I

116TH CONGRESS
1ST SESSION

H. R. 3502

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2019

Mr. RUIZ (for himself, Mr. BUCSHON, Mr. MORELLE, Mr. BERA, Mr. WENSTRUP, Ms. SHALALA, Mr. TAYLOR, Mr. DAVID P. ROE of Tennessee, Mr. BANKS, Mr. HIGGINS of New York, Mr. GRIJALVA, Mr. CISNEROS, Mr. SOTO, Mr. HARRIS, Mr. HUDSON, Ms. SCHRIER, Mr. MARSHALL, Mr. DUNN, Mr. STIVERS, Mr. DESJARLAIS, Mr. BURCHETT, Mr. RIGGLEMAN, Mr. WATKINS, Mr. JOYCE of Pennsylvania, Mr. SMUCKER, Ms. STEFANIK, Mr. THOMPSON of Pennsylvania, Mr. WRIGHT, Mr. NORCROSS, Mrs. LOWEY, Mr. CÁRDENAS, Mr. DESAULNIER, and Ms. KELLY of Illinois) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Oversight and Reform, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

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

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Protecting People From Surprise Medical Bills Act".

4 (b) TABLE OF CONTENTS.—The table of contents for
5 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Preventing surprise medical bills.
Sec. 3. Transparency regarding in-network and out-of-network deductibles.
Sec. 4. Transparency for in-network patients.
Sec. 5. Reporting requirements.
Sec. 6. Billing statute of limitations.
Sec. 7. Application.
Sec. 8. Studies by Secretaries of Health and Human Services and of Labor.
Sec. 9. Regulations.

6 **SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.**

7 (a) EMERGENCY SERVICES PERFORMED BY NON-
8 PARTICIPATING PROVIDERS.—Section 2719A of the Pub-
9 lic Health Service Act (42 U.S.C. 300gg–19a) is amend-
10 ed—

11 (1) in subsection (b)—

12 (A) in paragraph (1)—

13 (i) in the matter preceding subpara-
14 graph (A)—

15 (I) by striking "offering group or
16 individual health insurance issuer"
17 and inserting "offering group or indi-
18 vidual health insurance coverage";
19 and

1 (II) by striking "paragraph
2 (2)(B)" and inserting "paragraph
3 (2)";
4 (ii) in subparagraph (B), by inserting
5 "or a participating emergency facility, as
6 applicable," after "participating provider";
7 and
8 (iii) in subparagraph (C)—
9 (I) in the matter preceding clause
10 (i), by inserting "by a nonpartici-
11 pating provider or a nonparticipating
12 emergency facility" after "enrollee";
13 (II) by striking clause (i);
14 (III) by striking "(ii)(I) such
15 services" and inserting "(i) such serv-
16 ices";
17 (IV) by striking "where the pro-
18 vider of services does not have a con-
19 tractual relationship with the plan for
20 the providing of services";
21 (V) by striking "emergency de-
22 partment services received from pro-
23 viders who do have such a contractual
24 relationship with the plan; and" and
25 inserting "emergency services received

1 from participating providers and par-
2 ticipating emergency facilities with re-
3 spect to such plan;'';
4 (VI) by striking ``(II) if such serv-
5 ices'' and all that follows through
6 ``were provided in-network'' and in-
7 serting the following:
8 ``(ii) the cost-sharing requirement (ex-
9 pressed as a copayment amount, coinsur-
10 ance rate, or deductible) is not greater
11 than the requirement that would apply if
12 such services were provided by a partici-
13 pating provider or a participating emer-
14 gency facility;''; and
15 (VII) by adding at the end the
16 following new clauses:
17 ``(iii) the group health plan or health
18 insurance issuer offering group or indi-
19 vidual health insurance coverage pays to
20 such provider or facility, respectively, sub-
21 ject to subsection (f), the amount by which
22 the commercially reasonable rate, as deter-
23 mined by the plan or issuer, for such serv-
24 ices exceeds the cost-sharing amount for
25 such services (as determined in accordance

1 with clause (ii) and, if applicable, any
2 amount to reconcile the difference between
3 such rate so paid and the specified rate de-
4 termined under subsection (f)(1)) for such
5 services; and

6 ‘‘(iv) there shall be counted toward
7 any deductible or out-of-pocket maximums
8 applied under the plan any cost-sharing
9 payments made by the participant, bene-
10 ficiary, or enrollee with respect to such
11 emergency services so furnished in the
12 same manner as if such cost-sharing pay-
13 ments were with respect to emergency
14 services furnished by a participating pro-
15 vider and a participating emergency facil-
16 ity.’’; and

17 (B) in paragraph (2)—

18 (i) in the matter preceding subpara-
19 graph (A), by inserting ‘‘and subsection
20 (e)’’ after ‘‘this subsection’’;

21 (ii) by redesignating subparagraph
22 (C) as subparagraph (H); and

23 (iii) by inserting after subparagraph
24 (C) the following subparagraphs:

1 "(D) NONPARTICIPATING EMERGENCY FA-
2 CILITY; PARTICIPATING EMERGENCY FACIL-
3 ITY.—

4 "(i) NONPARTICIPATING EMERGENCY
5 FACILITY.—The term 'nonparticipating
6 emergency facility' means, with respect to
7 an item or service and a group health plan
8 or health insurance coverage offered by a
9 health insurance issuer, an emergency de-
10 partment of a hospital or an independent
11 freestanding emergency department, that
12 does not have a contractual relationship
13 with the plan or coverage for furnishing
14 such item or service.

15 "(ii) PARTICIPATING EMERGENCY FA-
16 CILITY.—The term 'participating emer-
17 gency facility' means, with respect to an
18 item or service and a group health plan or
19 health insurance coverage offered by a
20 health insurance issuer, an emergency de-
21 partment of a hospital or an independent
22 freestanding emergency department, that
23 has a contractual relationship with the
24 plan or coverage for furnishing such item
25 or service.

1 "(E) NONPARTICIPATING PROVIDERS; PAR-
2 TICIPATING PROVIDERS.—
3 "(i) NONPARTICIPATING PROVIDER.—
4 The term 'nonparticipating provider'
5 means, with respect to an item or service
6 and a group health plan or health insur-
7 ance coverage offered by a health insur-
8 ance issuer, a physician or other health
9 professional who is licensed by the State
10 involved to furnish such item or service
11 and who does not have a contractual rela-
12 tionship with the plan or coverage for fur-
13 nishing such item or service.
14 "(ii) PARTICIPATING PROVIDER.—The
15 term 'participating provider' means, with
16 respect to an item or service and a group
17 health plan or health insurance coverage
18 offered by a health insurance issuer, a phy-
19 sician or other health professional who is
20 licensed by the State involved to furnish
21 such item or service and who has a con-
22 tractual relationship with the plan or cov-
23 erage for furnishing such item or service.".
24 (b) NON-EMERGENCY SERVICES PERFORMED BY
25 NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-

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

4 ‘‘(e) NON-EMERGENCY SERVICES PERFORMED BY
5 NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-
6 PATING FACILITIES.—

7 ‘‘(1) IN GENERAL.—In the case of items or
8 services (other than emergency services to which
9 subsection (b) applies) furnished to a participant,
10 beneficiary, or enrollee of a health plan (as defined
11 in paragraph (2)(A)) by a nonparticipating provider
12 (as defined in subsection (b)(2)(G)) during a visit at
13 a participating health care facility (as defined in
14 paragraph (2)(B)) (including imaging or laboratory
15 services so furnished by a nonparticipating provider
16 when ordered by a participating provider or after-
17 emergency care furnished by a nonparticipating pro-
18 vider in the case that the participant, beneficiary, or
19 enrollee cannot travel without medical transport),
20 with respect to such plan, the plan—

21 ‘‘(A) shall not impose on such participant,
22 beneficiary, or enrollee a cost-sharing amount
23 (expressed as a copayment amount or coinsur-
24 ance rate) for such items and services so fur-
25 nished that is greater than the cost-sharing

1 amount that would apply under such plan had
2 such items or services been furnished by a par-
3 ticipating provider;
4 "(B) shall pay to such provider furnishing
5 such items and services to such participant,
6 beneficiary, or enrollee, subject to subsection
7 (f), the amount by which the commercially rea-
8 sonable rate, as determined by the plan or
9 issuer, for such services exceeds the cost-shar-
10 ing amount imposed for such services (as deter-
11 mined in accordance with subparagraph (A))
12 and, if applicable, any amount to reconcile the
13 difference between such rate so paid and the
14 specified rate (determined under subsection
15 (f)(1)) for such services; and
16 "(C) shall count toward any deductible or
17 out-of-pocket maximums applied under the plan
18 any cost-sharing payments made by the partici-
19 pant, beneficiary, or enrollee with respect to
20 such items and services so furnished in the
21 same manner as if such cost-sharing payments
22 were with respect to items and services fur-
23 nished by a participating provider.
24 "(2) DEFINITIONS.—In this subsection and
25 subsection (f):

1 ‘‘(A) HEALTH PLAN.—The term ‘health
2 plan’ means a group health plan and health in-
3 surance coverage offered by a heath insurance
4 issuer in the group or individual market.
5 ‘‘(B) PARTICIPATING HEALTH CARE FACIL-
6 ITY.—
7 ‘‘(i) IN GENERAL.—The term ‘partici-
8 pating health care facility’ means, with re-
9 spect to an item or service and a group
10 health plan or health insurance coverage
11 offered by a health insurance issuer, a
12 health care facility described in clause (ii)
13 that has a contractual relationship with
14 the plan or coverage for furnishing such
15 item or service.
16 ‘‘(ii) HEALTH CARE FACILITY DE-
17 SCRIBED.—A health care facility described
18 in this clause is each of the following:
19 ‘‘(I) A hospital (as defined in
20 1861(e) of the Social Security Act).
21 ‘‘(II) A critical access hospital
22 (as defined in section 1861(mm) of
23 such Act).

1 "(III) An ambulatory surgical
2 center (as defined in section
3 1833(i)(1)(A) of such Act).
4 "(IV) A laboratory.
5 "(V) A radiology or imaging cen-
6 ter.
7 "(VI) Any other facility that pro-
8 vides services that are covered under
9 a group health plan or health insur-
10 ance coverage.
11 "(VII) Any other facility speci-
12 fied by the Secretary.".
13 (c) NEGOTIATION AND ARBITRATION PROCESS FOR
14 DETERMINING PRICES.—Section 2719A of the Public
15 Health Service Act (42 U.S.C. 300gg–19a), as amended
16 by subsection (b), is further amended by adding at the
17 end the following new subsection:
18 "(f) NEGOTIATION AND ARBITRATION PROCESS.—
19 "(1) SPECIFIED AMOUNT.—For purposes of
20 subsections (b) and (e) and this subsection, the spec-
21 ified amount determined under this subsection, with
22 respect to a health plan and nonparticipating pro-
23 vider for an item or service, is—
24 "(A) in the case the plan and provider
25 enter into negotiations pursuant to paragraph

1 (2) and such negotiations are successful, the
2 amount determined for such item or service
3 pursuant to such negotiations; or
4 "(B) in the case the plans and provider
5 enter into such negotiations but such negotia-
6 tions are not successful, the reasonable amount
7 determined for such item or service pursuant to
8 the independent dispute resolution process
9 under paragraph (3).
10 "(2) NEGOTIATIONS.—For purposes of sub-
11 sections (b)(1)(C)(iii) and (e)(1)(B), in the case of
12 a payment of a commercially reasonable rate made
13 by a health plan to a nonparticipating provider pur-
14 suant to such respective subsection for an item or
15 service, the provider and plan may, not later than 30
16 days after the date of such payment, negotiate an
17 amount of payment (other than the commercially
18 reasonable rate specified in such subsection) to be
19 made for such item or service.
20 "(3) INDEPENDENT DISPUTE RESOLUTION.—
21 "(A) IN GENERAL.—If, by the end of such
22 30-day period specified in paragraph (2), the
23 plan and provider have not determined a nego-
24 tiated amount for the payment involved, the
25 plan or provider may initiate an independent

1 dispute resolution process under this paragraph
2 to determine the amount of payment.
3 "(B) ESTABLISHMENT OF IDR.—
4 "(i) IN GENERAL.—Not later than
5 January 1, 2021, the Secretary, in con-
6 sultation with the Secretary of Labor, shall
7 establish a process for resolving payment
8 disputes between health plans and non-
9 participating providers for purposes of de-
10 termining amounts of payments to be
11 made by the plans to the providers pursu-
12 ant to subsections (b) and (e) (referred to
13 in this section as the 'IDR process').
14 "(ii) ENTITIES.—An entity wishing to
15 participate in the IDR process under this
16 subsection shall request certification from
17 the Secretary. The Secretary, in consulta-
18 tion with the Secretary of Labor, shall de-
19 termine eligibility of applicant entities, tak-
20 ing into consideration whether the entity is
21 unbiased and unaffiliated with health plans
22 and providers and free of conflicts of inter-
23 est, in accordance with the Secretary's
24 rulemaking on determining criteria for con-
25 flicts of interest.

1 "(iii) APPLICABLE CLAIMS.—
2 "(I) IN GENERAL.—The IDR
3 process shall be with respect to one or
4 more Current Procedural Terminology
5 ('CPT') codes.
6 "(II) BATCHING OF CLAIMS.—
7 Claims may be batched if such
8 claims—
9 "(aa) involve identical plan
10 or issuer and provider or facility
11 parties;
12 "(bb) involve claims with the
13 same or related current proce-
14 dural terminology codes relevant
15 to a particular procedure; and
16 "(cc) involve claims that
17 occur within 60 days of each
18 other.
19 "(C) INDEPENDENT DISPUTE RESOLUTION
20 PROCESS.—
21 "(i) TIMING.—In the case of an IDR
22 entity that receives a request under this
23 paragraph, with respect to a payment
24 amount to be paid by a health plan to a
25 nonparticipating provider—

1 "(I) the plan and provider may,
2 during the 30-day period following the
3 date of receipt of such request, submit
4 any information or supporting docu-
5 mentation to the IDR entity; and
6 "(II) the IDR entity shall, not
7 later than 60 days after receiving
8 such request, determine such amount.
9 "(ii) DETERMINATION OF AMOUNT.—
10 "(I) IN GENERAL.—The amount
11 determined by the IDR entity under
12 clause (i), with respect to a payment
13 amount to be paid by a health plan to
14 a nonparticipating provider for an
15 item or service shall be—
16 "(aa) the initial charge for
17 the item or service made by the
18 provider or the commercially rea-
19 sonable rate paid by the plan for
20 the item or service under sub-
21 sections (b)(1)(C)(iii) or
22 (e)(1)(B), respectively, whichever
23 is determined reasonable by the
24 entity based on the factors de-
25 scribed in subclause (III); or

1 "(bb) in the case neither
2 such charge or such rate is deter-
3 mined by the entity to be reason-
4 able, the final offer submitted
5 under subclause (II) that is de-
6 termined more reasonable in ac-
7 cordance with such subclause.
8 "(II) FINAL OFFERS.—For pur-
9 poses of subclause (I)(bb), the health
10 plan and the nonparticipating pro-
11 vider party to the independent dispute
12 resolution under this paragraph shall
13 each submit to the IDR entity their
14 final offer for an amount for the pay-
15 ment that is subject to the dispute not
16 later than 30 days after the IDR enti-
17 ty determines under such subclause
18 that neither the charge or rate de-
19 scribed in subclause (I)(aa) were rea-
20 sonable. Not later than 60 days after
21 such date of such determination, such
22 entity shall determine which of the 2
23 final offers is more reasonable based
24 on the factors described in subclause
25 (III).

1 "(III) FACTORS.—For purposes
2 of subclauses (I) and (II), the factors
3 described in this subclause include, as
4 relevant—
5 "(aa) commercially reason-
6 able rates for comparable services
7 or items in the same geographic
8 area (which shall take into con-
9 sideration in-network rates for
10 that geographic area and not
11 charges);
12 "(bb) the usual and cus-
13 tomary cost of the item or service
14 involved, determined as the 80th
15 percentile of charges for com-
16 parable items and services for the
17 specialty involved in the geo-
18 graphical area in which the item
19 or service was furnished, as de-
20 termined through reference to a
21 medical claims database;
22 "(cc) other factors that may
23 be submitted at the discretion of
24 either party, which may in-
25 clude—

1 "(dd) the level of training,
2 education, experience, and quality
3 and outcomes measurements of
4 the nonparticipating provider;
5 "(ee) the circumstances and
6 complexity of the particular dis-
7 pute, including the time and
8 place of the service;
9 "(ff) the provider's quality
10 and outcome metrics;
11 "(gg) the provider's usual
12 charge for comparable services
13 with regard to patients in health
14 care plans in which the provider
15 is not participating;
16 "(hh) the individual patient
17 characteristics; and
18 "(ii) other relevant economic
19 and clinical factors.
20 "(IV) FINAL DECISIONS.—The
21 amount that is determined to be the
22 more reasonable amount under item
23 (aa) or (bb) of subclause (I), as appli-
24 cable, shall be the final decision of the
25 IDR entity as to the amount the

1 health plan is required to pay the pro-
2 vider.

3 "(V) EFFECT OF DETERMINA-
4 TION.—A final determination of an
5 IDR entity under subclause (IV)—

6 "(aa) shall be binding; and

7 "(bb) shall not be subject to
8 judicial review, except in cases
9 comparable to those described in
10 section 10(a) of title 9, United
11 States Code, as determined by
12 the Secretary in consultation
13 with the Secretary of Labor, and
14 cases in which information sub-
15 mitted by one party was deter-
16 mined to be fraudulent.

17 "(iii) PRIVACY LAWS.—An IDR entity
18 shall, in conducting an independent dispute
19 resolution process under this paragraph,
20 comply with all applicable Federal and
21 State privacy laws.

22 "(iv) PUBLIC AVAILABILITY.—The
23 reasonable amount determined by an IDR
24 entity under this paragraph with respect to
25 any claim shall not be confidential, except

that information submitted to the IDR entity shall be kept confidential. IDR entities may consider past decisions awarded by independent dispute entities during the independent dispute resolution process.

"(v) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The non-prevailing party shall be responsible for paying all fees charged by the IDR entity. If the parties reach a settlement prior to completion of the IDR process, the costs of the independent dispute resolution process shall be divided equally between the parties.

"(vi) PAYMENT.—Any difference between—

"(I) the amount determined to be paid by one party of the dispute resolution to another pursuant to this paragraph; and

"(II) the amounts already paid under subsection (b) or (e) before entering into the process under this paragraph,

1 shall be paid not later than 15 days after
2 the date on which the entity makes a de-
3 termination with respect to such amount.

4 ''(D) PUBLICATION.—The Secretary shall
5 publish aggregated results of the independent
6 dispute resolution by geographic region in order
7 to give more guidance to providers and health
8 plans.''.

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

13 ''(t)(1) Subject to paragraph (3), in the case of an
14 individual with benefits under a health plan or health in-
15 surance coverage offered in the group or individual market
16 who is furnished on or after January 1, 2021, emergency
17 services with respect to an emergency medical condition
18 during a visit at an emergency department of a hospital—

19 ''(A) if the emergency department of a hospital
20 holds the individual liable for a payment amount for
21 such emergency services so furnished that is more
22 than the cost-sharing amount for such services (as
23 determined in accordance with section
24 2719A(b)(1)(C)(ii) of the Public Health Service
25 Act); or

1 “(B) if any health care provider holds such in-
2 dividual liable for a payment amount for an emer-
3 gency service furnished to such individual by such
4 provider with respect to such emergency medical
5 condition and visit for which the individual receives
6 emergency services at the hospital or emergency de-
7 partment that is more than the cost-sharing amount
8 for such services furnished by the provider (as deter-
9 mined in accordance with section 2719A(b)(1)(C)(ii)
10 of the Public Health Service Act),

11 the hospital, emergency department or health care pro-
12 vider, respectively, shall be subject, in addition to any
13 other penalties that may be prescribed by law, to a civil
14 money penalty of not more than an amount determined
15 appropriate by the Secretary for each specified claim.

16 “(2) The provisions of subsections (c), (d), (e), (g),
17 (h), (k), and (l) shall apply to a civil money penalty or
18 assessment under paragraph (1) or subsection (u) in the
19 same manner as such provisions apply to a penalty, assess-
20 ment, or proceeding under subsection (a).

21 “(3) Paragraph (1) shall not apply to an emergency
22 department of a hospital or a provider, with respect to
23 items or services furnished to a participant, beneficiary,
24 or enrollee of a health plan or health insurance coverage
25 offered by a health insurance issuer, if the emergency de-

1 partment of the hospital or the provider, respectively, re-
2 imburses such participant, beneficiary, or enrollee any
3 amount for such an item or service that is more than the
4 cost-sharing amount for such item or service (as deter-
5 mined in accordance with section 2719A(e)(1)(A)) not
6 later than 30 days after the date the emergency depart-
7 ment of the hospital or provider, respectively, knew or
8 should have known such excess payment was in violation
9 of this subsection.

10 ''(4) In this subsection and subsection (u):

11 ''(A) The terms 'emergency medical condition'
12 and 'emergency services' have the meanings given
13 such terms, respectively, in section 2719A(b)(2) of
14 the Public Health Service Act.

15 ''(B) The terms 'group health plan', 'health in-
16 surance issuer', and 'health insurance coverage' have
17 the meanings given such terms, respectively, in sec-
18 tion 2791 of the Public Health Service Act.

19 ''(u)(1) Subject to paragraph (2), in the case of an
20 individual with benefits under a health plan or health in-
21 surance coverage offered in the group or individual market
22 who is furnished on or after January 1, 2021, items or
23 services (other than emergency services to which sub-
24 section (t) applies) during an episode of care (as defined
25 by the Secretary) at a participating health care facility

by a nonparticipating provider (including imaging or laboratory services so furnished by a nonparticipating provider when ordered by a participating provider or after-emergency care furnished by a nonparticipating provider in the case that the participant, beneficiary, or enrollee cannot travel without medical transport), if such nonparticipating provider holds such individual liable for a payment amount for such an item or service furnished by such provider that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A) of the Public Health Service Act), such provider shall be subject, in addition 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 items or 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 reimburses such participant, beneficiary, or enrollee any amount for such an item or service that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A)) not later than 30 days

1 after the date the provider knew or should have known
2 such excess payment was in violation of this subsection.
3 ''(3) For purposes of this subsection, the terms 'non-
4 participating provider' and 'participating health care facil-
5 ity' have such meanings given such terms under sub-
6 sections (b)(2) and (e)(2), respectively, of section 2719A
7 of the Public Health Service Act.''.
8 (e) EFFECTIVE DATE.—The amendments made by
9 this section shall apply with respect to plan years begin-
10 ning on or after January 1, 2021.

11 **SEC. 3. TRANSPARENCY REGARDING IN-NETWORK AND**
12 **OUT-OF-NETWORK DEDUCTIBLES.**

13 (a) IN GENERAL.—Subpart II of part A of title
14 XXVII of the Public Health Service Act (42 U.S.C. 300gg
15 et seq.) is amended by adding at the end the following:

16 **''SEC. 2729A. TRANSPARENCY REGARDING IN-NETWORK**
17 **AND OUT-OF-NETWORK DEDUCTIBLES.**

18 ''(a) IN GENERAL.—A group health plan or a health
19 insurance issuer offering group or individual health insur-
20 ance coverage and providing or covering any benefit with
21 respect to items or services shall include, in clear writing,
22 on any plan or insurance identification card issued to en-
23 rollees in the plan or coverage the amount of the in-net-
24 work and out-of-network deductibles and the out-of-pocket
25 maximum limitation that apply to such plan or coverage.

1 "(b) GUIDANCE.—The Secretary, in consultation
2 with the Secretary of Labor, shall issue guidance to imple-
3 ment subsection (a).".
4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall apply with respect to plan years begin-
6 ning on or after the date that is one year after the date
7 of the enactment of this Act.

8 **SEC. 4. TRANSPARENCY FOR IN-NETWORK PATIENTS.**

9 Subpart II of part A of title XXVII of the Public
10 Health Service Act (42 U.S.C. 300gg et seq.), as amended
11 by section 3, is further amended by adding at the end the
12 following:

13 **"SEC. 2729B. TRANSPARENCY FOR IN-NETWORK PATIENTS.**

14 "(a) STANDARDS.—Not later than January 1, 2021,
15 the Secretary shall, through rulemaking, establish trans-
16 parency standards to provide better information to individ-
17 uals who are enrolled in group health plans or health in-
18 surance coverage offered in the individual or group market
19 (as such terms are defined in section 2791 of the Public
20 Health Service Act (42 U.S.C. 300gg–91)) about which
21 health care providers are participating in the network of
22 the plan or coverage in which such an individual is en-
23 rolled. Such standards shall at a minimum provide for the
24 following:

1 "(1) Such plans and coverage offer provider di-
2 rectories online and in print.
3 "(2) Annual audits of such provider directories,
4 as specified by the Secretary.
5 "(3) Monthly updates of such online directories.
6 "(b) GUIDANCE.—Beginning January 1, 2022, a
7 group health plan or a health insurance issuer offering
8 group or individual health insurance coverage shall be in
9 compliance with the standards established pursuant to
10 subsection (a).".

11 **SEC. 5. REPORTING REQUIREMENTS.**

12 Subpart II of part A of title XXVII of the Public
13 Health Service Act (42 U.S.C. 300gg et seq.), as amended
14 by sections 3 and 4, is further amended by adding at the
15 end the following:

16 **"SEC. 2729C. TRANSPARENCY REQUIREMENTS.**

17 "(a) IN GENERAL.—Each group health plan and
18 health insurance issuer offering group or individual health
19 insurance coverage shall annually report (beginning for
20 plan year 2021) to the Secretary and the Secretary of
21 Labor, with respect to the applicable plan or coverage for
22 the applicable plan year—
23 "(1) the total claims that were submitted by in-
24 network health care providers with respect to enroll-
25 ees under the plan or coverage, and the number of

1 such claims that were paid and the number of such
2 claims that were denied;

3 "(2) the total claims that were submitted by
4 out-of-network health care providers with respect to
5 enrollees under the plan or coverage, and the num-
6 ber of such claims that were paid and the number
7 of such claims that were denied;

8 "(3) with respect to each out-of-network claim,
9 the out-of-pocket costs to the enrollee for the serv-
10 ices;

11 "(4) the number of out-of-network claims re-
12 ported under paragraph (2) that are for emergency
13 services; and

14 "(5) the number of out-of-network claims re-
15 ported under paragraph (2) that relate to care at in-
16 network hospitals or facilities provided by out-of-net-
17 work providers.

18 "(b) CLARIFICATION.—The information required to
19 be submitted under this section shall be in addition to the
20 information required to be submitted under section
21 2715A.".

22 **SEC. 6. BILLING STATUTE OF LIMITATIONS.**

23 Notwithstanding any other provision of law, a health
24 care provider may not seek reimbursement from an indi-
25 vidual for a service furnished by such provider to such in-

1 dividual more than a year after such date of service. Any
2 provider that bills an individual in violation of the previous
3 sentence shall be subject to a civil monetary penalty in
4 such amount as specified by the Secretary of Health and
5 Human Services.

6 **SEC. 7. APPLICATION.**

7 (a) NON-APPLICATION IN CASES OF STATES WITH
8 CERTAIN BALANCE BILLING LAWS.—Section 2719A of
9 the Public Health Service Act (42 U.S.C. 300gg–19a) is
10 amended by adding at the end the following new sub-
11 section:

12 ''(g) In any case in which a State has in effect a law
13 or regulation that prohibits balance billing or otherwise
14 provides an alternate method for resolving a dispute be-
15 tween a health plan and provider for determining com-
16 pensation for services described in subsections (b), (e), or
17 (f), the provisions of such law and not the provisions of
18 this Act shall apply to health plans (except self-insured
19 group health plans that are not subject to State insurance
20 regulation), health care providers, and individuals in such
21 State so long as such law does not require an individual
22 to pay more in cost-sharing than the amount that would
23 otherwise be required of such individual under this sec-
24 tion.''.

25 (b) APPLICATION TO FEHB.—

1 (1) IN GENERAL.—Section 8902 of title 5,
2 United States Code, is amended by adding at the
3 end the following new subsection:

4 ''(p) Each contract under this chapter shall require
5 the carrier to comply with requirements described in the
6 provisions of subsections (b), (e), and (f) of section 2719A
7 of the Public Health Service Act and sections 2729A and
8 2729B of such Act in the same manner as those provisions
9 apply to a groups health plan or health insurance issuer
10 offering health insurance coverage, as described in such
11 sections.''.

12 (2) EFFECTIVE DATE.—The amendment made
13 by this subsection shall apply with respect to con-
14 tracts entered into or renewed for contract years be-
15 ginning at least one year after the date of enactment
16 of this Act.

17 **SEC. 8. STUDIES BY SECRETARIES OF HEALTH AND HUMAN**
18 **SERVICES AND OF LABOR.**

19 (a) IMPACT STUDY.—Not later than 3 years after the
20 date of enactment of this Act, the Secretary of Health and
21 Human Services, in consultation with the Secretary of
22 Labor, shall conduct a study of the effects of this Act (in-
23 cluding the amendments made by this Act), and submit
24 to Congress (and make public) a report on the findings

1 of such study, which shall include information and anal-
2 ysis on—
3 (1) the financial impact on patient responsi-
4 bility for health care spending and overall health
5 care spending;
6 (2) the incidence and prevalence of the delivery
7 of unanticipated out-of-network health care services,
8 in the cases of emergency services and in the cases
9 of care at in-network hospitals or facilities provided
10 by out-of-network providers;
11 (3) the adequacy of provider networks offered
12 by health plans and health insurance issuers (as
13 such terms are defined in section 2791 of the Public
14 Health Service Act (42 U.S.C. 300gg–91));
15 (4) a comparison of the different claims data-
16 bases used and the impact of using such databases
17 on reimbursement rates;
18 (5) the number of bills that are settled through
19 negotiations pursuant to subsection (f)(2) of section
20 2719A of the Public Health Service Act (42 U.S.C.
21 300gg–19a), as added by section 2, and the number
22 of bills that go to the independent dispute resolution
23 process under subsection (f)(3) of such section, as so
24 added;

1 (6) the administrative cost of such independent
2 dispute resolution process; and
3 (7) the estimated impact of such independent
4 dispute resolution process on health insurance pre-
5 miums and deductibles.
6 (b) BILLING FEASIBILITY STUDY.—Not later than 3
7 years after the date of the enactment of this Act, the Sec-
8 retary of Health and Human Services shall conduct, and
9 submit to Congress (and make public), a feasibility study
10 on the provision of a single bill for all services provided
11 for a single episode of care, as defined by the Secretary.
12 **SEC. 9. REGULATIONS.**
13 Not later than one year after the date of the enact-
14 ment of this Act, the Secretary of Labor and the Secretary
15 of Health and Human Services shall promulgate regula-
16 tions pertaining to carry out the provisions (including
17 amendments made by) this Act.

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