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(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. _____

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

Mr. RUIZ introduced the following bill; which was referred to the Committee
on _____

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,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Protecting People From Surprise Medical Bills Act”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 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.

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

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

6 (1) in subsection (b)—

7 (A) in paragraph (1)—

8 (i) in the matter preceding subpara-
9 graph (A)—

10 (I) by striking “offering group or
11 individual health insurance issuer”
12 and inserting “offering group or indi-
13 vidual health insurance coverage”;
14 and

15 (II) by striking “paragraph
16 (2)(B)” and inserting “paragraph
17 (2)”;

18 (ii) in subparagraph (B), by inserting
19 “or a participating emergency facility, as
20 applicable,” after “participating provider”;
21 and

- 1 (iii) in subparagraph (C)—
- 2 (I) in the matter preceding clause
- 3 (i), by inserting “by a nonpartici-
- 4 pating provider or a nonparticipating
- 5 emergency facility” after “enrollee”;
- 6 (II) by striking clause (i);
- 7 (III) by striking “(ii)(I) such
- 8 services” and inserting “(i) such serv-
- 9 ices”;
- 10 (IV) by striking “where the pro-
- 11 vider of services does not have a con-
- 12 tractual relationship with the plan for
- 13 the providing of services”;
- 14 (V) by striking “emergency de-
- 15 partment services received from pro-
- 16 viders who do have such a contractual
- 17 relationship with the plan; and” and
- 18 inserting “emergency services received
- 19 from participating providers and par-
- 20 ticipating emergency facilities with re-
- 21 spect to such plan;”;
- 22 (VI) by striking “(II) if such serv-
- 23 ices” and all that follows through
- 24 “were provided in-network” and in-
- 25 serting the following:

1 “(ii) the cost-sharing requirement (ex-
2 pressed as a copayment amount or coinsur-
3 ance rate) is not greater than the require-
4 ment that would apply if such services
5 were provided by a participating provider
6 or a participating emergency facility;” and

7 (VII) by adding at the end the
8 following new clauses:

9 “(iii) the group health plan or health
10 insurance issuer offering group or indi-
11 vidual health insurance coverage pays to
12 such provider or facility, respectively, sub-
13 ject to subsection (f), the amount by which
14 the commercially reasonable rate, as deter-
15 mined by the plan or issuer, for such serv-
16 ices exceeds the cost-sharing amount for
17 such services (as determined in accordance
18 with clause (ii)) and, if applicable, any
19 amount to reconcile the difference between
20 such rate so paid and the specified rate de-
21 termined under subsection (f)(1)) for such
22 services; and

23 “(iv) there shall be counted toward
24 any deductible or out-of-pocket maximums
25 applied under the plan any cost-sharing

1 payments made by the participant, bene-
2 ficiary, or enrollee with respect to such
3 emergency services so furnished in the
4 same manner as if such cost-sharing pay-
5 ments were with respect to emergency
6 services furnished by a participating pro-
7 vider and a participating emergency facil-
8 ity.”; and

9 (B) in paragraph (2)—

10 (i) in the matter preceding subpara-
11 graph (A), by inserting “and subsection
12 (e)” after “this subsection”;

13 (ii) by redesignating subparagraph
14 (C) as subparagraph (H); and

15 (iii) by inserting after subparagraph
16 (C) the following subparagraphs:

17 “(D) NONPARTICIPATING EMERGENCY FA-
18 CILITY; PARTICIPATING EMERGENCY FACIL-
19 ITY.—

20 “(i) NONPARTICIPATING EMERGENCY
21 FACILITY.—The term ‘nonparticipating
22 emergency facility’ means, with respect to
23 an item or service and a group health plan
24 or health insurance coverage offered by a
25 health insurance issuer, an emergency de-

1 partment of a hospital or an independent
2 freestanding emergency department, that
3 does not have a contractual relationship
4 with the plan or coverage for furnishing
5 such item or service.

6 “(ii) PARTICIPATING EMERGENCY FA-
7 CILITY.—The term ‘participating emer-
8 gency facility’ means, with respect to an
9 item or service and a group health plan or
10 health insurance coverage offered by a
11 health insurance issuer, an emergency de-
12 partment of a hospital or an independent
13 freestanding emergency department, that
14 has a contractual relationship with the
15 plan or coverage for furnishing such item
16 or service.

17 “(E) NONPARTICIPATING PROVIDERS; PAR-
18 TICIPATING PROVIDERS.—

19 “(i) NONPARTICIPATING PROVIDER.—
20 The term ‘nonparticipating provider’
21 means, with respect to an item or service
22 and a group health plan or health insur-
23 ance coverage offered by a health insur-
24 ance issuer, a physician or other health
25 professional who is licensed by the State

1 involved to furnish such item or service
2 and who does not have a contractual rela-
3 tionship with the plan or coverage for fur-
4 nishing such item or service.

5 “(ii) PARTICIPATING PROVIDER.—The
6 term ‘participating provider’ means, with
7 respect to an item or service and a group
8 health plan or health insurance coverage
9 offered by a health insurance issuer, a phy-
10 sician or other health professional who is
11 licensed by the State involved to furnish
12 such item or service and who has a con-
13 tractual relationship with the plan or cov-
14 erage for furnishing such item or service.”.

15 (b) NON-EMERGENCY SERVICES PERFORMED BY
16 NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-
17 PATING FACILITIES.—Section 2719A of the Public Health
18 Service Act (42 U.S.C. 300gg–19a) is amended by adding
19 at the end the following new subsection:

20 “(e) NON-EMERGENCY SERVICES PERFORMED BY
21 NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-
22 PATING FACILITIES.—

23 “(1) IN GENERAL.—In the case of items or
24 services (other than emergency services to which
25 subsection (b) applies) furnished to a participant,

1 beneficiary, or enrollee of a health plan (as defined
2 in paragraph (2)(A)) by a nonparticipating provider
3 (as defined in subsection (b)(2)(G)) during a visit at
4 a participating health care facility (as defined in
5 paragraph (2)(B)) (including imaging or laboratory
6 services so furnished by a nonparticipating provider
7 when ordered by a participating provider or after-
8 emergency care furnished by a nonparticipating pro-
9 vider in the case that the participant, beneficiary, or
10 enrollee cannot travel without medical transport),
11 with respect to such plan, the plan—

12 “(A) shall not impose on such participant,
13 beneficiary, or enrollee a cost-sharing amount
14 (expressed as a copayment amount or coinsur-
15 ance rate) for such items and services so fur-
16 nished that is greater than the cost-sharing
17 amount that would apply under such plan had
18 such items or services been furnished by a par-
19 ticipating provider;

20 “(B) shall pay to such provider furnishing
21 such items and services to such participant,
22 beneficiary, or enrollee, subject to subsection
23 (f), the amount by which the commercially rea-
24 sonable rate, as determined by the plan or
25 issuer, for such services exceeds the cost-shar-

1 ing amount imposed for such services (as deter-
2 mined in accordance with subparagraph (A))
3 and, if applicable, any amount to reconcile the
4 difference between such rate so paid and the
5 specified rate determined under subsection
6 (f)(1)) for such services; and

7 “(C) shall count toward any deductible or
8 out-of-pocket maximums applied under the plan
9 any cost-sharing payments made by the partici-
10 pant, beneficiary, or enrollee with respect to
11 such items and services so furnished in the
12 same manner as if such cost-sharing payments
13 were with respect to items and services fur-
14 nished by a participating provider.

15 “(2) DEFINITIONS.—In this subsection and
16 subsection (f):

17 “(A) HEALTH PLAN.—The term ‘health
18 plan’ means a group health plan and health in-
19 surance coverage offered by a health insurance
20 issuer in the group or individual market.

21 “(B) PARTICIPATING HEALTH CARE FACIL-
22 ITY.—

23 “(i) IN GENERAL.—The term ‘partici-
24 pating health care facility’ means, with re-
25 spect to an item or service and a group

1 health plan or health insurance coverage
2 offered by a health insurance issuer, a
3 health care facility described in clause (ii)
4 that has a contractual relationship with
5 the plan or coverage for furnishing such
6 item or service.

7 “(ii) HEALTH CARE FACILITY DE-
8 SCRIBED.—A health care facility described
9 in this clause is each of the following:

10 “(I) A hospital (as defined in
11 1861(e) of the Social Security Act).

12 “(II) A critical access hospital
13 (as defined in section 1861(mm) of
14 such Act).

15 “(III) An ambulatory surgical
16 center (as defined in section
17 1833(i)(1)(A) of such Act).

18 “(IV) A laboratory.

19 “(V) A radiology or imaging cen-
20 ter.

21 “(VI) Any other facility that pro-
22 vides services that are covered under
23 a group health plan or health insur-
24 ance coverage.

1 “(VII) Any other facility speci-
2 fied by the Secretary.”.

3 (c) NEGOTIATION AND ARBITRATION PROCESS FOR
4 DETERMINING PRICES.—Section 2719A of the Public
5 Health Service Act (42 U.S.C. 300gg–19a), as amended
6 by subsection (b), is further amended by adding at the
7 end the following new subsection:

8 “(f) NEGOTIATION AND ARBITRATION PROCESS.—

9 “(1) SPECIFIED AMOUNT.—For purposes of
10 subsections (b) and (e) and this subsection, the spec-
11 ified amount determined under this subsection, with
12 respect to a health plan and nonparticipating pro-
13 vider for an item or service, is—

14 “(A) in the case the plan and provider
15 enter into negotiations pursuant to paragraph
16 (2) and such negotiations are successful, the
17 amount determined for such item or service
18 pursuant to such negotiations; or

19 “(B) in the case the plans and provider
20 enter into such negotiations but such negotia-
21 tions are not successful, the reasonable amount
22 determined for such item or service pursuant to
23 the independent dispute resolution process
24 under paragraph (3).

1 “(2) NEGOTIATIONS.—For purposes of sub-
2 sections (b)(1)(C)(iii) and (e)(1)(B), in the case of
3 a payment of a commercially reasonable rate made
4 by a health plan to a nonparticipating provider pur-
5 suant to such respective subsection for an item or
6 service, the provider and plan may, not later than 30
7 days after the date of such payment, negotiate an
8 amount of payment (other than the commercially
9 reasonable rate specified in such subsection) to be
10 made for such item or service.

11 “(3) INDEPENDENT DISPUTE RESOLUTION.—

12 “(A) IN GENERAL.—If, by the end of such
13 30-day period specified in paragraph (2), the
14 plan and provider have not determined a nego-
15 tiated amount for the payment involved, the
16 plan or provider may initiate an independent
17 dispute resolution process under this paragraph
18 to determine the amount of payment.

19 “(B) ESTABLISHMENT OF IDR.—

20 “(i) IN GENERAL.—Not later than
21 January 1, 2021, the Secretary, in con-
22 sultation with the Secretary of Labor, shall
23 establish a process for resolving payment
24 disputes between health plans and non-
25 participating providers for purposes of de-

1 termining amounts of payments to be
2 made by the plans to the providers pursu-
3 ant to subsections (b) and (e) (referred to
4 in this section as the ‘IDR process’).

5 “(ii) ENTITIES.—An entity wishing to
6 participate in the IDR process under this
7 subsection shall request certification from
8 the Secretary. The Secretary, in consulta-
9 tion with the Secretary of Labor, shall de-
10 termine eligibility of applicant entities, tak-
11 ing into consideration whether the entity is
12 unbiased and unaffiliated with health plans
13 and providers and free of conflicts of inter-
14 est, in accordance with the Secretary’s
15 rulemaking on determining criteria for con-
16 flicts of interest.

17 “(iii) APPLICABLE CLAIMS.—

18 “(I) IN GENERAL.—The IDR
19 process shall be with respect to one or
20 more Current Procedural Terminology
21 (‘CPT’) codes.

22 “(II) BATCHING OF CLAIMS.—
23 Claims may be batched if such
24 claims—

1 “(aa) involve identical plan
2 or issuer and provider or facility
3 parties;

4 “(bb) involve claims with the
5 same or related current proce-
6 dural terminology codes relevant
7 to a particular procedure; and

8 “(cc) involve claims that
9 occur within 60 days of each
10 other.

11 “(C) INDEPENDENT DISPUTE RESOLUTION
12 PROCESS.—

13 “(i) TIMING.—In the case of an IDR
14 entity that receives a request under this
15 paragraph, with respect to a payment
16 amount to be paid by a health plan to a
17 nonparticipating provider—

18 “(I) the plan and provider may,
19 during the 30-day period following the
20 date of receipt of such request, submit
21 any information or supporting docu-
22 mentation to the IDR entity; and

23 “(II) the IDR entity shall, not
24 later than 60 days after receiving
25 such request, determine such amount.

1 “(ii) DETERMINATION OF AMOUNT.—

2 “(I) IN GENERAL.—The amount
3 determined by the IDR entity under
4 clause (i), with respect to a payment
5 amount to be paid by a health plan to
6 a nonparticipating provider for an
7 item or service shall be—

8 “(aa) the initial charge for
9 the item or service made by the
10 provider or the commercially rea-
11 sonable rate paid by the plan for
12 the item or service under sub-
13 sections (b)(1)(C)(iii) or
14 (e)(1)(B), respectively, whichever
15 is determined reasonable by the
16 entity based on the factors de-
17 scribed in subclause (III); or

18 “(bb) in the case neither
19 such charge or such rate is deter-
20 mined by the entity to be reason-
21 able, the final offer submitted
22 under subclause (II) that is de-
23 termined more reasonable in ac-
24 cordance with such subclause.

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

19 “(III) FACTORS.—For purposes
20 of subclauses (I) and (II), the factors
21 described in this subclause include, as
22 relevant—

23 “(aa) commercially reason-
24 able rates for comparable services
25 or items in the same geographic

1 area (which shall take into con-
2 sideration in-network rates for
3 that geographic area and not
4 charges);

5 “(bb) the usual and cus-
6 tomary cost of the item or service
7 involved, determined as the 80th
8 percentile of charges for com-
9 parable items and services for the
10 specialty involved in the geo-
11 graphical area in which the item
12 or service was furnished, as de-
13 termined through reference to a
14 medical claims database;

15 “(cc) other factors that may
16 be submitted at the discretion of
17 either party, which may in-
18 clude—

19 “(dd) the level of training,
20 education, experience, and quality
21 and outcomes measurements of
22 the nonparticipating provider;

23 “(ee) the circumstances and
24 complexity of the particular dis-

1 pute, including the time and
2 place of the service;

3 “(ff) the provider’s quality
4 and outcome metrics;

5 “(gg) the provider’s usual
6 charge for comparable services
7 with regard to patients in health
8 care plans in which the provider
9 is not participating;

10 “(hh) the individual patient
11 characteristics; and

12 “(ii) other relevant economic
13 and clinical factors.

14 “(IV) FINAL DECISIONS.—The
15 amount that is determined to be the
16 more reasonable amount under item
17 (aa) or (bb) of subclause (I), as appli-
18 cable, shall be the final decision of the
19 IDR entity as to the amount the
20 health plan is required to pay the pro-
21 vider.

22 “(V) EFFECT OF DETERMINA-
23 TION.—A final determination of an
24 IDR entity under subclause (IV)—

25 “(aa) shall be binding; and

1 “(bb) shall not be subject to
2 judicial review, except in cases
3 comparable to those described in
4 section 10(a) of title 9, United
5 States Code, as determined by
6 the Secretary in consultation
7 with the Secretary of Labor, and
8 cases in which information sub-
9 mitted by one party was deter-
10 mined to be fraudulent.

11 “(iii) PRIVACY LAWS.—An IDR entity
12 shall, in conducting an independent dispute
13 resolution process under this paragraph,
14 comply with all applicable Federal and
15 State privacy laws.

16 “(iv) PUBLIC AVAILABILITY.—The
17 reasonable amount determined by an IDR
18 entity under this paragraph with respect to
19 any claim shall not be confidential, except
20 that information submitted to the IDR en-
21 tity shall be kept confidential. IDR entities
22 may consider past decisions awarded by
23 independent dispute entities during the
24 independent dispute resolution process.

1 “(v) COSTS OF INDEPENDENT DIS-
2 PUTE RESOLUTION PROCESS.—The non-
3 prevailing party shall be responsible for
4 paying all fees charged by the IDR entity.
5 If the parties reach a settlement prior to
6 completion of the IDR process, the costs of
7 the independent dispute resolution process
8 shall be divided equally between the par-
9 ties.

10 “(vi) PAYMENT.—Any difference be-
11 tween—

12 “(I) the amount determined to be
13 paid by one party of the dispute reso-
14 lution to another pursuant to this
15 paragraph; and

16 “(II) the amounts already paid
17 under subsection (b) or (e) before en-
18 tering into the process under this
19 paragraph,

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

23 “(D) PUBLICATION.—The Secretary shall
24 publish aggregated results of the independent
25 dispute resolution by geographic region in order

1 to give more guidance to providers and health
2 plans.”.

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

7 “(t)(1) Subject to paragraph (3), in the case of an
8 individual with benefits under a health plan or health in-
9 surance coverage offered in the group or individual market
10 who is furnished on or after January 1, 2021, emergency
11 services with respect to an emergency medical condition
12 during a visit at an emergency department of a hospital—

13 “(A) if the emergency department of a hospital
14 holds the individual liable for a payment amount for
15 such emergency services so furnished that is more
16 than the cost-sharing amount for such services (as
17 determined in accordance with section
18 2719A(b)(1)(C)(ii) of the Public Health Service
19 Act); or

20 “(B) if any health care provider holds such in-
21 dividual liable for a payment amount for an emer-
22 gency service furnished to such individual by such
23 provider with respect to such emergency medical
24 condition and visit for which the individual receives
25 emergency services at the hospital or emergency de-

1 partment that is more than the cost-sharing amount
2 for such services furnished by the provider (as deter-
3 mined in accordance with section 2719A(b)(1)(C)(ii)
4 of the Public Health Service Act);
5 the hospital, emergency department or health care
6 provider, respectively, shall be subject, in addition to
7 any other penalties that may be prescribed by law,
8 to a civil money penalty of not more than an amount
9 determined appropriate by the Secretary for each
10 specified claim.

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

16 “(3) Paragraph (1) shall not apply to an emergency
17 department of a hospital or a provider, with respect to
18 items or services furnished to a participant, beneficiary,
19 or enrollee of a health plan or health insurance coverage
20 offered by a health insurance issuer, if the emergency de-
21 partment of the hospital or the provider, respectively, re-
22 imburses such participant, beneficiary, or enrollee any
23 amount for such an item or service that is more than the
24 cost-sharing amount for such item or service (as deter-
25 mined in accordance with section 2719A(e)(1)(A)) not

1 later than 30 days after the date the emergency depart-
2 ment of the hospital or provider, respectively, knew or
3 should have known such excess payment was in violation
4 of this subsection.

5 “(4) In this subsection and subsection (u):

6 “(A) The terms ‘emergency medical condition’
7 and ‘emergency services’ have the meanings given
8 such terms, respectively, in section 2719A(b)(2) of
9 the Public Health Service Act.

10 “(B) The terms ‘group health plan’, ‘health in-
11 surance issuer’, and ‘health insurance coverage’ have
12 the meanings given such terms, respectively, in sec-
13 tion 2791 of the Public Health Service Act.

14 “(u)(1) Subject to paragraph (2), in the case of an
15 individual with benefits under a health plan or health in-
16 surance coverage offered in the group or individual market
17 who is furnished on or after January 1, 2021, items or
18 services (other than emergency services to which sub-
19 section (t) applies) during an episode of care (as defined
20 by the Secretary) at a participating health care facility
21 by a nonparticipating provider (including imaging or lab-
22 oratory services so furnished by a nonparticipating pro-
23 vider when ordered by a participating provider or after-
24 emergency care furnished by a nonparticipating provider
25 in the case that the participant, beneficiary, or enrollee

1 cannot travel without medical transport), if such non-
2 participating provider holds such individual liable for a
3 payment amount for such an item or service furnished by
4 such provider that is more than the cost-sharing amount
5 for such item or service (as determined in accordance with
6 section 2719A(e)(1)(A) of the Public Health Service Act),
7 such provider shall be subject, in addition to any other
8 penalties that may be prescribed by law, to a civil money
9 penalty of not more than \$an amount determined appro-
10 priate by the Secretary for each specified claim.

11 “(2) Paragraph (1) shall not apply to a nonpartici-
12 pating provider, with respect to items or services furnished
13 by the provider to a participant, beneficiary, or enrollee
14 of a health plan or health insurance coverage offered by
15 a health insurance issuer, if the provider reimburses such
16 participant, beneficiary, or enrollee any amount for such
17 an item or service that is more than the cost-sharing
18 amount for such item or service (as determined in accord-
19 ance with section 2719A(e)(1)(A) not later than 30 days
20 after the date the provider knew or should have known
21 such excess payment was in violation of this subsection.

22 “(3) For purposes of this subsection, the terms ‘non-
23 participating provider’ and ‘participating health care facil-
24 ity’ have such meanings given such terms under sub-

1 sections (b)(2) and (e)(2), respectively, of section 2719A
2 of the Public Health Service Act.”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply with respect to plan years begin-
5 ning on or after January 1, 2021.

6 **SEC. 3. TRANSPARENCY REGARDING IN-NETWORK AND**
7 **OUT-OF-NETWORK DEDUCTIBLES.**

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

11 **“SEC. 2729A. TRANSPARENCY REGARDING IN-NETWORK**
12 **AND OUT-OF-NETWORK DEDUCTIBLES.**

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

21 “(b) GUIDANCE.—The Secretary, in consultation
22 with the Secretary of Labor, shall issue guidance to imple-
23 ment subsection (a).”.

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply with respect to plan years begin-

1 ning on or after the date that is one year after the date
2 of the enactment of this Act.

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

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

8 **“SEC. 2729B. TRANSPARENCY FOR IN-NETWORK PATIENTS.**

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

20 “(1) Such plans and coverage offer provider di-
21 rectories online and in print.

22 “(2) Annual audits of such provider directories,
23 as specified by the Secretary.

24 “(3) Monthly updates of such online directories.

1 “(b) GUIDANCE.—Beginning January 1, 2022, a
2 group health plan or a health insurance issuer offering
3 group or individual health insurance coverage shall be in
4 compliance with the standards established pursuant to
5 subsection (a).”.

6 **SEC. 5. REPORTING REQUIREMENTS.**

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

11 **“SEC. 2729C. TRANSPARENCY REQUIREMENTS.**

12 “(a) IN GENERAL.—Each group health plan and
13 health insurance issuer offering group or individual health
14 insurance coverage shall annually report (beginning for
15 plan year 2021) to the Secretary and the Secretary of
16 Labor, with respect to the applicable plan or coverage for
17 the applicable plan year—

18 “(1) the total claims that were submitted by in-
19 network health care providers with respect to enroll-
20 ees under the plan or coverage, and the number of
21 such claims that were paid and the number of such
22 claims that were denied;

23 “(2) the total claims that were submitted by
24 out-of-network health care providers with respect to
25 enrollees under the plan or coverage, and the num-

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

3 “(3) with respect to each out-of-network claim,
4 the out-of-pocket costs to the enrollee for the serv-
5 ices;

6 “(4) the number of out-of-network claims re-
7 ported under paragraph (2) that are for emergency
8 services; and

9 “(5) the number of out-of-network claims re-
10 ported under paragraph (2) that relate to care at in-
11 network hospitals or facilities provided by out-of-net-
12 work providers.

13 “(b) CLARIFICATION.—The information required to
14 be submitted under this section shall be in addition to the
15 information required to be submitted under section
16 2715A.”.

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

18 Notwithstanding any other provision of law, a health
19 care provider may not seek reimbursement from an indi-
20 vidual for a service furnished by such provider to such in-
21 dividual more than a year after such date of service. Any
22 provider that bills an individual in violation of the previous
23 sentence shall be subject to a civil monetary penalty in
24 such amount as specified by the Secretary of Health and
25 Human Services.

1 **[SEC. 7. APPLICATION.**

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

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

20 (b) APPLICATION TO FEHB.—

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

24 “(p) Each contract under this chapter shall require
25 the carrier to comply with requirements described in the
26 provisions of subsections (b), (e), and (f) of section 2719A

1 of the Public Health Service Act and sections 2729A and
2 2729B of such Act in the same manner as those provisions
3 apply to a groups health plan or health insurance issuer
4 offering health insurance coverage, as described in such
5 sections.”.

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

11 **SEC. 8. STUDIES BY SECRETARIES OF HEALTH AND HUMAN**
12 **SERVICES AND OF LABOR.**

13 (a) IMPACT STUDY.—Not later than 3 years after the
14 date of enactment of this Act, the Secretary of Health and
15 Human Services, in consultation with the Secretary of
16 Labor, shall conduct a study of the effects of this Act (in-
17 cluding the amendments made by this Act), and submit
18 to Congress (and make public) a report on the findings
19 of such study, which shall include information and anal-
20 ysis on—

21 (1) the financial impact on patient responsi-
22 bility for health care spending and overall health
23 care spending;

24 (2) the incidence and prevalence of the delivery
25 of unanticipated out-of-network health care services,

1 in the cases of emergency services and in the cases
2 of care at in-network hospitals or facilities provided
3 by out-of-network providers;

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

8 (4) a comparison of the different claims data-
9 bases used and ;the impact of using such databases
10 on reimbursement rates;

11 (5) the number of bills that are settled through
12 negotiations pursuant to subsection (f)(2) of section
13 2719A of the Public Health Service Act (42 U.S.C.
14 300gg–19a), as added by section 2, and the number
15 of bills that go to the independent dispute resolution
16 process under subsection (f)(3) of such section, as so
17 added; and

18 (6) the administrative cost of such independent
19 dispute resolution process; and

20 (7) the estimated impact of such independent
21 dispute resolution process on health insurance pre-
22 miums and deductibles.

23 (b) BILLING FEASIBILITY STUDY.—Not later than 3
24 years after the date of the enactment of this Act, the Sec-
25 retary of Health and Human Services shall conduct, and

1 submit to Congress (and make public), a feasibility study
2 on the provision of a single bill for all services provided
3 for a single episode of care, as defined by the Secretary.

4 **SEC. 9. REGULATIONS.**

5 Not later than one year after the date of the enact-
6 ment of this Act, the Secretary of Labor and the Secretary
7 of Health and Human Services shall promulgate regula-
8 tions pertaining to carry out the provisions (including
9 amendments made by) this Act.