S. 3592

To amend the Public Health Service Act to prevent surprise medical billing practices, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 11, 2018

Ms. HASSAN (for herself and Mrs. SHAHEEN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to prevent surprise medical billing practices, and for other purposes.

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 “No More Surprise Medical Bills Act of 2018”.

SEC. 2. PREVENTING SURPRISE BILLING PRACTICES.

(a) IN GENERAL.—

(1) PROHIBITION.—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. 2729. PREVENTING SURPRISE BILLING PRACTICES.

“(a) DEFINITIONS.—In this section:

“(1) HEALTH CARE PROVIDER.—The term ‘health care provider’ means—

“(A) a hospital (as defined in section 1861(e) of the Social Security Act);

“(B) a critical access hospital (as defined in section 1861(mm) of such Act);

“(C) an ambulatory surgical center as described in section 1833(i)(1)(A) of such Act; or

“(D) a provider of services or supplier furnishing services at such hospital, critical access hospital, or ambulatory surgical center.

“(2) IN-NETWORK HEALTH CARE PROVIDER.—The term ‘in-network health care provider’, with respect to a group health plan or health insurance coverage offered in the group market, means a health care provider that is within the health care provider network of the plan or coverage or is otherwise a participating provider of services or supplier with respect to such plan or coverage.

“(3) OUT-OF-NETWORK HEALTH CARE PROVIDER.—The term ‘out-of-network health care pro-
provider', with respect to a group health plan or health
insurance coverage offered in the group market,
means a health care provider that is not within the
health care provider network of the plan or coverage
or is not otherwise a participating provider of serv-
ices or supplier with respect to such plan or cov-

erage.

“(b) REQUIREMENT FOR NOTICE AND CONSENT.—

“(1) NOTICE.—A health care provider, in the
case of an individual enrolled in a group health plan
or health insurance coverage offered in the group
market, who seeks to be furnished items or services
or is to be furnished items or services by the pro-
vider, shall—

“(A)(i) provide to the individual (or to a
representative of the individual), on the date on
which the individual makes an appointment to
be furnished such items or services, if applica-
ble, and on the date on which the individual is
furnished such items and services—

“(I) an oral explanation of the written
notification described in subclause (II) and
such documentation of the provision of
such explanation, as the Secretary deter-
mines appropriate; and
“(II) a written notice specified by the Secretary through rulemaking that—

“(aa) contains the information required under paragraph (2); and

“(bb) is signed and dated by the individual; and

“(ii) retain, for a period specified through rulemaking by the Secretary, a copy of the documentation described in clause (i)(I) and the written notice described in clause (i)(II); and

“(B) in the case that such provider is an out-of-network health care provider, obtain from the individual the consent described in paragraph (3).

“(2) INFORMATION INCLUDED IN NOTICE.—

The notice described in paragraph (1)(A) shall include, with respect to the individual described in such paragraph, a notification of each of the following:

“(A) Whether the health care provider is an out-of-network health care provider with respect to the group health plan, or health insurance coverage offered in the group market, of such individual.
“(B) If the health care provider is such an
out-of-network health care provider, the esti-
mated amount that such provider will charge
the individual for such items and services in ex-
cess of any cost sharing obligations that the in-
dividual would otherwise have under such plan
or coverage for such items and services if the
health care provider were an in-network health
care provider with respect to the plan or cov-
erage of such individual.

“(C) In the case of a health care provider
that is a hospital, critical access hospital, or
ambulatory surgical center as described in sub-
paragraph (A), (B), or (C) of subsection (a)(1),
respectively—

“(i) whether any of the providers of
services or suppliers furnishing items or
services at such hospital, critical access
hospital, or ambulatory surgical center who
will furnish the items or services to the in-
dividual are out-of-network health care
providers with respect to the group health
plan, or health insurance coverage offered
in the group market, of such individual; and
“(ii) if any such providers of services or suppliers are such out-of-network health care providers, the estimated amount that such providers or suppliers will charge the individual for such items and services in excess of any cost sharing obligations that the individual would otherwise have for such items and services if the providers or suppliers were in-network health care providers with respect to the plan or coverage of such individual.

“(3) CONSENT DESCRIBED.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to an individual enrolled in a group health plan, or health insurance coverage offered in the group market, who is to be furnished items or services by an out-of-network health care provider, is a document specified by the Secretary through rulemaking that is signed by the individual (or by a representative of the individual) not less than 24 hours prior to the individual being furnished such items or services by such health care provider, and that—

“(A) acknowledges that the individual has been—
“(i) provided with a written estimate and an oral explanation of the charge that the individual will be assessed for the items or services anticipated to be furnished to the individual by such out-of-network health care provider; and

“(ii) informed that the payment of such charge by the individual will not accrue toward meeting any limitation that the group health plan, or health insurance coverage offered in the group market, places on cost-sharing; and

“(B) documents the consent of the individual to—

“(i) be furnished with such items or services by such out-of-network health care provider; and

“(ii) in the case that the individual is so furnished such items or services, be charged an amount approximate to the estimated charge described in subparagraph (A)(i) with respect to such items or services.

“(c) LIMITATIONS ON BALANCE BILLING IN SURPRISE BILLING SITUATIONS.—
“(1) In case of noncompliance with notice and consent requirements.—In the case of an individual enrolled in a group health plan, or health insurance coverage offered in the group market, who is furnished items or services by an out-of-network health care provider with respect to such plan or coverage, if the out-of-network health care provider does not comply with the requirements of subsection (b) with respect to the furnishing of such items or services to such individual, the out-of-network health care provider may not charge the individual more than the amount that the individual would have been required to pay in cost sharing if such items or services had been furnished by an in-network health care provider with respect to such plan or coverage.

“(2) In case of same-day emergency services.—In the case of an individual enrolled in a group health plan or health insurance coverage offered in the group market who is furnished items or services by a health care provider that is an out-of-network health care provider with respect to such plan or coverage on the same date on which the individual makes an appointment for such items or services (or otherwise presents at the hospital, critical
access hospital, or ambulatory surgical center for such services such as in the case of items and services furnished with respect to an emergency medical condition, as defined in section 1867(e)), the out-of-network health care provider may not charge the individual more than the amount that the individual would have been required to pay in cost sharing if such items or services had been furnished by an in-network health care provider with respect to such plan or coverage.”.

(2) **Effective Date.**—The amendment made by paragraph (1) shall take effect beginning 2 years after the date of the enactment of this Act.

(b) **Condition of Participation in Medicare.**—

(1) **In general.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

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

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

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

“(Z) in the case of a hospital, a critical access hospital, or an ambulatory surgical center
described in section 1833(i)(1)(A), to adopt and
enforce a policy to ensure compliance with the
requirements of subsections (b) and (c) of sec-
tion 2729 of the Public Health Service Act and
to meet the requirements of such subsections
(relating to the prevention of surprise billing
practices);’’.

(2) EFFECTIVE DATE.—The amendments made
by paragraph (1) shall apply with respect to agree-
ments under such section 1866(a)(1) that are filed
with the Secretary of Health and Human Services
on a date that is not less than 2 years after the date
of the enactment of this Act.

SEC. 3. PAYMENTS MADE BY INSURED INDIVIDUALS IN
SURPRISE BILLING SITUATIONS INCLUDED
IN COST-SHARING LIMITATIONS.

(a) IN GENERAL.—Section 2707 of the Public Health
Service Act (42 U.S.C. 300gg–6) is amended by adding
at the end the following:

“(e) SURPRISE BILLING SITUATIONS.—Notwith-
standing section 1302(c)(3)(B) of the Patient Protection
and Affordable Care Act (42 U.S.C. 18022(c)(3)(B)), any
group health plan or health insurance issuer offering
health insurance coverage in the group market shall en-
sure that any amount paid by an individual enrolled in
such plan or coverage in a surprise billing situation, as defined in section 2730(a), accrues towards meeting any annual limitation on cost-sharing under the plan or coverage.”.

(b) Effective Date.—The amendments made by subsection (a) shall apply with respect to any plan year beginning not earlier than 2 years after the date of enactment of this Act.

SEC. 4. RESOLVING PAYMENT DISPUTES IN SURPRISE BILLING SITUATIONS.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 2(a), is further amended by adding at the end the following:

“SEC. 2730. RESOLVING PAYMENT DISPUTES IN SURPRISE BILLING SITUATIONS.

“(a) Definitions.—In this section:

“(1) Health care provider; in-network health care provider; out-of-network health care provider.—The terms ‘health care provider’, ‘in-network health care provider’, and ‘out-of-network health care provider’ have the meanings given such terms in section 2729(a).

“(2) Independent dispute resolution entity.—The term ‘independent dispute resolution en-
‘entity’ means an entity certified by the Secretary, in consultation with the Secretary of Labor, under subsection (b)(2) to conduct an independent dispute resolution process under subsection (d).

“(3) SURPRISE BILLING SITUATION.—The term ‘surprise billing situation’ means—

“(A) a situation in which an individual who is enrolled in a group health plan, or health insurance coverage offered in the group market, is furnished items or services by an out-of-network health care provider and such provider does not comply with the requirements of section 2729(b) with respect to the furnishing of such items or services to such individual; or

“(B) a situation in which an individual who is enrolled in a group health plan, or health insurance coverage offered in the group market, is furnished items or services by an out-of-network health care provider on the same date on which the individual makes an appointment for such items or services (or otherwise presents at the hospital, critical access hospital, or ambulatory surgical center for such services such as in the case of items and services fur-
nished with respect to an emergency medical condition, as defined in section 1867(e)).

“(b) Establishment of Independent Dispute Resolution Process.—

“(1) Establishment.—Not later than 2 years 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 billing situations in accordance with this section.

“(2) Certification of Independent Dispute Resolution Entities.—

“(A) In general.—The Secretary, in consultation with the Secretary of Labor, shall establish a process through rulemaking to certify entities as independent dispute resolution entities to conduct independent dispute resolution processes under subsection (d).

“(B) Requirements.—To be eligible for certification under this paragraph, an entity shall—
“(i) have experience in health care billing, health care pricing, and arbitration; and

“(ii) not have any conflict of interest, as determined in accordance with subparagraph (C).

“(C) CONFLICT OF INTEREST.—The Secretary, in consultation with the Secretary of Labor, shall determine, through rulemaking, the criteria for a conflict of interest for purposes of subparagraph (B)(ii), which shall include—

“(i) having any material arrangement, financial or otherwise, that could bias the entity, or an employee of the entity working on a particular dispute; or

“(ii) owning or controlling, being owned by or controlled by, or being under common control of—

“(I) any pharmaceutical company, disease group, or public advocacy group;

“(II) any national, State, or local society or association of hospitals, physicians, or other providers of health care services; or
“(III) any national, State, or local association of health care plans.

“(c) PRE-INDEPENDENT DISPUTE RESOLUTION PROCESS.—

“(1) REQUIREMENT TO PAY OUT-OF-NETWORK HEALTH CARE PROVIDERS.—

“(A) REQUIREMENT ON PLAN.—The process established by the Secretary, in consultation with the Secretary of Labor, under this section shall require that a group health plan, or health insurance issuer offering health insurance coverage in the group market, that receives a bill from an out-of-network health care provider for items or services furnished to an individual enrolled in the plan or coverage in a surprise billing situation, not later than 30 days after receiving such bill—

“(i) pay the out-of-network health care provider the amount in the bill; or

“(ii) attempt to negotiate with the out-of-network health care provider an alternative amount for the plan or issuer to pay the provider.

“(B) PRE-INDEPENDENT DISPUTE RESOLUTION NEGOTIATIONS.—If, not later than 30
days after the date on which negotiations begin under subparagraph (A)(ii), an out-of-network health care provider and group health plan, or health insurance issuer offering health insurance coverage in the group market, described in subparagraph (A) have not agreed upon an alternative amount for the plan or issuer to pay the provider, the plan or issuer shall—

“(i) pay the provider the amount the plan or issuer determines reasonable for the services (less the cost-sharing amount paid by the individual enrolled in the plan or coverage); and

“(ii) provide information to the provider on how the provider may initiate an independent dispute resolution process under paragraph (2).

“(2) INITIATING AN INDEPENDENT DISPUTE RESOLUTION PROCESS.—

“(A) IN GENERAL.—If, after a good faith attempt to negotiate under paragraph (1)(A)(ii), the out-of-network health care provider and group health plan, or health insurance issuer offering health insurance coverage in the group market, described in paragraph
(1)(A) are unable to reach an agreement on an amount for the plan or issuer to pay the provider, any party to the dispute may, not later than 30 days of being unable to come to an agreement, as determined by the Secretary, in consultation with the Secretary of Labor, initiate an independent dispute resolution process under subsection (d) by submitting a request for such process to the Secretary, and the Secretary of Labor, or directly to an independent dispute resolution entity, in accordance with the process established by the Secretary, in consultation with the Secretary of Labor, under this section.

“(B) REQUEST.—A request submitted under subparagraph (A) shall indicate—

“(i) the amount the out-of-network health care provider requested in the bill described in subparagraph (A) of paragraph (1) or after attempted negotiations in accordance with such paragraph; and

“(ii) the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, paid the out-of-network health
care provider in accordance with paragraph 
(1)(B) after such negotiations.

“(C) Notice to Other Party.—A party 
initiating an independent dispute resolution 
process under subparagraph (A) shall, not later 
than 10 days after submitting a request under 
such subparagraph, notify the other party that 
such request has been submitted.

“(d) Independent Dispute Resolution Proc-
ess.—

“(1) In General.—The Secretary, in consulta-
tion with the Secretary of Labor, shall establish pro-
cedures for independent dispute resolution entities to 
conduct independent dispute resolution processes 
under this subsection to resolve payment disputes 
between group health plans, or health insurance 
issuers offering health insurance coverage in the 
group market, and out-of-network health care pro-
viders.

“(2) Timing.—An independent dispute resolu-
tion entity that receives a request under subsection 
(c)(2)(A) shall, not later than 30 days after receiv-
ing such request, determine the amount the group 
health plan, or health insurance issuer offering 
health insurance coverage in the group market, is re-
quired to pay the out-of-network health care provider. Such amount shall be—

“(A) the amount determined by the parties through a settlement under paragraph (3); or

“(B) the amount determined reasonable by the entity in accordance with paragraph (4).

“(3) SettLement.—

“(A) IN GENeral.—If the independent dispute resolution entity determines, based on the amounts indicated in the request under subsection (c)(2)(B), that a settlement between the group health plan, or health insurance issuer offering health insurance coverage in the group market, and out-of-network health care provider is likely or that the amounts provided in such subsection each represent unreasonable extremes, 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.

“(B) TIMing.—The period for a settlement described in subparagraph (A) shall accrue towards the 30-day period required under paragraph (2).

“(4) DEtermination of AMount.—
“(A) Final offers.—In the absence of a settlement under paragraph (3), the group health plan, or health insurance issuer offering health insurance coverage in the group market, and out-of-network health care provider shall each submit to the independent dispute resolution entity an amount as a final offer. Such entity shall determine which of those 2 amounts is more reasonable based on the factors described in subparagraph (D).

“(B) Final decisions.—The amount that is determined to be the more reasonable amount under subparagraph (A) 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.

“(C) Service units.—A final offer submitted under subparagraph (A) shall be made per service unit, as defined by the Secretary, in consultation with the Secretary of Labor, through regulations. A final decision under subparagraph (B) may include the resolution of disputes for multiple items or services for a sin-
gle patient, such as for instances in which multiple specialists are involved.

“(D) FACTORS.—In determining which final offer to select as the more reasonable amount under subparagraph (A), the independent dispute resolution entity shall consider relevant factors including—

“(i) the average in-network payment rate for comparable items or services in the same geographic region, including as calculated by an independent database or an all-payer claims database;

“(ii) the level of training, education, and experience of the out-of-network health care provider;

“(iii) the circumstances and complexity of the particular dispute, including the time and place of the service; and

“(iv) the payment rate determined for the item or service under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act.
“(5) Effect of decision.—A final decision of
an independent dispute resolution entity under para-
graph (4)(B)—

“(A) shall be binding; and

“(B) 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.

“(6) 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) Responsibility to pay costs.—The costs for
an independent dispute resolution process under sub-
section (d) shall be paid for in accordance with the fol-
lowing:

“(1) In a case in which the independent dispute
resolution entity determines that the amount in the
final offer submitted under subsection (d)(4)(A) by
the out-of-network health care provider is the more
reasonable amount, the group health plan, or health
insurance issuer offering health insurance coverage
in the group market, shall pay all costs of the independent dispute resolution process.

“(2) In a case in which the independent dispute resolution entity determines that the amount in the final offer submitted under subsection (d)(4)(A) by the group health plan, or health insurance issuer offering health insurance coverage in the group market, is the more reasonable amount, the out-of-network health care provider shall pay all costs of the independent dispute resolution process.

“(3) In a case in which a settlement is reached under subsection (d)(3), 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 pay half of the costs of the independent dispute resolution process.

“(f) Reports.—

“(1) Entity reports.—Not later than 4 years after the date of enactment of this section, and each year thereafter, each independent dispute resolution entity shall submit to the Secretary, and the Secretary of Labor, a report on all independent dispute resolution processes conducted by the entity under subsection (d) for the period of the report. Each such report shall contain information determined ap-
propriate by the Secretary, in consultation with the Secretary of Labor, in order to prepare the report required under paragraph (2).

“(2) REPORTS BY SECRETARIES.—

“(A) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and each year thereafter, the Secretary, in consultation with the Secretary of Labor, shall based on the reports submitted under paragraph (1) prepare a report, disaggregated by State, that contains each of the following for the period of the report:

“(i) The total number of independent dispute resolution processes initiated under subsection (c)(2)(A), including an indication of the number of instances in which—

“(I) the amount in the final offer under subsection (d)(4)(A) made by the group health plan, or health insurance issuer offering health insurance coverage in the group market, was determined to be more reasonable than the amount in the final offer under such subsection made by the out-of-network health care provider;
“(II) the amount in the final offer under subsection (d)(4)(A) made by the out-of-network health care provider was determined to be more reasonable than the amount in the final offer under such subsection made by the group health plan, or health insurance issuer offering health insurance coverage in the group market; and

“(III) a settlement was reached under subsection (d)(3).

“(ii) The number of requests made for an independent dispute resolution process under subsection (c)(2)(A) that were determined to be ineligible for such process and the reason for such determination.

“(iii) The number of independent dispute resolution processes conducted under subsection (d) that—

“(I) were based on a situation described in subsection (a)(3)(A); and

“(II) were based on a situation described in subsection (a)(3)(B).
“(iv) The total number of final decisions rendered by independent dispute resolution entities under subsection (d)(4)(B).

“(v) For each independent dispute resolution process conducted under subsection (d)—

“(I) the type of coverage of the plan or issuer involved, such as whether the plan or issuer is a health maintenance organization or preferred provider organization;

“(II) the specialty of the out-of-network health care provider, and specific types of services, involved; and

“(III) the dollar amount of the final decision under subsection (d)(4)(B).

“(vi) Any additional information the Secretary, in consultation with the Secretary of Labor, determines necessary.

“(B) PUBLIC ACCESS.—The Secretary, in consultation with the Secretary of Labor, shall, each year, publish the report prepared under subparagraph (A) and make such report available to the public.
“(C) PRIVACY.—In carrying out this paragraph, the Secretary, in consultation with the Secretary of Labor, shall comply with all applicable Federal and State privacy laws.

“(g) APPLICABILITY OF STATE LAW.—

“(1) IN GENERAL.—Notwithstanding any other provision in this section, the process established by the Secretary, in consultation with the Secretary of Labor, under this section shall not apply with respect to any surprise billing situation involving a group health plan (other than a self-insured plan), or health insurance issuer offering health insurance coverage in the group market, in a State that has in effect a State law that applies to the dispute involved and meets the requirements under paragraph (2).

“(2) REQUIREMENTS.—

“(A) IN GENERAL.—The requirements under this paragraph are that the State law provides, in a surprise billing situation, for—

“(i) a dispute resolution process meeting the requirements under subparagraph (B); or

“(ii) a payment standard that meets the requirements under subparagraph (C).
“(B) Dispute resolution process.—

The requirements for a dispute resolution process under this subparagraph are that the entity conducting the process—

“(i) be an independent entity whereby the entity shall not represent the interests of any party to the dispute and shall be free of any conflict of interest; and

“(ii) report to the public on the results of the process.

“(C) Payment standard.—The requirements for a payment standard under this paragraph are that the group health plan, or health insurance issuer offering health insurance coverage in the group market, pay the out-of-network health care provider in the surprise billing situation an amount at a rate—

“(i) that does not exceed 125 percent of the allowed charges for items or services under the original Medicare fee-for-service program under parts A and B of title XXVIII of the Social Security Act; or

“(ii) that does not exceed a payment standard comparable to the standard described in clause (i), as determined by the
Secretary, in consultation with the Secretary of Labor.

“(3) CLARIFICATION FOR SELF-INSURED GROUP HEALTH PLANS.—With respect to any payment dispute in a surprise billing situation involving a self-insured group health plan—

“(A) the process established by the Secretary, in consultation with the Secretary of Labor, under this section shall apply; and

“(B) any State law that meets the requirements under paragraph (2), and may otherwise apply, shall not apply.”
S.

To prohibit surprise medical billing of patients.

IN THE SENATE OF THE UNITED STATES

Mr. Cassidy introduced the following bill; which was read twice and referred to the Committee on ____________________

A BILL

To prohibit surprise medical billing of patients.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Protecting Patients from Surprise Medical Bills Act”.

SEC. 2. STOPPING SURPRISE MEDICAL BILLS.

(a) In General.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b), by adding at the end the following:

“(3) Resolution of provider billing.—Any difference between the amount billed with respect to
emergency services provided by an out-of-network provider and the cost-sharing amount under paragraph (1)(C)(ii)(II) shall be paid by the health plan or health insurance issuer. The provider may not balance bill the patient for amounts beyond the cost-sharing amount allowed under this subsection.

“(4) Cost-sharing amount to be paid by plan or issuer.—

“(A) In general.—The amount of any cost-sharing or coinsurance applied with respect to an enrollee under paragraph (1)(C)(ii)(II) for emergency services provided by an out-of-network provider shall not exceed the cost-sharing requirement imposed with respect to the enrollee if the services were provided in-network.

“(B) Excess amounts.—A health plan or health insurance issuer shall pay to an out-of-network provider that provides emergency services to an enrollee, the excess of the amount the out-of-network provider charges for such services above the amount the enrollee is required to pay under subparagraph (A), as determined in accordance with this subparagraph. The amount the plan or issuer is required to pay under this subparagraph shall be—
“(i) an amount determined, and payable in such manner, in accordance with the law of the applicable State, county, parish, or tribal government; or

“(ii) in the case of State for which the applicable State law does not provide for determining such amount and manner of such payment, in such amount that is at least equal to the greater of the amount determined under clause (i) or (ii) of subparagraph (C), less the cost-sharing amount under subparagraph (A).

“(C) AMOUNTS DETERMINED.—The amounts determined under this subparagraph are as follows with respect to the service involved:

“(i) AVERAGE AMOUNT.—The average amount for the service involved as determined under this clause shall be equal to the median in-network amount negotiated by health plans and health insurance issuers for the service provided by a provider in the same or similar specialty and provided in the same geographical area (as determined by the insurance commissioner
of the applicable State or, if such State
does not determine a geographic area, as
determined by the Secretary).

“(ii) Usual, customary, and reason-
able rate.—The usual, customary,
and reasonable rate for the service involved
as determined under this clause, with re-
spect to any calendar year, shall be equal
to 125 percent of the average allowed
amount for all private health plans and
health insurance issuers for the service
provided by a provider in the same or simi-
lar specialty and provided in the same geo-
graphical area (as determined by the insur-
ance commissioner of the applicable State
using a database selected by such State, or, if such State does not select a data-
base, selected by the Secretary) for the ap-
plicable calendar year or the most recent
calendar year that is available, as reported
in a statistically significant benchmarking
database maintained by a nonprofit organi-
ization specified by the insurance commis-
sioner or the applicable State, so long as
such organization involved is not affiliated
with any plan or issuer and is transparent with the plan, issuer, provider, and insurance commissioner of the applicable State as to how the average amount negotiated is determined.

“(5) SUBSEQUENT NON-EMERGENCY SERVICES.—In the case of an enrollee who receives emergency services from a nonparticipating health care provider or facility as described in this subsection, for whom additional health care services after the enrollee has been stabilized that are not emergency services, the health care facility or hospital shall notify, in writing, prior to providing additional services, the enrollee or the enrollee’s designee that the provider or facility is a nonparticipating health care provider. Such notice shall include—

“(A) information about the potential for higher cost-sharing if such enrollee receives services at the out-of-network facility;

“(B) a written acknowledgement of such notice that the patient is required to sign and return to the hospital or health care facility in advance of the additional services; and

“(C) the option to transfer to an in-network facility.”; and
(2) by adding at the end the following:

“(e) NON-EMERGENCY SERVICES PERFORMED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.—

“(1) IN GENERAL.—Notwithstanding subsection (b), a group health plan or health insurance issuer with respect to group or individual health insurance coverage shall not impose cost-sharing on an enrollee, with respect to services provided by an out-of-network provider at an in-network facility for non-emergency services, that is greater than the cost-sharing that would apply under such plan or coverage had such services been provided by an in-network provider at such facility.

“(2) RESOLUTION OF PROVIDER BILLING.—Any difference between the amount billed with respect to services provided by an out-of-network provider described in paragraph (1) and the cost-sharing amount under paragraph (1) shall be paid by the health plan or health insurance issuer—

“(A) in such amount and in such manner as determined in accordance with the law of the applicable State, county, or parish; or

“(B) in the case of State for which the applicable State law does not provide for deter-
mining such amount and manner of such payment, in an amount that is at least equal to the greatest of the amounts specified in subsection (b)(4)(C) (which are adjusted for in-network cost-sharing requirements), less the cost-sharing amount under paragraph (1).

The provider may not balance bill the patient for amounts beyond the cost-sharing amount allowed under this subsection.”.

(b) APPLICATION.—The amendments made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2020.

SEC. 3. HHS STUDY ON IMPACT OF THIS ACT.

The Secretary of Health and Human Services shall—

(1) conduct a comprehensive study on the impacts of this Act (including the amendments made by this Act), including the impacts on patient cost-sharing, access to care, quality of care, insurance premiums, health care costs, emergency care use, network adequacy, and access to new and improved drugs and technology; and

(2) not later than December 31, 2025, issue a publicly available report based on such study that includes recommendations to Congress regarding po-
tentative changes to the law with respect to the issues described in paragraph (1).