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(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 3630

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

IN THE HOUSE OF REPRESENTATIVES
July 9, 2019

Mr. PALLONE introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XXVII of the Public Health Service 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,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the ''No Surprises Act''.

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

6 (a) COVERAGE OF EMERGENCY SERVICES.—Section
7 2719A(b) of the Public Health Service Act (42 U.S.C.
8 300gg–19a(b)) is amended—

1 (1) in paragraph (1)—
2 (A) in the matter preceding subparagraph
3 (A)—
4 (i) by striking "a group health plan,
5 or a health insurance issuer offering group
6 or individual health insurance issuer," and
7 inserting "a health plan (as defined in sub-
8 section (e)(2)(A))";
9 (ii) by inserting "or, for plan year
10 2021 or a subsequent plan year, with re-
11 spect to emergency services in an inde-
12 pendent freestanding emergency depart-
13 ment (as defined in paragraph (3)(D))"
14 after "emergency department of a hos-
15 pital";
16 (iii) by striking "the plan or issuer"
17 and inserting "the plan"; and
18 (iv) by striking "paragraph (2)(B)"
19 and inserting "paragraph (3)(C)";
20 (B) in subparagraph (B), by inserting "or
21 a participating emergency facility, as applica-
22 ble," after "participating provider"; and
23 (C) in subparagraph (C)—
24 (i) in the matter preceding clause (i),
25 by inserting "by a nonparticipating pro-

1 vider or a nonparticipating emergency fa-
2 cility'' after ''enrollee'';
3 (ii) by striking clause (i);
4 (iii) by striking ''(ii)(I) such services''
5 and inserting ''(i)such services'';
6 (iv) by striking ''where the provider of
7 services does not have a contractual rela-
8 tionship with the plan for the providing of
9 services'';
10 (v) by striking ''emergency depart-
11 ment services received from providers who
12 do have such a contractual relationship
13 with the plan; and'' and inserting ''emer-
14 gency services received from participating
15 providers and participating emergency fa-
16 cilities with respect to such plan;'';
17 (vi) by striking ''(II) if such services''
18 and all that follows through ''were pro-
19 vided in-network'' and inserting the fol-
20 lowing:
21 ''(ii) the cost-sharing requirement (ex-
22 pressed as a copayment amount or coinsur-
23 ance rate) is not greater than the require-
24 ment that would apply if such services

1 were provided by a participating provider
2 or a participating emergency facility;''; and
3 (vii) by adding at the end the fol-
4 lowing new clauses:
5 ''(iii) such requirement is calculated
6 as if the total amount that would have
7 been charged for such services by such
8 participating provider or participating
9 emergency facility were equal to—
10 ''(I) in the case of such services
11 furnished in a State described in
12 paragraph (3)(H)(ii), the median con-
13 tracted rate (as defined in paragraph
14 (3)(E)(i)) for such services; and
15 ''(II) in the case of such services
16 furnished in a State described in
17 paragraph (3)(H)(i), the lesser of—
18 ''(aa) the amount deter-
19 mined by such State for such
20 services in accordance with the
21 method described in such para-
22 graph; and
23 ''(bb) the median contracted
24 rate (as so defined) for such
25 services;

1 "(iv) the health plan pays to such pro-
2 vider or facility, respectively, the amount
3 by which the recognized amount (as de-
4 fined in paragraph (3)(H)) for such serv-
5 ices exceeds the cost-sharing amount for
6 such services (as determined in accordance
7 with clauses (ii) and (iii)); and
8 "(v) any cost-sharing payments made
9 by the participant, beneficiary, or enrollee
10 with respect to such emergency services so
11 furnished shall be counted toward any in-
12 network deductible or out-of-pocket maxi-
13 mums applied under the plan in the same
14 manner as if such cost-sharing payments
15 were with respect to emergency services
16 furnished by a participating provider and a
17 participating emergency facility; and";
18 (2) by redesignating paragraph (2) as para-
19 graph (3);
20 (3) by inserting after paragraph (1) the fol-
21 lowing new paragraph:
22 "(2) AUDIT PROCESS FOR MEDIAN CON-
23 TRACTED RATES.—Not later than July 1, 2020, the
24 Secretary shall, in consultation with appropriate
25 State agencies, establish through rulemaking a proc-

1 ess under which sponsors and issuers of health plans
2 are audited to ensure that such sponsors and issuers
3 are in compliance with the requirement of applying
4 a median contracted rate under this section that sat-
5 isfies the definition under paragraph (3)(E).''; and
6 (4) in paragraph (3), as redesignated by para-
7 graph (2) of this subsection—
8 (A) in the matter preceding subparagraph
9 (A), by inserting ''and subsections (e) and (f)''
10 after ''this subsection'';
11 (B) by redesignating subparagraphs (A)
12 through (C) as subparagraphs (B) through (D),
13 respectively;
14 (C) by inserting before subparagraph (B),
15 as redesignated by subparagraph (B) of this
16 paragraph, the following new subparagraph:
17 ''(A) EMERGENCY DEPARTMENT OF A HOS-
18 PITAL.—The term 'emergency department of a
19 hospital' includes a hospital outpatient depart-
20 ment that provides emergency services.'';
21 (D) by amending subparagraph (C), as re-
22 designated by subparagraph (B) of this para-
23 graph, to read as follows:
24 ''(C) EMERGENCY SERVICES.—

1 "(i) IN GENERAL.—The term 'emer-
2 gency services', with respect to an emer-
3 gency medical condition means—
4 "(I) a medical screening exam-
5 ination (as required under section
6 1867 of the Social Security Act, or as
7 would be required under such section
8 if such section applied to an inde-
9 pendent freestanding emergency de-
10 partment) that is within the capability
11 of the emergency department of a hos-
12 pital or of an independent free-
13 standing emergency department, as
14 applicable, including ancillary services
15 routinely available to the emergency
16 department to evaluate such emer-
17 gency medical condition; and
18 "(II) within the capabilities of
19 the staff and facilities available at the
20 hospital or the independent free-
21 standing emergency department, as
22 applicable, such further medical exam-
23 ination and treatment as are required
24 under section 1867 of such Act, or as
25 would be required under such section

1 if such section applied to an inde-
2 pendent freestanding emergency de-
3 partment, to stabilize the patient.
4 "(ii) INCLUSION OF
5 POSTSTABILIZATION SERVICES.—For pur-
6 poses of this subsection and section 2799,
7 in the case of an individual enrolled in a
8 health plan who is furnished services de-
9 scribed in clause (i) by a provider or facil-
10 ity to stabilize such individual with respect
11 to an emergency medical condition, the
12 term 'emergency services' shall include
13 such items and services in addition to
14 those described in clause (i) that such a
15 provider or facility determines are needed
16 to be furnished to such individual during
17 the visit in which such individual is so sta-
18 bilized after such stabilization, unless each
19 of the following conditions are met:
20 "(I) Such a provider or facility
21 determines such individual is able to
22 travel using nonmedical transpor-
23 tation or nonemergency medical trans-
24 portation.

1 "(II) Such provider furnishing
2 such additional items and services is
3 in compliance with section 2799A(d)
4 with respect to such items and serv-
5 ices.";
6 (E) by redesignating subparagraph (D), as
7 redesignated by subparagraph (B) of this para-
8 graph, as subparagraph (I); and
9 (F) by inserting after subparagraph (C),
10 as redesignated by subparagraph (B) of this
11 paragraph, the following new subparagraphs:
12 "(D) INDEPENDENT FREESTANDING
13 EMERGENCY DEPARTMENT.—The term 'inde-
14 pendent freestanding emergency department'
15 means a facility that—
16 "(i) is geographically separate and
17 distinct and licensed separately from a hos-
18 pital under applicable State law; and
19 "(ii) provides emergency services.
20 "(E) MEDIAN CONTRACTED RATE.—
21 "(i) IN GENERAL.—The term 'median
22 contracted rate' means, with respect to an
23 item or service and a health plan (as de-
24 fined in subsection (e)(2)(A))—

1 "(I) for 2021, the median of the
2 negotiated rates recognized by the
3 sponsor or issuer of such plan (deter-
4 mined with respect to all such plans
5 of such sponsor or such issuer) as the
6 total maximum payment (including
7 the cost-sharing amount imposed for
8 such services (as determined in ac-
9 cordance with paragraph (1)(C)(ii) or
10 subsection (e)(1)(A), as applicable)
11 and the amount to be paid by the plan
12 or issuer) under such plans in 2019
13 for the same or a similar item or serv-
14 ice that is provided by a provider in
15 the same or similar specialty and pro-
16 vided in the geographic region in
17 which the item or service is furnished,
18 consistent with the methodology es-
19 tablished by the Secretary under sec-
20 tion 2(e) of the No Surprises Act, in-
21 creased by the percentage increase in
22 the consumer price index for all urban
23 consumers (United States city aver-
24 age) over 2019 and 2020; and

1 "(II) for 2022 and each subse-
2 quent year, the median contracted
3 rate for the previous year, increased
4 by the percentage increase in the con-
5 sumer price index for all urban con-
6 sumers (United States city average)
7 over such previous year.
8 "(ii) SPECIAL RULE; RULE OF CON-
9 STRUCTION.—
10 "(I) CERTAIN INSURERS.—The
11 Secretary shall provide pursuant to
12 rulemaking described in clause (ii)
13 that—
14 "(aa) if the sponsor or
15 issuer of a health plan does not
16 have sufficient information to
17 calculate a median contracted
18 rate for an item or service or
19 provider type, or amount of,
20 claims for items or services (as
21 determined by the Secretary)
22 provided in a particular geo-
23 graphic area (other than in a
24 case described in item (bb)), such
25 sponsor or issuer shall dem-

1 onstrate that such sponsor or
2 issuer will use any database free
3 of conflicts of interest that has
4 sufficient information reflecting
5 allowed amounts paid to indi-
6 vidual health care providers for
7 relevant services provided in the
8 applicable geographic region
9 (such as All Payer Claims Data-
10 bases (as defined in section 4(d)
11 of the No Surprises Act) of
12 States), and that such sponsor or
13 issuer will use any such database
14 to determine a median contracted
15 rate and cover the cost of access-
16 ing any such database; and
17 "(bb) in the case of a spon-
18 sor or issuer offering a health
19 plan in a geographic region that
20 did not offer any health plan in
21 such region during 2019, such
22 sponsor or issuer shall use a
23 methodology established by the
24 Secretary for determining the
25 median contracted rate for items

1 and services covered by such plan
2 for the first year in which such
3 plan is offered in such region,
4 and that, for each succeeding
5 year, the median contracted rate
6 for such items and services under
7 such plan shall be the median
8 contracted rate for such items
9 and services under such plan for
10 the previous year, increased by
11 the percentage increase in the
12 consumer price index for all
13 urban consumers (United States
14 city average) over such previous
15 year.

16 "(II) RULE OF CONSTRUC-
17 TION.—Nothing in this subparagraph
18 shall prevent the sponsor or issuer of
19 a health plan from establishing sepa-
20 rate calculations of a median con-
21 tracted rate under this subparagraph
22 for items and services delivered in
23 non-hospital facilities, including inde-
24 pendent freestanding emergency de-
25 partments.

1 "(F) 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 health plan, an
8 emergency department of a hospital, or an
9 independent freestanding emergency de-
10 partment, that does not have a contractual
11 relationship with the plan (or, if applicable,
12 issuer offering the plan) for furnishing
13 such item or service under the plan.
14 "(ii) PARTICIPATING EMERGENCY FA-
15 CILITY.—The term 'participating emer-
16 gency facility' means, with respect to an
17 item or service and a health plan, an emer-
18 gency department of a hospital, or an inde-
19 pendent freestanding emergency depart-
20 ment, that has a contractual relationship
21 with the plan (or, if applicable, issuer of-
22 fering the plan) for furnishing such item
23 or service under the plan.
24 "(G) NONPARTICIPATING PROVIDERS; PAR-
25 TICIPATING PROVIDERS.—

1 "(i) NONPARTICIPATING PROVIDER.—
2 The term 'nonparticipating provider'
3 means, with respect to an item or service
4 and a health plan, a physician or other
5 health care provider who is acting within
6 the scope of practice of that provider's li-
7 cense or certification under applicable
8 State law and who does not have a con-
9 tractual relationship with the plan (or, if
10 applicable, issuer offering the plan) for
11 furnishing such item or service under the
12 plan.
13 "(ii) PARTICIPATING PROVIDER.—The
14 term 'participating provider' means, with
15 respect to an item or service and a health
16 plan, a physician or other health care pro-
17 vider who is acting within the scope of
18 practice of that provider's license or certifi-
19 cation under applicable State law and who
20 has a contractual relationship with the
21 plan (or, if applicable, issuer offering the
22 plan) for furnishing such item or service
23 under the plan.

1 "(H) RECOGNIZED AMOUNT.—The term
2 'recognized amount' means, with respect to an
3 item or service—
4 "(i) in the case of such item or service
5 furnished in a State that has in effect a
6 State law that provides for a method for
7 determining the amount of payment that is
8 required to be covered by a health plan
9 regulated by such State in the case of a
10 participant, beneficiary, or enrollee covered
11 under such plan and receiving such item or
12 service from a nonparticipating provider or
13 facility, not more than the amount deter-
14 mined in accordance with such law plus
15 the cost-sharing amount imposed under the
16 plan for such item or service (as deter-
17 mined in accordance with paragraph
18 (1)(C)(ii) or subsection (e)(1)(A), as appli-
19 cable); or
20 "(ii) in the case of such item or serv-
21 ice furnished in a State that does not have
22 in effect such a law, an amount that is at
23 least the median contracted rate (as de-
24 fined in subparagraph (E)(i) and deter-
25 mined in accordance with rulemaking de-

1 scribed in subparagraph (E)(ii)) for such
2 item or service.''.
3 (b) COVERAGE OF NON-EMERGENCY SERVICES PER-
4 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
5 PARTICIPATING FACILITIES.—Section 2719A of the Pub-
6 lic Health Service Act (42 U.S.C. 300gg–19a) is amended
7 by adding at the end the following new subsection:
8 ''(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
9 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
10 PARTICIPATING FACILITIES.—
11 ''(1) IN GENERAL.—Subject to paragraph (3),
12 in the case of items or services (other than emer-
13 gency services to which subsection (b) applies) fur-
14 nished to a participant, beneficiary, or enrollee of a
15 health plan (as defined in paragraph (2)(A)) by a
16 nonparticipating provider (as defined in subsection
17 (b)(3)(G)(i)) during a visit (as defined by the Sec-
18 retary in accordance with paragraph (2)(C)) at a
19 participating health care facility (as defined in para-
20 graph (2)(B)), 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 (as defined in subsection
4 (b)(3)(G)(ii));
5 "(B) shall calculate such cost-sharing
6 amount as if the amount that would have been
7 charged for such items and services by such
8 participating provider were equal to—
9 "(i) in the case of such items and
10 services furnished in a State described in
11 subsection (b)(3)(H)(ii), the median con-
12 tracted rate (as defined in subsection
13 (b)(3)(E)(i)) for such items and services;
14 and
15 "(ii) in the case of such items and
16 services furnished in a State described in
17 subsection (b)(3)(H)(i), the lesser of—
18 "(I) the amount determined by
19 such State for such items and services
20 in accordance with the method de-
21 scribed in such subsection; and
22 "(II) the median contracted rate
23 (as so defined) for such items and
24 services;

1 "(C) shall pay to such provider furnishing
2 such items and services to such participant,
3 beneficiary, or enrollee the amount by which the
4 recognized amount (as defined in subsection
5 (b)(3)(H)) for such items and services exceeds
6 the cost-sharing amount imposed under the
7 plan for such items and services (as determined
8 in accordance with subparagraphs (A) and (B));
9 and

10 "(D) shall count toward any in-network
11 deductible or out-of-pocket maximums applied
12 under the plan any cost-sharing payments made
13 by the participant, beneficiary, or enrollee with
14 respect to such items and services so furnished
15 in the same manner as if such cost-sharing pay-
16 ments were with respect to items and services
17 furnished by a participating provider.

18 "(2) DEFINITIONS.—In this subsection and
19 subsection (b):

20 "(A) HEALTH PLAN.—The term 'health
21 plan' means a group health plan and health in-
22 surance coverage offered by a heath insurance
23 issuer in the group or individual market and in-
24 cludes a grandfathered health plan (as defined

1 in section 1251(e) of the Patient Protection and
2 Affordable Care Act).
3 "(B) PARTICIPATING HEALTH CARE FACIL-
4 ITY.—
5 "(i) IN GENERAL.—The term 'partici-
6 pating health care facility' means, with re-
7 spect to an item or service and a health
8 plan, a health care facility described in
9 clause (ii) that has a contractual relation-
10 ship with the plan (or, if applicable, issuer
11 offering the plan) for furnishing such item
12 or service.
13 "(ii) HEALTH CARE FACILITY DE-
14 SCRIBED.—A health care facility described
15 in this clause is each of the following:
16 "(I) A hospital (as defined in
17 1861(e) of the Social Security Act).
18 "(II) A critical access hospital
19 (as defined in section 1861(mm) of
20 such Act).
21 "(III) An ambulatory surgical
22 center (as defined in section
23 1833(i)(1)(A) of such Act).
24 "(IV) A laboratory.

1 "(V) A radiology facility or imag-
2 ing center.
3 "(C) DURING A VISIT.—The term 'during
4 a visit' shall, with respect to items and services
5 furnished to an individual at a participating
6 health care facility, include equipment and de-
7 vices, telemedicine services, imaging services,
8 laboratory services, and such other items and
9 services as the Secretary may specify, regard-
10 less of whether or not the provider furnishing
11 such items or services is at the facility.
12 "(3) EXCEPTION.—Paragraph (1) shall not
13 apply to a health plan in the case of items or serv-
14 ices (other than emergency services to which sub-
15 section (b) applies) furnished to a participant, bene-
16 ficiary, or enrollee of a health plan (as defined in
17 paragraph (2)(A)) by a nonparticipating provider (as
18 defined in subsection (b)(3)(G)(i)) during a visit (as
19 defined by the Secretary in accordance with para-
20 graph (2)(C)) at a participating health care facility
21 (as defined in paragraph (2)(B)) if such provider is
22 in compliance with section 2799A(d) with respect to
23 such items and services.".
24 (c) PROVIDER DIRECTORY REQUIREMENTS; DISCLO-
25 SURE ON PATIENT PROTECTIONS.—Section 2719A of the

1 Public Health Service Act, as amended by subsection (b),
2 is further amended by adding at the end the following new
3 subsections:

4 "(f) PROVIDER DIRECTORY INFORMATION REQUIRE-
5 MENTS.—

6 "(1) IN GENERAL.—Not later than 1 year after
7 the date of the enactment of this subsection, each
8 group health plan and health insurance issuer offer-
9 ing group or individual health insurance coverage
10 shall—

11 "(A) establish the verification process de-
12 scribed in paragraph (2);

13 "(B) establish the response protocol de-
14 scribed in paragraph (3);

15 "(C) establish the database described in
16 paragraph (4); and

17 "(D) include in any print directory con-
18 taining provider directory information with re-
19 spect to such plan or such coverage the infor-
20 mation described in paragraph (5).

21 "(2) VERIFICATION PROCESS.—The verification
22 process described in this paragraph is, with respect
23 to a group health plan or a health insurance issuer
24 offering group or individual health insurance cov-
25 erage, a process under which—

1 "(A) not less frequently than once every 90
2 days, such plan or such issuer (as applicable)
3 verifies and updates the provider directory in-
4 formation included on the database described in
5 paragraph (4) of such plan or issuer of each
6 health care provider and health care facility in-
7 cluded in such database; and
8 "(B) such plan or such issuer removes any
9 such provider or facility with respect to which
10 such plan or such issuer has been unable to
11 verify such information during any 6-month pe-
12 riod.
13 "(3) RESPONSE PROTOCOL.—The response pro-
14 tocol described in this paragraph is, in the case of
15 an individual enrolled under a group health plan or
16 group or individual health insurance coverage of-
17 fered by a health insurance issuer who requests in-
18 formation on whether a health care provider or
19 health care facility has a contractual relationship to
20 furnish items and services under such plan or such
21 coverage, a protocol under which such plan or such
22 issuer (as applicable), in the case such request is
23 made through a telephone call—
24 "(A) responds to such individual as soon
25 as practicable and in no case later than 1 busi-

1 ness day after such call is received through a
2 written electronic communication; and
3 "(B) retains such communication in such
4 individual's file for at least 2 years following
5 such response.
6 "(4) DATABASE.—The database described in
7 this paragraph is, with respect to a group health
8 plan or health insurance issuer offering group or in-
9 dividual health insurance coverage, a database on
10 the public website of such plan or issuer that con-
11 tains—
12 "(A) a list of each health care provider and
13 health care facility with which such plan or
14 such issuer has a contractual relationship for
15 furnishing items and services under such plan
16 or such coverage; and
17 "(B) provider directory information with
18 respect to each such provider and facility.
19 "(5) INFORMATION.—The information de-
20 scribed in this paragraph is, with respect to a print
21 directory containing provider directory information
22 with respect to a group health plan or individual or
23 group health insurance coverage offered by a health
24 insurance issuer, a notification that such informa-
25 tion contained in such directory was accurate as of

1 the date of publication of such directory and that an
2 individual enrolled under such plan or such coverage
3 should consult the database described in paragraph
4 (4) with respect to such plan or such coverage or
5 contact such plan or the issuer of such coverage to
6 obtain the most current provider directory informa-
7 tion with respect to such plan or such coverage.

8 ''(6) DEFINITION.—For purposes of this sub-
9 section, the term 'provider directory information' in-
10 cludes, with respect to a group health plan and a
11 health insurance issuer offering group or individual
12 health insurance coverage, the name, address, spe-
13 cialty, and telephone number of each health care
14 provider or health care facility with which such plan
15 or such issuer has a contractual relationship for fur-
16 nishing items and services under such plan or such
17 coverage.

18 ''(g) DISCLOSURE ON PATIENT PROTECTIONS.—
19 Each group health plan and health insurance issuer offer-
20 ing group or individual health insurance coverage shall
21 make publicly available, and (if applicable) post on a pub-
22 lic website of such plan or issuer—

23 ''(1) information in plain language on—

24 ''(A) the requirements and prohibitions ap-
25 plied under sections 2799 and 2799A (relating

1 to prohibitions on balance billing in certain cir-
2 cumstances);
3 "(B) if provided for under applicable State
4 law, any other requirements on providers and
5 facilities regarding the amounts such providers
6 and facilities may, with respect to an item or
7 service, charge a participant, beneficiary, or en-
8 rollee of such plan or coverage with respect to
9 which such a provider or facility does not have
10 a contractual relationship for furnishing such
11 item or service under the plan or coverage after
12 receiving payment from the plan or coverage for
13 such item or service and any applicable cost-
14 sharing payment from such participant, bene-
15 ficiary, or enrollee; and
16 "(C) the requirements applied under sub-
17 sections (b) and (e); and
18 "(2) information on contacting appropriate
19 State and Federal agencies in the case that an indi-
20 vidual believes that such a provider or facility has
21 violated any requirement described in paragraph (1)
22 with respect to such individual.".
23 (d) PREVENTING CERTAIN CASES OF BALANCE
24 BILLING.—Title XXVII of the Public Health Service Act
25 is amended by adding at the end the following new part:

1 "PART D—PREVENTING CERTAIN CASES OF
2 BALANCE BILLING

3 "SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY
4 SERVICES.

5 "(a) IN GENERAL.—In the case of a participant, ben-
6 eficiary, or enrollee with benefits under a health plan who
7 is furnished on or after January 1, 2021, emergency serv-
8 ices with respect to an emergency medical condition during
9 a visit at an emergency department of a hospital or an
10 independent freestanding emergency department—
11 "(1) the emergency department of a hospital or
12 independent freestanding emergency department
13 shall not hold the participant, beneficiary, or enrollee
14 liable for a payment amount for such emergency
15 services so furnished that is more than the cost-
16 sharing amount for such services (as determined in
17 accordance with section 2719A(b)(1)(C)(ii)); and
18 "(2) a health care provider shall not hold such
19 participant, beneficiary, or enrollee liable for a pay-
20 ment amount for an emergency service furnished to
21 such individual by such provider with respect to such
22 emergency medical condition and visit for which the
23 individual receives emergency services at the hospital
24 or emergency department that is more than the cost-
25 sharing amount for such services furnished by the

1 provider (as determined in accordance with section
2 2719A(b)(1)(C)(ii)).
3 ''(b) DEFINITIONS.—In this section:
4 ''(1) The terms 'emergency department of a
5 hospital', 'emergency medical condition', 'emergency
6 services', and 'independent freestanding emergency
7 department' have the meanings given such terms, re-
8 spectively, in section 2719A(b)(3).
9 ''(2) The term 'health plan' has the meaning
10 given such term in section 2719A(e).
11 ''(3) The term 'during a visit' shall have such
12 meaning as applied to such term for purposes of sec-
13 tion 2719A(e).
14 **''SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMER-**
15 **GENCY SERVICES PERFORMED BY NON-**
16 **PARTICIPATING PROVIDERS AT CERTAIN**
17 **PARTICIPATING FACILITIES.**
18 ''(a) IN GENERAL.—Subject to subsection (b), in the
19 case of a participant, beneficiary, or enrollee with benefits
20 under a health plan (as defined in section 2799(b)) who
21 is furnished on or after January 1, 2021, items or services
22 (other than emergency services to which section 2799 ap-
23 plies) at a participating health care facility by a non-
24 participating provider, such provider shall not hold such
25 participant, beneficiary, or enrollee liable for a payment

1 amount for such an item or service furnished by such pro-
2 vider during a visit at such facility that is more than the
3 cost-sharing amount for such item or service (as deter-
4 mined in accordance with subparagraphs (A) and (B) of
5 section 2719A(e)(1)).

6 ‘‘(b) EXCEPTION.—

7 ‘‘(1) IN GENERAL.—Subsection (a) shall not
8 apply to a nonparticipating provider (other than a
9 specified provider at a participating health care fa-
10 cility), with respect to items or services furnished by
11 the provider to a participant, beneficiary, or enrollee
12 of a health plan, if the provider is in compliance
13 with the notice and consent requirements of sub-
14 section (d).

15 ‘‘(2) SPECIFIED PROVIDER DEFINED.—For pur-
16 poses of paragraph (1), the term ‘specified provider’,
17 with respect to a participating health care facility—

18 ‘‘(A) means a facility-based provider, in-
19 cluding emergency medicine providers, anesthe-
20 siologists, pathologists, radiologists,
21 neonatologists, assistant surgeons, hospitalists,
22 intensivists, or other providers as determined by
23 the Secretary; and

24 ‘‘(B) includes, with respect to an item or
25 service, a nonparticipating provider if there is

1 no participating provider at such facility who
2 can furnish such item or service.
3 “(c) CLARIFICATION.—In the case of a nonpartici-
4 pating provider (other than a specified provider at a par-
5 ticipating health care facility) that complies with the no-
6 tice and consent requirements of subsection (d) with re-
7 spect to an item or service (referred to in this subsection
8 as a ‘covered item or service’), such notice and consent
9 requirements may not be construed as applying with re-
10 spect to any item or service that is furnished as a result
11 of unforeseen medical needs that arise at the time such
12 covered item or service is furnished.
13 “(d) COMPLIANCE WITH NOTICE AND CONSENT RE-
14 QUIREMENTS.—
15 “(1) IN GENERAL.—A nonparticipating provider
16 or nonparticipating facility is in compliance with this
17 subsection, with respect to items or services fur-
18 nished by the provider or facility to a participant,
19 beneficiary, or enrollee of a health plan, if the pro-
20 vider (or, if applicable, the participating health care
21 facility on behalf of such provider) or nonpartici-
22 pating facility—
23 “(A) provides to the participant, bene-
24 ficiary, or enrollee (or to an authorized rep-
25 resentative of the participant, beneficiary, or

1 enrollee), on the date on which the participant,
2 beneficiary, or enrollee makes an appointment
3 to be furnished such items or services, if appli-
4 cable, and on the date on which the individual
5 is furnished such items or services—

6 "(i) an oral explanation of the written
7 notice described in clause (ii); and

8 "(ii) a written notice specified, not
9 later than July 1, 2020, by the Secretary
10 through guidance (which shall be updated
11 as determined necessary by the Secretary)
12 that—

13 "(I) contains the information re-
14 quired under paragraph (2); and

15 "(II) is signed and dated by the
16 participant, beneficiary, or enrollee (or
17 by an authorized representative of the
18 participant, beneficiary, or enrollee)
19 and, with respect to items or services
20 to be furnished by such a provider
21 that are not poststabilization services
22 described in section
23 2719A(b)(3)(C)(ii), is so signed and
24 dated not less than 72 hours prior to
25 the participant, beneficiary, or en-

1 rollee being furnished such items or
2 services by such provider; and
3 ''(B) obtains from the participant, bene-
4 ficiary, or enrollee (or from such an authorized
5 representative) the consent described in para-
6 graph (3).
7 ''(2) INFORMATION REQUIRED UNDER WRITTEN
8 NOTICE.—For purposes of paragraph (1)(A)(ii)(I),
9 the information described in this paragraph, with re-
10 spect to a nonparticipating provider or nonpartici-
11 pating facility and a participant, beneficiary, or en-
12 rollee of a health plan, is each of the following:
13 ''(A) Notification, as applicable, that the
14 health care provider is a nonparticipating pro-
15 vider with respect to the health plan or the
16 health care facility is a nonparticipating facility
17 with respect to the health plan;
18 ''(B) Notification of the estimated amount
19 that such provider or facility may charge the
20 participant, beneficiary, or enrollee for such
21 items and services involved.
22 ''(C) In the case of a nonparticipating fa-
23 cility, a list of any participating providers at the
24 facility who are able to furnish such items and
25 services involved and notification that the par-

1 ticipant, beneficiary, or enrollee may be re-
2 ferred, at their option, to such a participating
3 provider.
4 "(3) CONSENT DESCRIBED.—For purposes of
5 paragraph (1)(B), the consent described in this
6 paragraph, with respect to a participant, beneficiary,
7 or enrollee of a health plan who is to be furnished
8 items or services by a nonparticipating provider or
9 nonparticipating facility, is a document specified by
10 the Secretary through rulemaking that—
11 "(A) is signed by the participant, bene-
12 ficiary, or enrollee (or by an authorized rep-
13 resentative of the participant, beneficiary, or
14 enrollee) and, with respect to items or services
15 to be furnished by such a provider or facility
16 that are not poststabilization services described
17 in section 2719A(b)(3)(C)(ii), is so signed not
18 less than 72 hours prior to the participant, ben-
19 eficiary, or enrollee being furnished such items
20 or services by such provider or facility;
21 "(B) acknowledges that the participant,
22 beneficiary, or enrollee has been—
23 "(i) provided with a written estimate
24 and an oral explanation of the charge that
25 the participant, beneficiary, or enrollee will

be assessed for the items or services anticipated to be furnished to the participant, beneficiary, or enrollee by such provider or facility; and

"(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the health plan places on cost-sharing; and

"(C) documents the consent of the participant, beneficiary, or enrollee to—

"(i) be furnished with such items or services by such provider or facility; and

"(ii) in the case that the individual is so furnished such items or services, be charged an amount that may be greater than the amount that would otherwise be charged the individual if furnished by a participating provider or participating facility with respect to such items or services and plan.

"(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating provider (or, in the case of a nonparticipating provider at a participating health care facility, such facility) or nonparticipating facility that obtains from a

1 participant, beneficiary, or enrollee of a health plan (or
2 an authorized representative of such participant, bene-
3 ficiary, or enrollee) a written notice in accordance with
4 subsection (c)(1)(ii), with respect to furnishing an item
5 or service to such participant, beneficiary, or enrollee,
6 shall retain such notice for at least a 2-year period after
7 the date on which such item or service is so furnished.
8 ''(f) DEFINITIONS.—In this section:
9 ''(1) The terms 'nonparticipating provider' and
10 'participating provider' have the meanings given
11 such terms, respectively, in subsection (b)(3) of sec-
12 tion 2719A.
13 ''(2) The terms 'participating health care facil-
14 ity' and 'health plan' have the meanings given such
15 terms, respectively, in subsection (e)(2) of section
16 2719A.
17 ''(3) The term 'nonparticipating facility'
18 means—
19 ''(A) with respect to emergency services (as
20 defined in section 2719A(b)(3)(C)(i)) and a
21 health plan, an emergency department of a hos-
22 pital, or an independent freestanding emergency
23 department, that does not have a contractual
24 relationship with the plan (or, if applicable,

1 issuer offering the plan) for furnishing such
2 services under the plan; and
3 ‘‘(B) with respect to poststabilization serv-
4 ices described in section 2719A(b)(3)(C)(ii) and
5 a health plan, an emergency department of a
6 hospital (or other department of such hospital),
7 or an independent freestanding emergency de-
8 partment, that does not have a contractual rela-
9 tionship with the plan (or, if applicable, issuer
10 offering the plan) for furnishing such services
11 under the plan.
12 ‘‘(4) The term ‘participating facility’ means—
13 ‘‘(A) with respect to emergency services (as
14 defined in section 2719A(b)(3)(C)(i)) and a
15 health plan, an emergency department of a hos-
16 pital, or an independent freestanding emergency
17 department, that has a contractual relationship
18 with the plan (or, if applicable, issuer offering
19 the plan) for furnishing such services under the
20 plan; and
21 ‘‘(B) with respect to poststabilization serv-
22 ices described in section 2719A(b)(3)(C)(ii) and
23 a health plan, an emergency department of a
24 hospital (or other department of such hospital),
25 or an independent freestanding emergency de-

1 partment, that has a contractual relationship
2 with the plan (or, if applicable, issuer offering
3 the plan) for furnishing such services under the
4 plan.

5 **"SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO**
6 **PROVIDER DIRECTORY INFORMATION.**

7 ''Not later than 1 year after the date of the enact-
8 ment of this section, each health care provider and health
9 care facility shall establish a process under which such
10 provider or facility transmits, to each health insurance
11 issuer offering group or individual health insurance cov-
12 erage and group health plan with which such provider or
13 facility has in effect a contractual relationship for fur-
14 nishing items and services under such coverage or such
15 plan, provider directory information (as defined in section
16 2719A(f)(6)) with respect to such provider or facility, as
17 applicable. Such provider or facility shall so transmit such
18 information to such issuer offering such coverage or such
19 group health plan—

20 ''(1) when the provider or facility enters into
21 such a relationship with respect to such coverage of-
22 fered by such issuer or with respect to such plan;

23 ''(2) when the provider or facility terminates
24 such relationship with respect to such coverage of-
25 fered by such issuer or with respect to such plan;

1 "(3) when there are any other material changes
2 to such provider directory information of the pro-
3 vider or facility with respect to such coverage offered
4 by such issuer or with respect to such plan; and
5 "(4) at any other time determined appropriate
6 by the provider, facility, or the Secretary.
7 **"SEC. 2799C. PROVIDER REQUIREMENT WITH RESPECT TO**
8 **PUBLIC PROVISION OF INFORMATION.**
9 "Each health care provider and health care facility
10 shall make publicly available, and (if applicable) post on
11 a public website of such provider or facility—
12 "(1) information in plain language on—
13 "(A) the requirements and prohibitions of
14 such provider or facility under sections 2799
15 and 2799A (relating to prohibitions on balance
16 billing in certain circumstances); and
17 "(B) if provided for under applicable State
18 law, any other requirements on such provider or
19 facility regarding the amounts such provider or
20 facility may, with respect to an item or service,
21 charge a participant, beneficiary, or enrollee of
22 a health plan (as defined in section
23 2719A(e)(2)) with respect to which such pro-
24 vider or facility does not have a contractual re-
25 lationship for furnishing such item or service

under the plan after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

"(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

"SEC. 2799D. ENFORCEMENT.

"(a) STATE ENFORCEMENT.—

"(1) STATE AUTHORITY.—Each State may require a provider or health care facility subject to the requirements of sections 2799, 2799A, 2799B, or 2799C to satisfy such requirements applicable to the provider or facility.

"(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to applicable providers and facilities in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to actions prohibited under this part occurring in such State.

"(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

1 "(1) IN GENERAL.—If a provider or facility is
2 found to be in violation of this part by the Sec-
3 retary, the Secretary may apply a civil monetary
4 penalty with respect to such provider or facility in
5 an amount not to exceed $10,000 per violation. The
6 provisions of subsections (c), (d), (e), (g), (h), (k),
7 and (l) of section 1128A of the Social Security Act
8 shall apply to a civil monetary penalty or assessment
9 under this subsection in the same manner as such
10 provisions apply to a penalty, assessment, or pro-
11 ceeding under subsection (a) of such section.
12 "(2) LIMITATION.—The provisions of para-
13 graph (1) shall apply to enforcement of a provision
14 (or provisions) of this part only as provided under
15 subsection (a)(2).
16 "(3) COMPLAINT PROCESS.—The Secretary
17 shall, through rulemaking, establish a process to re-
18 ceive consumer complaints of violations of this part
19 and resolve such complaints within 60 days of re-
20 ceipt of such complaints.
21 "(4) EXCEPTION.—The Secretary shall waive
22 the penalties described under paragraph (1) with re-
23 spect to a facility or provider who does not know-
24 ingly violate, and should not have reasonably known
25 it violated, a provision of this part with respect to

1 a participant, beneficiary, or enrollee, if such facility
2 or practitioner, within 30 days of the violation, with-
3 draws the bill that was in violation of such provision,
4 and reimburses the health plan or enrollee, as appli-
5 cable, in an amount equal to the difference between
6 the amount billed and the amount allowed to be
7 billed under the provision, plus interest, at an inter-
8 est rate determined by the Secretary.

9 ''(5) HARDSHIP EXEMPTION.—The Secretary
10 may establish a hardship exemption to the penalties
11 under this subsection.

12 ''(c) CONTINUED APPLICABILITY OF STATE LAW.—
13 This part shall not be construed to supersede any provi-
14 sion of State law which establishes, implements, or con-
15 tinues in effect any requirement or prohibition except to
16 the extent that such requirement or prohibition prevents
17 the application of a requirement or prohibition of this
18 part.''.

19 (e) RULEMAKING FOR MEDIAN CONTRACTED
20 RATES.—Not later than July 1, 2020, the Secretary of
21 Health and Human Services, jointly with the Secretary of
22 Labor, shall establish through rulemaking the method-
23 ology the sponsor or issuer of a health plan (as defined
24 in subsection (e) of section 2719A of the Public Health
25 Service Act (42 U.S.C. 300gg–19a), as added by sub-

section (b) of this section) shall use to determine the median contracted rate (as defined in section 2719A(b) of such Act, as amended by subsection (a) of this section), the information such sponsor or issuer shall share with the nonparticipating provider (as defined in such section) involved when making such a determination, and the geographic regions applied for purposes of this subparagraph (E) of section 2719A(b)(3), as amended by subsection (a) of this section.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 3. GOVERNMENT ACCOUNTABILITY OFFICE STUDY ON PROFIT- AND REVENUE-SHARING IN HEALTH CARE.

(a) STUDY.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study to—

(1) describe what is known about profit- and revenue-sharing relationships in the commercial health care markets, including those relationships that—

(A) involve one or more—

(i) physician groups that practice within a hospital included in the profit- or

1 revenue-sharing relationship, or refer pa-
2 tients to such hospital;
3 (ii) laboratory, radiology, or pharmacy
4 services that are delivered to privately in-
5 sured patients of such hospital;
6 (iii) surgical services;
7 (iv) hospitals or group purchasing or-
8 ganizations; or
9 (v) rehabilitation or physical therapy
10 facilities or services; and
11 (B) include revenue- or profit-sharing
12 whether through a joint venture, management
13 or professional services agreement, or other
14 form of gain-sharing contract;
15 (2) describe Federal oversight of such relation-
16 ships, including authorities of the Department of
17 Health and Human Services and the Federal Trade
18 Commission to review such relationships and their
19 potential to increase costs for patients, and identify
20 limitations in such oversight; and
21 (3) as appropriate, make recommendations to
22 improve Federal oversight of such relationships.
23 (b) REPORT.—Not later than 1 year after the date
24 of enactment of this Act, the Comptroller General of the
25 United States shall prepare and submit a report on the

study conducted under subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and Committee on Energy and Commerce of the House of Representatives.

SEC. 4. STATE ALL PAYER CLAIMS DATABASES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make one-time grants to eligible States for the purposes described in subsection (b).

(b) USES.—A State may use a grant received under subsection (a) for one of the following purposes:

(1) To establish an All Payer Claims Database for the State.

(2) To maintain an existing All Payer Claims Databases for the State.

(c) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary specifies. Such information shall include, with respect to an All Payer Claims Database for the State, at least specifics on how the State will ensure uniform data collection through the database and the security of such data submitted to and maintained in the database.

1 (d) ALL PAYER CLAIMS DATABASE.—For purposes
2 of this section, the term ‘‘All Payer Claims Database’’
3 means, with respect to a State, a State database that may
4 include medical claims, pharmacy claims, dental claims,
5 and eligibility and provider files, which are collected from
6 private and public payers.

7 (e) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there are authorized to be appropriated
9 $50,000,000, to remain available until expended.

10 **SEC. 5. SIMPLIFYING EMERGENCY AIR AMBULANCE BILL-**
11 **ING.**

12 (a) IN GENERAL.—Providers of emergency air med-
13 ical services shall submit to a group health plan or health
14 insurance issuer offering group or individual health insur-
15 ance coverage, together with an electronic claims trans-
16 action with respect to an enrollee in such plan or coverage,
17 a description of charges for such services that are sepa-
18 rated by—

19 (1) the cost of air travel; and

20 (2) the cost of emergency medical services and
21 supplies.

22 (b) RULEMAKING.—Not later than 1 year after the
23 date of the enactment of this Act, the Secretary of Health
24 and Human Services shall determine the form and manner

1 for submitting the description of charges in subsection (a)
2 through notice and comment rulemaking.
3 (c) CIVIL MONETARY PENALTIES.—
4 (1) IN GENERAL.—A provider of emergency air
5 medical services who violates the requirement of sub-
6 section (a) shall be subject to a civil monetary pen-
7 alty of not more than $10,000 for each act consti-
8 tuting such violation.
9 (2) PROCEDURE.—The provisions of section
10 1128A of the Social Security Act (42 U.S.C. 1320a–
11 7a), other than subsections (a) and (b) and the first
12 sentence of subsection (c)(1) of such section, shall
13 apply to civil money penalties under this subsection
14 in the same manner as such provisions apply to a
15 penalty or proceeding under section 1128A of the
16 Social Security Act.
17 (d) DEFINITIONS.—In this section, the terms ''group
18 health plan'', ''health insurance coverage'', and ''health in-
19 surance issuer'' have the meanings given such terms in
20 section 2791 of the Public Health Service Act (42 U.S.C.
21 300gg–91).
22 (e) EFFECTIVE DATE.—The requirement under sub-
23 section (a) shall take effect 6 months after the rules de-
24 scribed in subsection (b) are finalized.

1 **SEC. 6. REPORT BY SECRETARY OF LABOR.**

2 Not later than one year after the date of the enact-
3 ment of this Act, and annually thereafter for each of the
4 following 5 years, the Secretary of Labor shall—

5 (1) conduct a study of—

6 (A) the effects of the provisions of, includ-
7 ing amendments made by, this Act on pre-
8 miums and out-of-pocket costs in group health
9 plans, including out-of-pocket costs that are
10 permitted by reason of compliance with section
11 2799A(d) of the Public Health Service Act, as
12 added by section 2(d);

13 (B) the adequacy of provider networks in
14 group health plans; and

15 (C) such other effects of such provisions,
16 and amendments, as the Secretary deems rel-
17 evant; and

18 (2) submit a report on such study to the Com-
19 mittee on Health, Education, Labor, and Pensions
20 of the Senate and the Committee on Education and
21 Labor and the Committee on Energy and Commerce
22 of the House of Representatives.