116TH CONGRESS
1ST SESSION

S. 1531

To amend the Public Health Service Act to provide protections for health insurance consumers from surprise billing.

IN THE SENATE OF THE UNITED STATES

MAY 16, 2019

Mr. CASSIDY (for himself, Mr. BENNET, Mr. YOUNG, Ms. HASSAN, Ms. MURKOWSKI, Mr. CARPER, Mr. SULLIVAN, Mr. BROWN, Mr. CRAMER, Mr. CARDIN, Mr. KENNEDY, and Mr. CASEY) 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 provide protections for health insurance consumers from surprise billing.

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 ''Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019'' or the ''STOP Surprise Medical Bills Act of 2019''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Consumers frequently struggle to determine when and how much they will pay for a medical service or procedure. A majority of consumers say health care providers rarely, if ever, discuss costs of recommended treatments and whether these treatments are covered by health insurance. Almost 70 percent of patients who receive bills from out-of-network providers did not realize the provider was out-of-network at the time of treatment. Patients using in-network facilities still receive claims from out-of-network providers at high rates, over 15 percent of inpatient admissions and 5 percent of outpatient service days. Even when patients try to schedule an in-network procedure at an in-network hospital and try to ensure that all providers who administer treatment will be in-network, they may be sent a balance bill by an out-of-network provider after receiving care. If providers accepted the same health plans as the facilities at which they practice and administer care, out-of-network surprise medical bills would not be a complication for consumers scheduling elective procedures.

(2) Surprise medical bills affect a sizeable portion of the insured population. Approximately 30 percent of individuals covered by private health in-

surance have received a surprise medical bill within the past year. Almost 20 percent of inpatient admissions by enrollees in large employer plans include at least 1 claim from an out-of-network provider, while 8 percent of outpatient service days include an out-of-network claim.

(3) Surprise medical bills are an issue of particular concern to consumers. A majority of Americans feel that softening the impact of surprise medical bills should be a priority for the current Congress. Eighty-six percent of Americans think it is important to protect individuals from surprise medical bills.

(4) Surprise medical bills for emergency care are frequently unavoidable due to the emergent and serious nature of the patient's condition at the time of treatment. One in 5 cases of inpatient hospital admissions that originate within the emergency department result in a surprise medical bill. For inpatient admissions, those that include an emergency room claim are much more likely to include a claim from an out-of-network provider than admissions without an emergency room claim. This is true whether or not enrollees use in-network facilities. Most cases of surprise medical billing occur when

privately insured individuals involuntarily see out-of-network providers during medical emergencies.

(5) The financial implications of surprise medical bills can be devastating for American consumers and can prevent them from seeking timely follow-up care or from accessing necessary services. Approximately 20 percent of insured Americans struggle to pay their medical bills. Almost a third of consumers who report they are struggling to pay a medical bill also report this bill was due to charges from an out-of-network provider that were not covered or were only partially covered by their insurer. Consumers with outstanding medical bills report delaying or skipping needed health care at rates 2 to 3 times higher than consumers without outstanding bills. Over 60 percent of consumers with outstanding medical bills report difficulties paying other bills (including necessities such as food, heat, or housing costs) as a result of their medical bills.

SEC. 3. PROHIBITION ON SURPRISE BALANCE BILLING AND INDEPENDENT DISPUTE RESOLUTION WITH RESPECT TO OUT-OF-NETWORK HEALTH CARE SERVICES.

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

"SEC. 2729A. GENERAL PROHIBITION ON SURPRISE BALANCE BILLING.

"(a) SURPRISE MEDICAL BILL.—In this title, the term 'surprise medical bill' means a balance bill, as described in subsection (b), that an enrollee receives for services provided to the enrollee where such services were—

"(1) emergency services provided by an out-of-network health care professional or at an out-of-network facility;

"(2) health care services that were provided—

"(A) at an in-network facility (including the use of equipment, devices, telemedicine services, or other treatments or services); and

"(B) by an out-of-network health care professional; or

"(3) additional health care services required in the case of an enrollee who initially enters a hospital through the emergency room for emergency services, and then receives nonemergency services from an

out-of-network health care professional or at an out-of-network hospital or facility after the enrollee has been stabilized (as defined in section 2719A(b)(2)(C)), as determined by the treating physician.

Paragraph (3) shall not apply in the case of an enrollee who is stabilized and able to travel in nonmedical transport, and the enrollee (or designee of the enrollee where the enrollee is not able to comprehend the information to be provided or make related decisions) has been provided with clear, written notification that the professional or facility is an out-of-network health care professional or facility, has been given a cost estimate for services provided by the out-of-network professional or facility, and has assumed, in writing, full responsibility for out-of-pocket costs associated with such out-of-network care.

''(b) BALANCE BILL.—In subsection (a), the term 'balance bill' refers to a claim for payment for services provided to an enrollee that is in an amount equal to the difference between the actual amount charged with respect to services or care described in subsection (a) and the expected in-network cost-sharing required by the enrollee under the plan or coverage involved.

''(c) PROHIBITION ON BALANCE BILLING.—

''(1) PROHIBITION.—

"(A) IN GENERAL.—A group health plan, a health insurance issuer in connection with group or individual health insurance coverage, or a health care provider shall not engage in balance billing practices prohibited under this section.

"(B) APPLICATION OF PROVISIONS.—Subparagraph (A) shall apply—

"(i) to all services provided at hospitals, emergency rooms, State-accredited free-standing emergency departments, hospital outpatient departments, and ambulatory surgery centers; and

"(ii) with respect to subsection (a)(2), to the health care provider's offices and related services (including laboratory and imaging services ordered by an in-network provider and provided by an out-of-network provider or laboratory).

"(2) ENROLLEE LIABILITY.—With respect to the services and care described in subsection (a), an enrollee shall only be liable for the in-network cost-sharing amount provided for in their plan or coverage. For purposes of this section, such payments by the enrollee shall count toward the in-network de-

ductible under the plan or coverage as well as toward the enrollee's out-of-pocket maximum limitation.

''(3) PENALTY.—Violations of this section shall subject the violator to a civil monetary penalty as provided for in this title. Such provisions shall not apply to a health care provider, group health plan, or health insurance issuer that unknowingly balance bills an enrollee and reimburses such enrollee within 30 calendar days of such billing.

"SEC. 2729B. OUT-OF-NETWORK BILLING.

''(a) PROHIBITION.—

''(1) IN GENERAL.—An enrollee may not be billed in excess of the in-network cost-sharing amount for services or care provided under section 2729A (a surprise medical bill situation).

''(2) AUTOMATIC PAYMENT.—

''(A) IN GENERAL.—A group health plan, or health insurance issuer in connection with group or individual health insurance coverage, shall pay the median in-network rate under the plan or coverage, less the applicable enrollee in-network cost-sharing, directly to the health care provider as provided for in this section.

"(B) REQUEST FOR ALTERNATIVE RATE.—Upon payment under subparagraph (A), the plan or issuer shall provide to the health care provider information about how the provider may initiate independent dispute resolution under such subsection with respect to such payment. The plan, issuer, or provider may negotiate an alternative amount or initiate independent dispute resolution under subsection (b) during the 30-day period beginning on the date on which the automatic payment is made under this subsection.

"(b) ESTABLISHMENT OF IDR PROCESS; CERTIFICATION OF ENTITIES.—

"(1) ESTABLISHMENT.—Not later than 1 year 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 medical bill situations in accordance with this section (referred to in this section as the 'IDR process').

''(2) CERTIFICATION OF ENTITIES.—An entity wishing to participate in the IDR process under this subsection shall request certification from the Secretary. The Secretary, in consultation with the Secretary of Labor, shall determine eligibility of applicant entities, taking into consideration whether the entity is unbiased and unaffiliated with health plans and providers and free of conflicts of interest, in accordance with the Secretary's rulemaking on determining criteria for conflicts of interest.

''(3) IDR ENTITY.—Under the process established under paragraph (1), the parties in the independent dispute resolution process shall jointly agree upon an independent dispute resolution entity. In the event that parties cannot agree, one will be selected at random jointly by the Department of Health and Human Services and the Department of Labor.

''(c) APPLICABLE CLAIMS.—

''(1) IN GENERAL.—The IDR process shall be with respect to one or more Current Procedural Terminology ('CPT') codes.

''(2) BATCHING OF CLAIMS.—Health care facilities and providers and group health plans or health insurance issuers may batch claims if such claims—

"(A) involve identical plan or issuer and provider or facility parties;

"(B) involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

"(C) involve claims that occur within 30 days of each other.

"(d) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(1) TIMING.—An independent dispute resolution entity that receives a request under this section shall, not later than 30 days after receiving such request, determine 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. Such amount shall be—

"(A) the amount determined by the parties through a settlement under paragraph (2); or

"(B) the amount determined reasonable by the entity in accordance with paragraph (3).

"(2) SETTLEMENT.—

"(A) IN GENERAL.—If the independent dispute resolution entity determines, based on the amounts indicated in the request under this

section, that a settlement between the group health plan, or health insurance issuer offering health insurance coverage in the group market, and the out-of-network health care provider is likely, 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 (1).

''(3) DETERMINATION OF AMOUNT.—

''(A) FINAL OFFERS.—In the absence of a settlement under paragraph (2), 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 submit to the independent dispute resolution entity their final offer. Such entity shall determine which of the 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 determination under subparagraph (B) may include the resolution of disputes for multiple items or services, if such determination is in regard to items or services that are eligible for independent dispute resolution under subsection (c)(2).

''(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) commercially reasonable rates for comparable services or items in the same geographic area (which shall take into consideration in-network rates for that geographic area and not charges); and

''(ii) other factors that may be submitted at the discretion of either party, which may include—

''(I) the level of training, education, experience, and quality and outcomes measurements of the out-of-network health care provider;

''(II) the circumstances and complexity of the particular dispute, including the time and place of the service;

''(III) the market share held by the out-of-network health care provider or that of the plan or issuer;

''(IV) demonstration of good faith efforts (or lack of good faith efforts) made by the out-of-network provider or the plan to contract and prior negotiated rates, if applicable; and

''(V) other relevant economic aspects of provider reimbursement for the same specialty within the same geographic area.

''(E) EFFECT OF DETERMINATION.—A final determination of an independent dispute resolution entity under subparagraph (B)—

''(i) shall be binding; and

''(ii) 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, and cases in which information submitted by one party was determined to be fraudulent.

''(4) 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.

''(5) PUBLIC AVAILABILITY.—The reasonable amount determined by an independent dispute resolution entity under this subsection with respect to any claim shall not be confidential, except that information submitted to the independent dispute entity shall be kept confidential. Independent dispute entities may consider past decisions awarded by independent dispute entities during the independent dispute resolution process.

''(6) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The nonprevailing party shall be responsible for paying all fees charged by the inde-

pendent dispute resolution entity. If the parties reach a settlement prior to completion of the independent dispute resolution process, the costs of the independent dispute resolution process shall be divided equally between the parties.

''(7) PAYMENT.—Group health plans and health insurance issuers with respect to group health coverage shall pay directly to the health care provider amounts determined by the independent dispute resolution entity within 30 days of the date on which the entity makes a determination with respect to such amount. A plan or issuer that fails to comply with this paragraph shall be subject to the penalties described in section 2729A(c)(3).''.

(b) EMERGENCY SERVICES.—Section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act (42 U.S.C. 300gg–19a(b)(1)(C)(ii)(II)) is amended by inserting '', deductible amount,'' after ''copayment amount''.

SEC. 4. NOTIFICATION OF NEW INSURANCE PRODUCTS TO IN-NETWORK PROVIDERS.

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

"SEC. 2729C. NOTIFICATION OF NEW INSURANCE PRODUCTS TO IN-NETWORK PROVIDERS.

"If a health care provider has a contract to provide in-network services to enrollees in a group health plan or health insurance coverage offered by a health insurance issuer, the plan or issuer shall notify the in-network provider within 7 days of offering any new insurance product for which the in-network provider would be eligible to enroll as an in-network provider.".

SEC. 5. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES.

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

"SEC. 2729D. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES.

"(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to enrollees in the plan or coverage the amount of the in-network and out-of-network deductibles and the out-of-pocket maximum limitation that apply to such plan or coverage.

''(b) GUIDANCE.—The Secretary, in consultation with the Secretary of Labor, shall issue guidance to implement subsection (a).''.

SEC. 6. ENSURING ENROLLEE ACCESS TO COST-SHARING INFORMATION.

(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.), as amended by section 5, is further amended by adding at the end the following:

''SEC. 2729E. PROVISION OF COST-SHARING INFORMATION.

''(a) COST-SHARING DISCLOSURE FOR MEDICAL SERVICES.—

''(1) PROVIDER DISCLOSURES.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not contract with a health care provider with respect to the plan or coverage unless the provider agrees to provide an enrollee in the plan or coverage, at the time of scheduling an elective health care service, or not later than 48 hours of the enrollee requesting such information, the expected enrollee cost-sharing for the provision of a particular health care service involved (including any service that is reasonably expected to be provided in conjunction with such spe-

cific service, such as expected cost-sharing of laboratory services).

''(2) INSURER DISCLOSURES.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide an enrollee in the plan or coverage with a good faith estimate of the enrollee's cost-sharing (including deductibles, copayments, and coinsurance) for which the enrollee would be responsible for paying with respect to a specific elective health care service (including any service that is reasonably expected to be provided in conjunction with such specific service such as expected cost-sharing of laboratory services), not later than 48 hours after receiving a request for such information by an enrollee.

''(b) ELECTRONICALLY AVAILABLE PRICE INFORMATION.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide to enrollees the out-of-pocket costs and benefits information at all sites of care and for all providers included in the plan network. Such information shall be made available to enrollees through an internet website or an application. Information about the availability of such price information through such means shall be provided

to each enrollee upon enrollment, or renewal, in the health plan or health insurance coverage.''.

(b) EFFECTIVE DATES.—

(1) COST-SHARING DISCLOSURES.—Subsection (a)(1) of section 2729E of the Public Health Service Act, as added by subsection (a), shall apply with respect to plan years beginning on or after January 1, 2020.

(2) AVAILABILITY OF INFORMATION.—Subsection (b) of section 2729E of the Public Health Service Act, as added by subsection (a), shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 7. MEDICAL LOSS RATIO.

Section 2718(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–18(a)(1)) is amended by inserting before the period the following: ''(including, in the case of group health plans, the amount of independent dispute process expenses incurred by the plan)''.

SEC. 8. TRANSPARENCY REQUIREMENTS ON HOSPITALS.

Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18) is amended by adding at the end the following:

''(f) TRANSPARENCY REQUIREMENTS ON HOSPITALS.—

''(1) REQUIREMENTS FOR HOSPITALS AND PHYSICIAN GROUPS.—Each hospital operating within the United States shall for each year disclose on its internet website and in printed materials, any financial relationship or profit-sharing agreement the hospital maintains with a physician group.

''(2) REQUIRED INFORMATION.—

''(A) IN GENERAL.—Each hospital operating within the United States shall include ancillary services provided by individuals such as phlebotomists, laboratory technicians, and echocardiogram technicians within each hospital bill that is provided to patients.

''(B) STUDY.—Not later than 1 year after the date of enactment of this Act, the Secretary shall conduct a study on the feasibility of hospitals and hospital-based provider groups providing to patients a single, unified bill for all services provided within an episode of care.''.

SEC. 9. TRANSPARENCY REQUIREMENTS ON INSURANCE.

(a) GROUP HEALTH PLAN REPORTING.—Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

"SEC. 2795. TRANSPARENCY REQUIREMENTS FOR GROUP HEALTH PLANS.

"(a) IN GENERAL.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually report to the Secretary of Health and Human Services and the Secretary of Labor, with respect to the applicable plan or coverage for the applicable plan year—

"(1) the total claims that were submitted by in-network health care providers with respect to enrollees under the plan or coverage, and the number of such claims that were paid and the number of such claims that were denied;

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

"(3) with respect to each out-of-network claim, the out-of-pocket costs, including applicable cost-sharing amounts, to the enrollee for the services, and the difference between the billed charge and the amount the plan pays, adjusted by any balance billing limitation through State and Federal regulatory and statutory requirements that might apply;

''(4) the number of out-of-network claims reported under paragraph (2) that are for emergency services; and

''(5) the number of out-of-network claims reported under paragraph (2) that relate to care at in-network hospitals or facilities provided by out-of-network providers.

''(b) CLARIFICATION.—The information required to be submitted under this section shall be in addition to the information required to be submitted under section 2715A.''.

SEC. 10. APPLICABILITY TO STATES WITH SURPRISE BILLING LAWS.

(a) GENERAL APPLICATION.—

(1) IN GENERAL.—Nothing in this Act, or the amendments made by this Act, shall be construed to prohibit a State from enacting patient protections that are greater than those provided for in such amendments.

(2) APPLICATION TO ALL PLANS.—In the case of a group health plan, individual health plan, and non-Federal governmental health plan offered in a State that has not enacted a law to determine the payment resolution between enrollees and health care facilities or professionals relating to surprise

medical bills, the procedures applicable to self-insured group health plans for the resolution of surprise medical bills under this Act (including the amendments made by this Act), shall apply to determine compensation with respect to a surprise medical bill, until such time as the State enacts a law providing for such a resolution methodology.

(b) PROVISIONS APPLICABLE TO ERISA.—Section 715 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d) is amended by adding at the end the following:

''(c) PROHIBITIONS ON BALANCE BILLING.—

''(1) FULLY INSURED PLANS.—In the case of a fully insured group health plan—

''(A) a State may establish procedures for determining the appropriate compensation applicable to surprise medical bills between a participant or beneficiary and a health care facility or professional so long as the methodology used relies on the definition of 'surprise medical bill' and the prohibitions contained in section 2729A of the Public Health Service Act; and

''(B) a State may enact laws relating to rate-setting, independent dispute resolution, an

in-network guarantee, or an alternative methodology that complies with paragraph (1).

''(2) SELF-INSURED PLANS.—In the case of a self-insured group health plan, the resolution methodology provided for under section 2729A of the Public Health Service Act, shall be used to determine compensation with respect to a surprise medical bill.''.

(c) FEHBP.—In the case of a health plan under chapter 89 of title 5, United States Code, the resolution methodology provided for under this Act (including the amendments made by this Act), shall be used to determine compensation with respect to a surprise medical bill.

SEC. 11. BALANCE BILLING STUDY.

(a) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study of the effects of this Act (including the amendments made by this Act), and submit to Congress a report on the findings of such study, which shall include information and analysis on—

(1) the financial impact on patient responsibility for health care spending and overall health care spending;

(2) the incidence and prevalence of the delivery of out-of-network health care services;

(3) the adequacy of provider networks offered by health plans and health insurance issuers (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91));

(4) the impact of connecting reimbursement to different claims databases;

(5) the number of bills that go to the independent dispute resolution process; and

(6) the administrative cost of the independent dispute resolution process and estimated impact on health insurance premiums and deductibles.

(b) INFORMATION REQUIREMENTS.—The information provided in the report under subsection (a) shall be—

(1) disaggregated by State and according to the fully insured and the self-insured markets; and

(2) with respect to paragraphs (1) through (3) of such subsection, made available to the public electronically in a searchable database.

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