115TH CONGRESS
2D SESSION

# S. 3541

To amend the Public Health Service Act to establish limitations on cost-sharing for out-of-network services, to prohibit balance billing for such services, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

OCTOBER 3 (legislative day, SEPTEMBER 28), 2018

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

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# A BILL

To amend the Public Health Service Act to establish limitations on cost-sharing for out-of-network services, to prohibit balance billing for such services, 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 ''Reducing Costs for Out-of-Network Services Act of 2018''.

**SEC. 2. LIMITATIONS ON COST-SHARING FOR OUT-OF-NETWORK SERVICES.**

(a) IN GENERAL.—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. LIMITATIONS ON COST-SHARING FOR OUT-OF-NETWORK SERVICES.**

"(a) HEALTH INSURANCE ISSUER REQUIREMENT.—A health insurance issuer offering individual health insurance coverage that offers benefits with respect to a health care service provided in a State by a participating provider shall ensure that the cost-sharing requirement with respect to such service provided in the State by a nonparticipating provider does not exceed the rate selected by the applicable State authority under subsection (c)(1) for such service.

"(b) LIMITATION ON CHARGES BY HEALTH CARE PROVIDERS.—

"(1) IN GENERAL.—A health care provider may not charge a patient for health care services in excess of the following:

"(A) In the case of a patient who is enrolled in individual health insurance coverage that does not provide out-of-network benefits for a given service, the health care provider may

charge such patient no more than the rate selected by the applicable State authority under subsection (c)(1).

''(B) In the case of a patient enrolled in individual health insurance coverage that provides out-of-network benefits for a given service, the health care provider may charge such patient no more than—

''(i) the rate selected by the applicable State authority under subsection (c)(1); minus

''(ii) the sum of—

''(I) the payment made to the health care provider pursuant to such coverage; and

''(II) the out-of-network cost-sharing amount required under such coverage.

''(C) In the case of an uninsured individual, the health care provider may charge such patient no more than the lower of—

''(i) the rate selected by the applicable State authority under subsection (c)(2); or

''(ii) the rate otherwise allowed to be charged to such an individual for such a service under State law.

''(2) ENFORCEMENT.—A health care provider that violates the requirement under paragraph (1) shall be subject to the same civil monetary penalties described in paragraph (1) of section 922(f), including the provisions described in paragraph (2) of such section, as a person who commits a violation described in paragraph (1) of such section.

''(c) RATE.—

''(1) INDIVIDUALS ENROLLED IN INDIVIDUAL HEALTH INSURANCE COVERAGE.—An applicable State authority shall select for the State as applicable for purposes of subsection (a) and subparagraphs (A) and (B) of subsection (b)(1) one of the following as a maximum rate for health care services for individuals enrolled in individual health insurance coverage:

''(A) 125 percent (or, in a case described in paragraph (3) and at the discretion of the applicable State authority, 200 percent) of the allowed charges determined for the item or service under the original Medicare fee-for-serv-

ice program under parts A and B of title XVIII of the Social Security Act.

''(B) 80 percent of the usual, customary, and reasonable charge for the service, as determined by a database of usual, customary, and reasonable charges chosen by the applicable State authority and approved as appropriate by the Secretary.

''(C) 100 percent of the allowed charges for the service if the service were provided by a participating provider, which shall be determined based upon the actual allowed rate under the coverage.

''(2) UNINSURED INDIVIDUALS.—An applicable State authority shall select for the State as applicable for purposes of subsection (b)(1)(C) one of the following as a maximum rate for health care services for uninsured individuals:

''(A) The rate described in subparagraph (A) of paragraph (1).

''(B) The rate described in subparagraph (B) of paragraph (1).

''(3) SERVICES PROVIDED IN RURAL AREAS.—A case described in this paragraph is a case in which the item or service is furnished by a provider of

services (as defined in subsection (u) of section 1861 of the Social Security Act) or supplier (as defined in subsection (d) of such section) in a rural area (as defined in section 1886(d)(2)(D) of such Act).

''(4) DEFAULT RATE.—In the case in which an applicable State authority does not select a rate under paragraph (1) or (2) for a service, the maximum rate applicable in the State for the service for purposes of subsections (a) and (b) shall—

''(A) be the rate described in subparagraph (A) of paragraph (1), if the service is covered under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act; or

''(B) be a rate established by the Secretary, if the service is not covered under such program.

''(5) CLARIFICATION.—In selecting a rate under paragraph (1) or (2) for a health care service, the applicable State may select a rate that differs from the rate selected under such paragraph for a different health care service.

''(d) DEFINITIONS.—For purposes of this section:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' includes a hospital (as defined

in section 1861(e) of the Social Security Act), a critical access hospital (as defined in section 1861(mm) of such Act), a physician (as defined in section 1861(r) of such Act), and other providers as determined by the Secretary.

''(2) UNINSURED INDIVIDUAL.—The term 'uninsured individual', with respect to an individual receiving a health care service, means an individual who, at the time at which the service was furnished, was not enrolled in a plan that provides medical care benefits, including any Federal health benefit program, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—Section 2729 of the Public Health Service Act, as added by subsection (a), shall take effect on January 1, 2020.

**SEC. 3. GRANTS FOR GROUP MARKET.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall award grants to States for the purpose of studying the potential for imposing limitations on charges for health care services provided to individuals enrolled in group health plans or group health insurance coverage offered by a health insurance issuer that are similar to the limitations that apply under section 2729 of the Public Health Service Act, as added by section 2.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(c) DEFINITIONS.—In this section, the terms ''group health plan'', ''group health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

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