

115TH CONGRESS
2D SESSION

S. 3592

To amend the Public Health Service Act to prevent surprise medical billing practices, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 11, 2018

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

A BILL

To amend the Public Health Service Act to prevent surprise medical 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 More Surprise
5 Medical Bills Act of 2018”.

6 **SEC. 2. PREVENTING SURPRISE BILLING PRACTICES.**

7 (a) IN GENERAL.—

8 (1) PROHIBITION.—Subpart II of part A of
9 title XXVII of the Public Health Service Act (42

1 U.S.C. 300gg–11 et seq.) is amended by adding at
 2 the end the following:

3 **“SEC. 2729. PREVENTING SURPRISE BILLING PRACTICES.**

4 “(a) DEFINITIONS.—In this section:

5 “(1) HEALTH CARE PROVIDER.—The term
 6 ‘health care provider’ means—

7 “(A) a hospital (as defined in section
 8 1861(e) of the Social Security Act);

9 “(B) a critical access hospital (as defined
 10 in section 1861(mm) of such Act);

11 “(C) an ambulatory surgical center as de-
 12 scribed in section 1833(i)(1)(A) of such Act; or

13 “(D) a provider of services or supplier fur-
 14 nishing services at such hospital, critical access
 15 hospital, or ambulatory surgical center.

16 “(2) IN-NETWORK HEALTH CARE PROVIDER.—
 17 The term ‘in-network health care provider’, with re-
 18 spect to a group health plan or health insurance cov-
 19 erage offered in the group market, means a health
 20 care provider that is within the health care provider
 21 network of the plan or coverage or is otherwise a
 22 participating provider of services or supplier with re-
 23 spect to such plan or coverage.

24 “(3) OUT-OF-NETWORK HEALTH CARE PRO-
 25 VIDER.—The term ‘out-of-network health care pro-

vider’, with respect to a group health plan or health insurance coverage offered in the group market, means a health care provider that is not within the health care provider network of the plan or coverage or is not otherwise a participating provider of services or supplier with respect to such plan or coverage.

“(b) REQUIREMENT FOR NOTICE AND CONSENT.—

“(1) NOTICE.—A health care provider, in the case of an individual enrolled in a group health plan or health insurance coverage offered in the group market, who seeks to be furnished items or services or is to be furnished items or services by the provider, shall—

“(A)(i) provide to the individual (or to a representative of the individual), on the date on which the individual makes an appointment to be furnished such items or services, if applicable, and on the date on which the individual is furnished such items and services—

“(I) an oral explanation of the written notification described in subclause (II) and such documentation of the provision of such explanation, as the Secretary determines appropriate; and

1 “(II) a written notice specified by the
2 Secretary through rulemaking that—

3 “(aa) contains the information
4 required under paragraph (2); and

5 “(bb) is signed and dated by the
6 individual; and

7 “(ii) retain, for a period specified through
8 rulemaking by the Secretary, a copy of the doc-
9 umentation described in clause (i)(I) and the
10 written notice described in clause (i)(II); and

11 “(B) in the case that such provider is an
12 out-of-network health care provider, obtain
13 from the individual the consent described in
14 paragraph (3).

15 “(2) INFORMATION INCLUDED IN NOTICE.—
16 The notice described in paragraph (1)(A) shall in-
17 clude, with respect to the individual described in
18 such paragraph, a notification of each of the fol-
19 lowing:

20 “(A) Whether the health care provider is
21 an out-of-network health care provider with re-
22 spect to the group health plan, or health insur-
23 ance coverage offered in the group market, of
24 such individual.

1 “(B) If the health care provider is such an
2 out-of-network health care provider, the esti-
3 mated amount that such provider will charge
4 the individual for such items and services in ex-
5 cess of any cost sharing obligations that the in-
6 dividual would otherwise have under such plan
7 or coverage for such items and services if the
8 health care provider were an in-network health
9 care provider with respect to the plan or cov-
10 erage of such individual.

11 “(C) In the case of a health care provider
12 that is a hospital, critical access hospital, or
13 ambulatory surgical center as described in sub-
14 paragraph (A), (B), or (C) of subsection (a)(1),
15 respectively—

16 “(i) whether any of the providers of
17 services or suppliers furnishing items or
18 services at such hospital, critical access
19 hospital, or ambulatory surgical center who
20 will furnish the items or services to the in-
21 dividual are out-of-network health care
22 providers with respect to the group health
23 plan, or health insurance coverage offered
24 in the group market, of such individual;
25 and

1 “(ii) if any such providers of services
2 or suppliers are such out-of-network health
3 care providers, the estimated amount that
4 such providers or suppliers will charge the
5 individual for such items and services in
6 excess of any cost sharing obligations that
7 the individual would otherwise have for
8 such items and services if the providers or
9 suppliers were in-network health care pro-
10 viders with respect to the plan or coverage
11 of such individual.

12 “(3) CONSENT DESCRIBED.—For purposes of
13 paragraph (1)(B), the consent described in this
14 paragraph, with respect to an individual enrolled in
15 a group health plan, or health insurance coverage of-
16 fered in the group market, who is to be furnished
17 items or services by an out-of-network health care
18 provider, is a document specified by the Secretary
19 through rulemaking that is signed by the individual
20 (or by a representative of the individual) not less
21 than 24 hours prior to the individual being furnished
22 such items or services by such health care provider,
23 and that—

24 “(A) acknowledges that the individual has
25 been—

1 “(i) provided with a written estimate
 2 and an oral explanation of the charge that
 3 the individual will be assessed for the items
 4 or services anticipated to be furnished to
 5 the individual by such out-of-network
 6 health care provider; and

7 “(ii) informed that the payment of
 8 such charge by the individual will not ac-
 9 crue toward meeting any limitation that
 10 the group health plan, or health insurance
 11 coverage offered in the group market,
 12 places on cost-sharing; and

13 “(B) documents the consent of the indi-
 14 vidual to—

15 “(i) be furnished with such items or
 16 services by such out-of-network health care
 17 provider; and

18 “(ii) in the case that the individual is
 19 so furnished such items or services, be
 20 charged an amount approximate to the es-
 21 timated charge described in subparagraph
 22 (A)(i) with respect to such items or serv-
 23 ices.

24 “(c) LIMITATIONS ON BALANCE BILLING IN SUR-
 25 PRISE BILLING SITUATIONS.—

1 “(1) IN CASE OF NONCOMPLIANCE WITH NO-
2 TICE AND CONSENT REQUIREMENTS.—In the case of
3 an individual enrolled in a group health plan, or
4 health insurance coverage offered in the group mar-
5 ket, who is furnished items or services by an out-of-
6 network health care provider with respect to such
7 plan or coverage, if the out-of-network health care
8 provider does not comply with the requirements of
9 subsection (b) with respect to the furnishing of such
10 items or services to such individual, the out-of-net-
11 work health care provider may not charge the indi-
12 vidual more than the amount that the individual
13 would have been required to pay in cost sharing if
14 such items or services had been furnished by an in-
15 network health care provider with respect to such
16 plan or coverage.

17 “(2) IN CASE OF SAME-DAY EMERGENCY SERV-
18 ICES.—In the case of an individual enrolled in a
19 group health plan or health insurance coverage of-
20 fered in the group market who is furnished items or
21 services by a health care provider that is an out-of-
22 network health care provider with respect to such
23 plan or coverage on the same date on which the indi-
24 vidual makes an appointment for such items or serv-
25 ices (or otherwise presents at the hospital, critical

1 access hospital, or ambulatory surgical center for
 2 such services such as in the case of items and serv-
 3 ices furnished with respect to an emergency medical
 4 condition, as defined in section 1867(e)), the out-of-
 5 network health care provider may not charge the in-
 6 dividual more than the amount that the individual
 7 would have been required to pay in cost sharing if
 8 such items or services had been furnished by an in-
 9 network health care provider with respect to such
 10 plan or coverage.”.

11 (2) EFFECTIVE DATE.—The amendment made
 12 by paragraph (1) shall take effect beginning 2 years
 13 after the date of the enactment of this Act.

14 (b) CONDITION OF PARTICIPATION IN MEDICARE.—

15 (1) IN GENERAL.—Section 1866(a)(1) of the
 16 Social Security Act (42 U.S.C. 1395cc(a)(1)) is
 17 amended—

18 (A) in subparagraph (X), by striking
 19 “and” at the end;

20 (B) in subparagraph (Y), by striking at
 21 the end the period and inserting “, and”; and

22 (C) by inserting after such subparagraph
 23 (Y) the following new subparagraph:

24 “(Z) in the case of a hospital, a critical ac-
 25 cess hospital, or an ambulatory surgical center

described in section 1833(i)(1)(A), to adopt and enforce a policy to ensure compliance with the requirements of subsections (b) and (c) of section 2729 of the Public Health Service Act and to meet the requirements of such subsections (relating to the prevention of surprise billing practices);”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to agreements under such section 1866(a)(1) that are filed with the Secretary of Health and Human Services on a date that is not less than 2 years after the date of the enactment of this Act.

**SEC. 3. PAYMENTS MADE BY INSURED INDIVIDUALS IN
SURPRISE BILLING SITUATIONS INCLUDED
IN COST-SHARING LIMITATIONS.**

(a) IN GENERAL.—Section 2707 of the Public Health Service Act (42 U.S.C. 300gg–6) is amended by adding at the end the following:

“(e) SURPRISE BILLING SITUATIONS.—Notwithstanding section 1302(c)(3)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(c)(3)(B)), any group health plan or health insurance issuer offering health insurance coverage in the group market shall ensure that any amount paid by an individual enrolled in

1 such plan or coverage in a surprise billing situation, as
 2 defined in section 2730(a), accrues towards meeting any
 3 annual limitation on cost-sharing under the plan or cov-
 4 erage.”.

5 (b) **EFFECTIVE DATE.**—The amendments made by
 6 subsection (a) shall apply with respect to any plan year
 7 beginning not earlier than 2 years after the date of enact-
 8 ment of this Act.

9 **SEC. 4. RESOLVING PAYMENT DISPUTES IN SURPRISE BILL-**
 10 **ING SITUATIONS.**

11 Subpart II of part A of title XXVII of the Public
 12 Health Service Act (42 U.S.C. 300gg–11 et seq.), as
 13 amended by section 2(a), is further amended by adding
 14 at the end the following:

15 **“SEC. 2730. RESOLVING PAYMENT DISPUTES IN SURPRISE**
 16 **BILLING SITUATIONS.**

17 “(a) **DEFINITIONS.**—In this section:

18 “(1) **HEALTH CARE PROVIDER; IN-NETWORK**
 19 **HEALTH CARE PROVIDER; OUT-OF-NETWORK**
 20 **HEALTH CARE PROVIDER.**—The terms ‘health care
 21 provider’, ‘in-network health care provider’, and
 22 ‘out-of-network health care provider’ have the mean-
 23 ings given such terms in section 2729(a).

24 “(2) **INDEPENDENT DISPUTE RESOLUTION EN-**
 25 **TITY.**—The term ‘independent dispute resolution en-

1 tity’ means an entity certified by the Secretary, in
2 consultation with the Secretary of Labor, under sub-
3 section (b)(2) to conduct an independent dispute res-
4 olution process under subsection (d).

5 “(3) SURPRISE BILLING SITUATION.—The term
6 ‘surprise billing situation’ means—

7 “(A) a situation in which an individual
8 who is enrolled in a group health plan, or
9 health insurance coverage offered in the group
10 market, is furnished items or services by an
11 out-of-network health care provider and such
12 provider does not comply with the requirements
13 of section 2729(b) with respect to the fur-
14 nishing of such items or services to such indi-
15 vidual; or

16 “(B) a situation in which an individual
17 who is enrolled in a group health plan, or
18 health insurance coverage offered in the group
19 market, is furnished items or services by an
20 out-of-network health care provider on the same
21 date on which the individual makes an appoint-
22 ment for such items or services (or otherwise
23 presents at the hospital, critical access hospital,
24 or ambulatory surgical center for such services
25 such as in the case of items and services fur-

1 nished with respect to an emergency medical
2 condition, as defined in section 1867(e)).

3 “(b) ESTABLISHMENT OF INDEPENDENT DISPUTE
4 RESOLUTION PROCESS.—

5 “(1) ESTABLISHMENT.—Not later than 2 years
6 after the date of enactment of this section, the Sec-
7 retary, in consultation with the Secretary of Labor,
8 shall establish a process for resolving payment dis-
9 putes between group health plans, or health insur-
10 ance issuers offering health insurance coverage in
11 the group market, and out-of-network health care
12 providers in surprise billing situations in accordance
13 with this section.

14 “(2) CERTIFICATION OF INDEPENDENT DIS-
15 PUTE RESOLUTION ENTITIES.—

16 “(A) IN GENERAL.—The Secretary, in con-
17 sultation with the Secretary of Labor, shall es-
18 tablish a process through rulemaking to certify
19 entities as independent dispute resolution enti-
20 ties to conduct independent dispute resolution
21 processes under subsection (d).

22 “(B) REQUIREMENTS.—To be eligible for
23 certification under this paragraph, an entity
24 shall—

1 “(i) have experience in health care
 2 billing, health care pricing, and arbitration;
 3 and

4 “(ii) not have any conflict of interest,
 5 as determined in accordance with subpara-
 6 graph (C).

7 “(C) CONFLICT OF INTEREST.—The Sec-
 8 retary, in consultation with the Secretary of
 9 Labor, shall determine, through rulemaking, the
 10 criteria for a conflict of interest for purposes of
 11 subparagraph (B)(ii), which shall include—

12 “(i) having any material arrangement,
 13 financial or otherwise, that could bias the
 14 entity, or an employee of the entity work-
 15 ing on a particular dispute; or

16 “(ii) owning or controlling, being
 17 owned by or controlled by, or being under
 18 common control of—

19 “(I) any pharmaceutical com-
 20 pany, disease group, or public advoca-
 21 cy group;

22 “(II) any national, State, or local
 23 society or association of hospitals,
 24 physicians, or other providers of
 25 health care services; or

1 “(III) any national, State, or
2 local association of health care plans.

3 “(c) PRE-INDEPENDENT DISPUTE RESOLUTION
4 PROCESS.—

5 “(1) REQUIREMENT TO PAY OUT-OF-NETWORK
6 HEALTH CARE PROVIDERS.—

7 “(A) REQUIREMENT ON PLAN.—The proc-
8 ess established by the Secretary, in consultation
9 with the Secretary of Labor, under this section
10 shall require that a group health plan, or health
11 insurance issuer offering health insurance cov-
12 erage in the group market, that receives a bill
13 from an out-of-network health care provider for
14 items or services furnished to an individual en-
15 rolled in the plan or coverage in a surprise bill-
16 ing situation, not later than 30 days after re-
17 ceiving such bill—

18 “(i) pay the out-of-network health
19 care provider the amount in the bill; or

20 “(ii) attempt to negotiate with the
21 out-of-network health care provider an al-
22 ternative amount for the plan or issuer to
23 pay the provider.

24 “(B) PRE-INDEPENDENT DISPUTE RESO-
25 LUTION NEGOTIATIONS.—If, not later than 30

1 days after the date on which negotiations begin
 2 under subparagraph (A)(ii), an out-of-network
 3 health care provider and group health plan, or
 4 health insurance issuer offering health insur-
 5 ance coverage in the group market, described in
 6 subparagraph (A) have not agreed upon an al-
 7 ternative amount for the plan or issuer to pay
 8 the provider, the plan or issuer shall—

9 “(i) pay the provider the amount the
 10 plan or issuer determines reasonable for
 11 the services (less the cost-sharing amount
 12 paid by the individual enrolled in the plan
 13 or coverage); and

14 “(ii) provide information to the pro-
 15 vider on how the provider may initiate an
 16 independent dispute resolution process
 17 under paragraph (2).

18 “(2) INITIATING AN INDEPENDENT DISPUTE
 19 RESOLUTION PROCESS.—

20 “(A) IN GENERAL.—If, after a good faith
 21 attempt to negotiate under paragraph
 22 (1)(A)(ii), the out-of-network health care pro-
 23 vider and group health plan, or health insur-
 24 ance issuer offering health insurance coverage
 25 in the group market, described in paragraph

1 (1)(A) are unable to reach an agreement on an
2 amount for the plan or issuer to pay the pro-
3 vider, any party to the dispute may, not later
4 than 30 days of being unable to come to an
5 agreement, as determined by the Secretary, in
6 consultation with the Secretary of Labor, ini-
7 tiate an independent dispute resolution process
8 under subsection (d) by submitting a request
9 for such process to the Secretary, and the Sec-
10 retary of Labor, or directly to an independent
11 dispute resolution entity, in accordance with the
12 process established by the Secretary, in con-
13 sultation with the Secretary of Labor, under
14 this section.

15 “(B) REQUEST.—A request submitted
16 under subparagraph (A) shall indicate—

17 “(i) the amount the out-of-network
18 health care provider requested in the bill
19 described in subparagraph (A) of para-
20 graph (1) or after attempted negotiations
21 in accordance with such paragraph; and

22 “(ii) the amount the group health
23 plan, or health insurance issuer offering
24 health insurance coverage in the group
25 market, paid the out-of-network health

1 care provider in accordance with paragraph
 2 (1)(B) after such negotiations.

3 “(C) NOTICE TO OTHER PARTY.—A party
 4 initiating an independent dispute resolution
 5 process under subparagraph (A) shall, not later
 6 than 10 days after submitting a request under
 7 such subparagraph, notify the other party that
 8 such request has been submitted.

9 “(d) INDEPENDENT DISPUTE RESOLUTION PROC-
 10 ESS.—

11 “(1) IN GENERAL.—The Secretary, in consulta-
 12 tion with the Secretary of Labor, shall establish pro-
 13 cedures for independent dispute resolution entities to
 14 conduct independent dispute resolution processes
 15 under this subsection to resolve payment disputes
 16 between group health plans, or health insurance
 17 issuers offering health insurance coverage in the
 18 group market, and out-of-network health care pro-
 19 viders.

20 “(2) TIMING.—An independent dispute resolu-
 21 tion entity that receives a request under subsection
 22 (c)(2)(A) shall, not later than 30 days after receiv-
 23 ing such request, determine the amount the group
 24 health plan, or health insurance issuer offering
 25 health insurance coverage in the group market, is re-

quired 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 (3); or

“(B) the amount determined reasonable by the entity in accordance with paragraph (4).

“(3) SETTLEMENT.—

“(A) IN GENERAL.—If the independent dispute resolution entity determines, based on the amounts indicated in the request under subsection (c)(2)(B), that a settlement between the group health plan, or health insurance issuer offering health insurance coverage in the group market, and out-of-network health care provider is likely or that the amounts provided in such subsection each represent unreasonable extremes, 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 (2).

“(4) DETERMINATION OF AMOUNT.—

1 “(A) FINAL OFFERS.—In the absence of a
2 settlement under paragraph (3), the group
3 health plan, or health insurance issuer offering
4 health insurance coverage in the group market,
5 and out-of-network health care provider shall
6 each submit to the independent dispute resolu-
7 tion entity an amount as a final offer. Such en-
8 tity shall determine which of those 2 amounts
9 is more reasonable based on the factors de-
10 scribed in subparagraph (D).

11 “(B) FINAL DECISIONS.—The amount that
12 is determined to be the more reasonable amount
13 under subparagraph (A) shall be the final deci-
14 sion of the independent dispute resolution entity
15 as to the amount the group health plan, or
16 health insurance issuer offering health insur-
17 ance coverage in the group market, is required
18 to pay the out-of-network health care provider.

19 “(C) SERVICE UNITS.—A final offer sub-
20 mitted under subparagraph (A) shall be made
21 per service unit, as defined by the Secretary, in
22 consultation with the Secretary of Labor,
23 through regulations. A final decision under sub-
24 paragraph (B) may include the resolution of
25 disputes for multiple items or services for a sin-

1 gle patient, such as for instances in which mul-
2 tiple specialists are involved.

3 “(D) FACTORS.—In determining which
4 final offer to select as the more reasonable
5 amount under subparagraph (A), the inde-
6 pendent dispute resolution entity shall consider
7 relevant factors including—

8 “(i) the average in-network payment
9 rate for comparable items or services in
10 the same geographic region, including as
11 calculated by an independent database or
12 an all-payer claims database;

13 “(ii) the level of training, education,
14 and experience of the out-of-network health
15 care provider;

16 “(iii) the circumstances and com-
17 plexity of the particular dispute, including
18 the time and place of the service; and

19 “(iv) the payment rate determined for
20 the item or service under the original
21 Medicare fee-for-service program under
22 parts A and B of title XVIII of the Social
23 Security Act.

1 “(5) EFFECT OF DECISION.—A final decision of
2 an independent dispute resolution entity under para-
3 graph (4)(B)—

4 “(A) shall be binding; and

5 “(B) shall not be subject to judicial review,
6 except in cases comparable to those described in
7 section 10(a) of title 9, United States Code, as
8 determined by the Secretary in consultation
9 with the Secretary of Labor.

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

15 “(e) RESPONSIBILITY TO PAY COSTS.—The costs for
16 an independent dispute resolution process under sub-
17 section (d) shall be paid for in accordance with the fol-
18 lowing:

19 “(1) In a case in which the independent dispute
20 resolution entity determines that the amount in the
21 final offer submitted under subsection (d)(4)(A) by
22 the out-of-network health care provider is the more
23 reasonable amount, the group health plan, or health
24 insurance issuer offering health insurance coverage

1 in the group market, shall pay all costs of the inde-
2 pendent dispute resolution process.

3 “(2) In a case in which the independent dispute
4 resolution entity determines that the amount in the
5 final offer submitted under subsection (d)(4)(A) by
6 the group health plan, or health insurance issuer of-
7 fering health insurance coverage in the group mar-
8 ket, is the more reasonable amount, the out-of-net-
9 work health care provider shall pay all costs of the
10 independent dispute resolution process.

11 “(3) In a case in which a settlement is reached
12 under subsection (d)(3), the group health plan, or
13 health insurance issuer offering health insurance
14 coverage in the group market, and the out-of-net-
15 work health care provider shall each pay half of the
16 costs of the independent dispute resolution process.

17 “(f) REPORTS.—

18 “(1) ENTITY REPORTS.—Not later than 4 years
19 after the date of enactment of this section, and each
20 year thereafter, each independent dispute resolution
21 entity shall submit to the Secretary, and the Sec-
22 retary of Labor, a report on all independent dispute
23 resolution processes conducted by the entity under
24 subsection (d) for the period of the report. Each
25 such report shall contain information determined ap-

1 appropriate by the Secretary, in consultation with the
 2 Secretary of Labor, in order to prepare the report
 3 required under paragraph (2).

4 “(2) REPORTS BY SECRETARIES.—

5 “(A) IN GENERAL.—Not later than 5 years
 6 after the date of enactment of this section, and
 7 each year thereafter, the Secretary, in consulta-
 8 tion with the Secretary of Labor, shall based on
 9 the reports submitted under paragraph (1) pre-
 10 pare a report, disaggregated by State, that con-
 11 tains each of the following for the period of the
 12 report:

13 “(i) The total number of independent
 14 dispute resolution processes initiated under
 15 subsection (c)(2)(A), including an indica-
 16 tion of the number of instances in which—

17 “(I) the amount in the final offer
 18 under subsection (d)(4)(A) made by
 19 the group health plan, or health insur-
 20 ance issuer offering health insurance
 21 coverage in the group market, was de-
 22 termined to be more reasonable than
 23 the amount in the final offer under
 24 such subsection made by the out-of-
 25 network health care provider;

1 “(II) the amount in the final
2 offer under subsection (d)(4)(A) made
3 by the out-of-network health care pro-
4 vider was determined to be more rea-
5 sonable than the amount in the final
6 offer under such subsection made by
7 the group health plan, or health insur-
8 ance issuer offering health insurance
9 coverage in the group market; and

10 “(III) a settlement was reached
11 under subsection (d)(3).

12 “(ii) The number of requests made for
13 an independent dispute resolution process
14 under subsection (c)(2)(A) that were deter-
15 mined to be ineligible for such process and
16 the reason for such determination.

17 “(iii) The number of independent dis-
18 pute resolution processes conducted under
19 subsection (d) that—

20 “(I) were based on a situation
21 described in subsection (a)(3)(A); and

22 “(II) were based on a situation
23 described in subsection (a)(3)(B).

1 “(iv) The total number of final deci-
2 sions rendered by independent dispute res-
3 olution entities under subsection (d)(4)(B).

4 “(v) For each independent dispute
5 resolution process conducted under sub-
6 section (d)—

7 “(I) the type of coverage of the
8 plan or issuer involved, such as wheth-
9 er the plan or issuer is a health main-
10 tenance organization or preferred pro-
11 vider organization;

12 “(II) the specialty of the out-of-
13 network health care provider, and spe-
14 cific types of services, involved; and

15 “(III) the dollar amount of the
16 final decision under subsection
17 (d)(4)(B).

18 “(vi) Any additional information the
19 Secretary, in consultation with the Sec-
20 retary of Labor, determines necessary.

21 “(B) PUBLIC ACCESS.—The Secretary, in
22 consultation with the Secretary of Labor, shall,
23 each year, publish the report prepared under
24 subparagraph (A) and make such report avail-
25 able to the public.

1 “(C) PRIVACY.—In carrying out this para-
 2 graph, the Secretary, in consultation with the
 3 Secretary of Labor, shall comply with all appli-
 4 cable Federal and State privacy laws.

5 “(g) APPLICABILITY OF STATE LAW.—

6 “(1) IN GENERAL.—Notwithstanding any other
 7 provision in this section, the process established by
 8 the Secretary, in consultation with the Secretary of
 9 Labor, under this section shall not apply with re-
 10 spect to any surprise billing situation involving a
 11 group health plan (other than a self-insured plan),
 12 or health insurance issuer offering health insurance
 13 coverage in the group market, in a State that has
 14 in effect a State law that applies to the dispute in-
 15 volved and meets the requirements under paragraph
 16 (2).

17 “(2) REQUIREMENTS.—

18 “(A) IN GENERAL.—The requirements
 19 under this paragraph are that the State law
 20 provides, in a surprise billing situation, for—

21 “(i) a dispute resolution process meet-
 22 ing the requirements under subparagraph
 23 (B); or

24 “(ii) a payment standard that meets
 25 the requirements under subparagraph (C).

1 “(B) DISPUTE RESOLUTION PROCESS.—

2 The requirements for a dispute resolution proc-
 3 ess under this subparagraph are that the entity
 4 conducting the process—

5 “(i) be an independent entity whereby
 6 the entity shall not represent the interests
 7 of any party to the dispute and shall be
 8 free of any conflict of interest; and

9 “(ii) report to the public on the re-
 10 sults of the process.

11 “(C) PAYMENT STANDARD.—The require-
 12 ments for a payment standard under this para-
 13 graph are that the group health plan, or health
 14 insurance issuer offering health insurance cov-
 15 erage in the group market, pay the out-of-net-
 16 work health care provider in the surprise billing
 17 situation an amount at a rate—

18 “(i) that does not exceed 125 percent
 19 of the allowed charges for items or services
 20 under the original Medicare fee-for-service
 21 program under parts A and B of title
 22 XXVIII of the Social Security Act; or

23 “(ii) that does not exceed a payment
 24 standard comparable to the standard de-
 25 scribed in clause (i), as determined by the

1 Secretary, in consultation with the Sec-
2 retary of Labor.

3 “(3) CLARIFICATION FOR SELF-INSURED GROUP
4 HEALTH PLANS.—With respect to any payment dis-
5 pute in a surprise billing situation involving a self-
6 insured group health plan—

7 “(A) the process established by the Sec-
8 retary, in consultation with the Secretary of
9 Labor, under this section shall apply; and

10 “(B) any State law that meets the require-
11 ments under paragraph (2), and may otherwise
12 apply, shall not apply.”.

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