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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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''No More Surprise Medical Bills Act of 2018''.

SEC. 2. PREVENTING SURPRISE BILLING PRACTICES.

(a) IN GENERAL.—

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

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

"SEC. 2729. PREVENTING SURPRISE BILLING PRACTICES.

"(a) DEFINITIONS.—In this section:

"(1) HEALTH CARE PROVIDER.—The term 'health care provider' means—

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

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

"(C) an ambulatory surgical center as described in section 1833(i)(1)(A) of such Act; or

"(D) a provider of services or supplier furnishing services at such hospital, critical access hospital, or ambulatory surgical center.

"(2) IN-NETWORK HEALTH CARE PROVIDER.—The term 'in-network health care provider', with respect to a group health plan or health insurance coverage offered in the group market, means a health care provider that is within the health care provider network of the plan or coverage or is otherwise a participating provider of services or supplier with respect to such plan or coverage.

"(3) OUT-OF-NETWORK HEALTH CARE PROVIDER.—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

"(II) a written notice specified by the Secretary through rulemaking that—

"(aa) contains the information required under paragraph (2); and

"(bb) is signed and dated by the individual; and

"(ii) retain, for a period specified through rulemaking by the Secretary, a copy of the documentation described in clause (i)(I) and the written notice described in clause (i)(II); and

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

"(2) INFORMATION INCLUDED IN NOTICE.—The notice described in paragraph (1)(A) shall include, with respect to the individual described in such paragraph, a notification of each of the following:

"(A) Whether the health care provider is an out-of-network health care provider with respect to the group health plan, or health insurance coverage offered in the group market, of such individual.

''(B) If the health care provider is such an out-of-network health care provider, the estimated amount that such provider will charge the individual for such items and services in excess of any cost sharing obligations that the individual would otherwise have under such plan or coverage for such items and services if the health care provider were an in-network health care provider with respect to the plan or coverage of such individual.

''(C) In the case of a health care provider that is a hospital, critical access hospital, or ambulatory surgical center as described in subparagraph (A), (B), or (C) of subsection (a)(1), respectively—

''(i) whether any of the providers of services or suppliers furnishing items or services at such hospital, critical access hospital, or ambulatory surgical center who will furnish the items or services to the individual are out-of-network health care providers with respect to the group health plan, or health insurance coverage offered in the group market, of such individual; and

"(ii) if any such providers of services or suppliers are such out-of-network health care providers, the estimated amount that such providers or suppliers will charge the individual for such items and services in excess of any cost sharing obligations that the individual would otherwise have for such items and services if the providers or suppliers were in-network health care providers with respect to the plan or coverage of such individual.

"(3) CONSENT DESCRIBED.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to an individual enrolled in a group health plan, or health insurance coverage offered in the group market, who is to be furnished items or services by an out-of-network health care provider, is a document specified by the Secretary through rulemaking that is signed by the individual (or by a representative of the individual) not less than 24 hours prior to the individual being furnished such items or services by such health care provider, and that—

"(A) acknowledges that the individual has been—

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

"(ii) informed that the payment of such charge by the individual will not accrue toward meeting any limitation that the group health plan, or health insurance coverage offered in the group market, places on cost-sharing; and

"(B) documents the consent of the individual to—

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

"(ii) in the case that the individual is so furnished such items or services, be charged an amount approximate to the estimated charge described in subparagraph (A)(i) with respect to such items or services.

"(c) LIMITATIONS ON BALANCE BILLING IN SURPRISE BILLING SITUATIONS.—

''(1) IN CASE OF NONCOMPLIANCE WITH NOTICE AND CONSENT REQUIREMENTS.—In the case of an individual enrolled in a group health plan, or health insurance coverage offered in the group market, who is furnished items or services by an out-of-network health care provider with respect to such plan or coverage, if the out-of-network health care provider does not comply with the requirements of subsection (b) with respect to the furnishing of such items or services to such individual, the out-of-network health care provider may not charge the individual more than the amount that the individual would have been required to pay in cost sharing if such items or services had been furnished by an in-network health care provider with respect to such plan or coverage.

''(2) IN CASE OF SAME-DAY EMERGENCY SERVICES.—In the case of an individual enrolled in a group health plan or health insurance coverage offered in the group market who is furnished items or services by a health care provider that is an out-of-network health care provider with respect to such plan or coverage on the same date on which the individual makes an appointment for such items or services (or otherwise presents at the hospital, critical

access hospital, or ambulatory surgical center for such services such as in the case of items and services furnished with respect to an emergency medical condition, as defined in section 1867(e)), the out-of-network health care provider may not charge the individual more than the amount that the individual would have been required to pay in cost sharing if such items or services had been furnished by an in-network health care provider with respect to such plan or coverage.''.

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

(b) CONDITION OF PARTICIPATION IN MEDICARE.—

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

(A) in subparagraph (X), by striking ''and'' at the end;

(B) in subparagraph (Y), by striking at the end the period and inserting '', and''; and

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

''(Z) in the case of a hospital, a critical access 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

such plan or coverage in a surprise billing situation, as defined in section 2730(a), accrues towards meeting any annual limitation on cost-sharing under the plan or coverage.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any plan year beginning not earlier than 2 years after the date of enactment of this Act.

SEC. 4. RESOLVING PAYMENT DISPUTES IN SURPRISE BILLING SITUATIONS.

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

''SEC. 2730. RESOLVING PAYMENT DISPUTES IN SURPRISE BILLING SITUATIONS.

''(a) DEFINITIONS.—In this section:

''(1) HEALTH CARE PROVIDER; IN-NETWORK HEALTH CARE PROVIDER; OUT-OF-NETWORK HEALTH CARE PROVIDER.—The terms 'health care provider', 'in-network health care provider', and 'out-of-network health care provider' have the meanings given such terms in section 2729(a).

''(2) INDEPENDENT DISPUTE RESOLUTION ENTITY.—The term 'independent dispute resolution en-

tity' means an entity certified by the Secretary, in consultation with the Secretary of Labor, under subsection (b)(2) to conduct an independent dispute resolution process under subsection (d).

"(3) SURPRISE BILLING SITUATION.—The term 'surprise billing situation' means—

"(A) a situation in which an individual who is enrolled in a group health plan, or health insurance coverage offered in the group market, is furnished items or services by an out-of-network health care provider and such provider does not comply with the requirements of section 2729(b) with respect to the furnishing of such items or services to such individual; or

"(B) a situation in which an individual who is enrolled in a group health plan, or health insurance coverage offered in the group market, is furnished items or services by an out-of-network health care provider on the same date on which the individual makes an appointment for such items or services (or otherwise presents at the hospital, critical access hospital, or ambulatory surgical center for such services such as in the case of items and services fur-

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

''(b) ESTABLISHMENT OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) ESTABLISHMENT.—Not later than 2 years after the date of enactment of this section, the Secretary, in consultation with the Secretary of Labor, shall establish a process for resolving payment disputes between group health plans, or health insurance issuers offering health insurance coverage in the group market, and out-of-network health care providers in surprise billing situations in accordance with this section.

''(2) CERTIFICATION OF INDEPENDENT DISPUTE RESOLUTION ENTITIES.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, shall establish a process through rulemaking to certify entities as independent dispute resolution entities to conduct independent dispute resolution processes under subsection (d).

''(B) REQUIREMENTS.—To be eligible for certification under this paragraph, an entity shall—

''(i) have experience in health care billing, health care pricing, and arbitration; and

''(ii) not have any conflict of interest, as determined in accordance with subparagraph (C).

''(C) CONFLICT OF INTEREST.—The Secretary, in consultation with the Secretary of Labor, shall determine, through rulemaking, the criteria for a conflict of interest for purposes of subparagraph (B)(ii), which shall include—

''(i) having any material arrangement, financial or otherwise, that could bias the entity, or an employee of the entity working on a particular dispute; or

''(ii) owning or controlling, being owned by or controlled by, or being under common control of—

''(I) any pharmaceutical company, disease group, or public advocacy group;

''(II) any national, State, or local society or association of hospitals, physicians, or other providers of health care services; or

"(III) any national, State, or local association of health care plans.

"(c) PRE-INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(1) REQUIREMENT TO PAY OUT-OF-NETWORK HEALTH CARE PROVIDERS.—

"(A) REQUIREMENT ON PLAN.—The process established by the Secretary, in consultation with the Secretary of Labor, under this section shall require that a group health plan, or health insurance issuer offering health insurance coverage in the group market, that receives a bill from an out-of-network health care provider for items or services furnished to an individual enrolled in the plan or coverage in a surprise billing situation, not later than 30 days after receiving such bill—

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

"(ii) attempt to negotiate with the out-of-network health care provider an alternative amount for the plan or issuer to pay the provider.

"(B) PRE-INDEPENDENT DISPUTE RESOLUTION NEGOTIATIONS.—If, not later than 30

days after the date on which negotiations begin under subparagraph (A)(ii), an out-of-network health care provider and group health plan, or health insurance issuer offering health insurance coverage in the group market, described in subparagraph (A) have not agreed upon an alternative amount for the plan or issuer to pay the provider, the plan or issuer shall—

''(i) pay the provider the amount the plan or issuer determines reasonable for the services (less the cost-sharing amount paid by the individual enrolled in the plan or coverage); and

''(ii) provide information to the provider on how the provider may initiate an independent dispute resolution process under paragraph (2).

''(2) INITIATING AN INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(A) IN GENERAL.—If, after a good faith attempt to negotiate under paragraph (1)(A)(ii), the out-of-network health care provider and group health plan, or health insurance issuer offering health insurance coverage in the group market, described in paragraph

(1)(A) are unable to reach an agreement on an amount for the plan or issuer to pay the provider, any party to the dispute may, not later than 30 days of being unable to come to an agreement, as determined by the Secretary, in consultation with the Secretary of Labor, initiate an independent dispute resolution process under subsection (d) by submitting a request for such process to the Secretary, and the Secretary of Labor, or directly to an independent dispute resolution entity, in accordance with the process established by the Secretary, in consultation with the Secretary of Labor, under this section.

''(B) REQUEST.—A request submitted under subparagraph (A) shall indicate—

''(i) the amount the out-of-network health care provider requested in the bill described in subparagraph (A) of paragraph (1) or after attempted negotiations in accordance with such paragraph; and

''(ii) the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, paid the out-of-network health

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

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

''(d) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, shall establish procedures for independent dispute resolution entities to conduct independent dispute resolution processes under this subsection to resolve payment disputes between group health plans, or health insurance issuers offering health insurance coverage in the group market, and out-of-network health care providers.

''(2) TIMING.—An independent dispute resolution entity that receives a request under subsection (c)(2)(A) shall, not later than 30 days after receiving such request, determine the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, is 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.—

"(A) FINAL OFFERS.—In the absence of a settlement under paragraph (3), the group health plan, or health insurance issuer offering health insurance coverage in the group market, and out-of-network health care provider shall each submit to the independent dispute resolution entity an amount as a final offer. Such entity shall determine which of those 2 amounts is more reasonable based on the factors described in subparagraph (D).

"(B) FINAL DECISIONS.—The amount that is determined to be the more reasonable amount under subparagraph (A) shall be the final decision of the independent dispute resolution entity as to the amount the group health plan, or health insurance issuer offering health insurance coverage in the group market, is required to pay the out-of-network health care provider.

"(C) SERVICE UNITS.—A final offer submitted under subparagraph (A) shall be made per service unit, as defined by the Secretary, in consultation with the Secretary of Labor, through regulations. A final decision under subparagraph (B) may include the resolution of disputes for multiple items or services for a sin-

gle patient, such as for instances in which multiple specialists are involved.

''(D) FACTORS.—In determining which final offer to select as the more reasonable amount under subparagraph (A), the independent dispute resolution entity shall consider relevant factors including—

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

''(ii) the level of training, education, and experience of the out-of-network health care provider;

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

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

''(5) EFFECT OF DECISION.—A final decision of an independent dispute resolution entity under paragraph (4)(B)—

''(A) shall be binding; and

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

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

''(e) RESPONSIBILITY TO PAY COSTS.—The costs for an independent dispute resolution process under subsection (d) shall be paid for in accordance with the following:

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

in the group market, shall pay all costs of the independent dispute resolution process.

''(2) In a case in which the independent dispute resolution entity determines that the amount in the final offer submitted under subsection (d)(4)(A) by the group health plan, or health insurance issuer offering health insurance coverage in the group market, is the more reasonable amount, the out-of-network health care provider shall pay all costs of the independent dispute resolution process.

''(3) In a case in which a settlement is reached under subsection (d)(3), the group health plan, or health insurance issuer offering health insurance coverage in the group market, and the out-of-network health care provider shall each pay half of the costs of the independent dispute resolution process.

''(f) REPORTS.—

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

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

''(2) REPORTS BY SECRETARIES.—

''(A) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and each year thereafter, the Secretary, in consultation with the Secretary of Labor, shall based on the reports submitted under paragraph (1) prepare a report, disaggregated by State, that contains each of the following for the period of the report:

''(i) The total number of independent dispute resolution processes initiated under subsection (c)(2)(A), including an indication of the number of instances in which—

''(I) the amount in the final offer under subsection (d)(4)(A) made by the group health plan, or health insurance issuer offering health insurance coverage in the group market, was determined to be more reasonable than the amount in the final offer under such subsection made by the out-of-network health care provider;

"(II) the amount in the final offer under subsection (d)(4)(A) made by the out-of-network health care provider was determined to be more reasonable than the amount in the final offer under such subsection made by the group health plan, or health insurance issuer offering health insurance coverage in the group market; and

"(III) a settlement was reached under subsection (d)(3).

"(ii) The number of requests made for an independent dispute resolution process under subsection (c)(2)(A) that were determined to be ineligible for such process and the reason for such determination.

"(iii) The number of independent dispute resolution processes conducted under subsection (d) that—

"(I) were based on a situation described in subsection (a)(3)(A); and

"(II) were based on a situation described in subsection (a)(3)(B).

"(iv) The total number of final decisions rendered by independent dispute resolution entities under subsection (d)(4)(B).

"(v) For each independent dispute resolution process conducted under subsection (d)—

"(I) the type of coverage of the plan or issuer involved, such as whether the plan or issuer is a health maintenance organization or preferred provider organization;

"(II) the specialty of the out-of-network health care provider, and specific types of services, involved; and

"(III) the dollar amount of the final decision under subsection (d)(4)(B).

"(vi) Any additional information the Secretary, in consultation with the Secretary of Labor, determines necessary.

"(B) PUBLIC ACCESS.—The Secretary, in consultation with the Secretary of Labor, shall, each year, publish the report prepared under subparagraph (A) and make such report available to the public.

''(C) PRIVACY.—In carrying out this paragraph, the Secretary, in consultation with the Secretary of Labor, shall comply with all applicable Federal and State privacy laws.

''(g) APPLICABILITY OF STATE LAW.—

''(1) IN GENERAL.—Notwithstanding any other provision in this section, the process established by the Secretary, in consultation with the Secretary of Labor, under this section shall not apply with respect to any surprise billing situation involving a group health plan (other than a self-insured plan), or health insurance issuer offering health insurance coverage in the group market, in a State that has in effect a State law that applies to the dispute involved and meets the requirements under paragraph (2).

''(2) REQUIREMENTS.—

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

''(i) a dispute resolution process meeting the requirements under subparagraph (B); or

''(ii) a payment standard that meets the requirements under subparagraph (C).

''(B) DISPUTE RESOLUTION PROCESS.—The requirements for a dispute resolution process under this subparagraph are that the entity conducting the process—

''(i) be an independent entity whereby the entity shall not represent the interests of any party to the dispute and shall be free of any conflict of interest; and

''(ii) report to the public on the results of the process.

''(C) PAYMENT STANDARD.—The requirements for a payment standard under this paragraph are that the group health plan, or health insurance issuer offering health insurance coverage in the group market, pay the out-of-network health care provider in the surprise billing situation an amount at a rate—

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

''(ii) that does not exceed a payment standard comparable to the standard described in clause (i), as determined by the

Secretary, in consultation with the Secretary of Labor.

''(3) CLARIFICATION FOR SELF-INSURED GROUP HEALTH PLANS.—With respect to any payment dispute in a surprise billing situation involving a self-insured group health plan—

''(A) the process established by the Secretary, in consultation with the Secretary of Labor, under this section shall apply; and

''(B) any State law that meets the requirements under paragraph (2), and may otherwise apply, shall not apply.''.

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