later than 30 days after
266 the addition or termination of a facility or provider.

267 (b) An insurer shall provide an enrollee with:

268 (1) A clear description of the health benefit plan's out-of-network health benefits;

269 (2) The notice of consumer rights developed under section 7 of this act.

270 (3) Notification that if the enrollee receives services from an out-of-network
271 provider or facility, under circumstances other than those described in section 3 of this act, the
272 enrollee will have the financial responsibility applicable to services provided outside the health
273 benefit plan's network in excess of applicable cost-sharing amounts and that the enrollee may be
274 responsible for any costs in excess of those allowed by the health plan;

275 (4) Upon request, information regarding whether a provider is in-network or out-
276 of-network, and whether there are in-network providers available to provide surgical or ancillary
277 services at specified in-network hospitals or ambulatory surgical facilities; and

278 (5) Upon request, an estimated range of the out-of-pocket costs for an out-of-
279 network benefit.

280 Sec. 11. Enforcement.

281 If the Commissioner has cause to believe that a provider, hospital, or ambulatory surgical
282 facility has engaged in a pattern of unresolved violations of section 3 or 4 of this act, the
283 Commissioner shall have the authority to levy fines or other civil penalties as determined by
284 rulemaking, refer the matter to another enforcement authority for action, or take other action as
285 permitted under the authority of the Department or other enforcement authority. Before initiating
286 an enforcement action against a provider, hospital, or ambulatory surgical facility or referring the
287 matter to another enforcement authority, the Commissioner may allow the provider, hospital, or
288 ambulatory surgical facility to cure the alleged violations, or explain why the actions in question
289 did not violate sections 3 or 4 of this act.

290 Sec. 12. Exemption.

291 This act shall not apply to a self-funded group health benefit plan governed by the
292 provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1001 *et*
293 *seq.*).

294 Sec. 13. Rules.

295 The Mayor, pursuant to Title I of the District of Columbia Administrative Procedures
296 Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), shall issue
297 rules to implement the provisions of this act.

298 Sec. 14. Fiscal impact statement.

299 The Council adopts the fiscal impact statement in the committee report as the fiscal
300 impact statement required by section 4a of the General Legislative Procedures Act of 1975,
301 approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

302 Sec. 15. Effective date.

303 This act shall take effect following approval by the Mayor (or in the event of veto by the
304 Mayor, action by the Council to override the veto), a 30-day period of congressional review as
305 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
306 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of
307 Columbia Register.