[DISCUSSION DRAFT]

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. PALLONE (for himself and Mr. WALDEN) 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.

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 Surprises Act''.

SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

(a) EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS.—Section 2719A of the Pub-

lic Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''offering group or individual health insurance issuer'' and inserting ''offering group or individual health insurance coverage''; and

(II) by inserting ''or, for plan year 2021 or a subsequent plan year, with respect to services in an independent freestanding emergency department (as defined in paragraph (2)(C))'' after ''emergency department of a hospital''; and

(III) by striking ''paragraph (2)(B)'' and inserting ''paragraph (2)'';

(ii) in subparagraph (B), by inserting ''or a participating emergency facility, as applicable,'' after ''participating provider''; and

(iii) in subparagraph (C)—

(I) in the matter preceding clause (i), by inserting ''by a nonparticipating provider or a nonparticipating emergency facility'' after ''enrollee'';

(II) by striking clause (i);

(III) by striking ''(ii)(I) such services'' and inserting ''(i) such services'';

(IV) by striking ''where the provider of services does not have a contractual relationship with the plan for the providing of services'';

(V) by striking ''emergency department services received from providers who do have such a contractual relationship with the plan; and'' and inserting ''emergency services received from participating providers and participating emergency facilities with respect to such plan;'';

(VI) by striking ''(II) if such services'' and all that follows through ''were provided in-network'' and inserting the following:

''(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;''; and

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

''(iii) the group health plan or health insurance issuer offering group or individual health insurance coverage pays to such provider or facility, respectively, the amount by which the recognized amount (as defined in paragraph (2)(H)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clause (ii)); and

''(iv) there shall be counted toward any deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished in the same manner as if such cost-sharing payments were with respect to emergency

services furnished by a participating provider and a participating emergency facility.''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ''and subsection (e)'' after ''this subsection'';

(ii) by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively;

(iii) by inserting before subparagraph (B), as redesignated by clause (ii), the following new subparagraph:

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.''.

(iv) in subparagraph (C), as redesignated by clause (ii)—

(I) in clause (i)—

(aa) by inserting '', or as would be required under such section if such section applied to an independent freestanding emergency department'' after

''section 1867 of the Social Security Act''; and

(bb) by inserting ''or of the independent freestanding emergency department, as applicable'' after ''of a hospital''; and

(II) in clause (ii)—

(aa) by inserting ''or the independent freestanding emergency department, as applicable'' after ''at the hospital''; and

(bb) by inserting '', or as would be required under such section if such section applied to an independent freestanding emergency department,'' after ''section 1867 of such Act'';

(v) by redesignating subparagraph (D), as redesignated by clause (ii), as subparagraph (I); and

(vi) by inserting after subparagraph (C), as redesignated by clause (ii), the following subparagraphs:

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'inde-

pendent freestanding emergency department' means a facility that provides emergency or unscheduled outpatient services to patients whose conditions require immediate care in a setting that is geographically separate and distinct from a hospital and independently licensed.

''(E) MEDIAN CONTRACTED RATE.—

''(i) IN GENERAL.—The term 'median contracted rate' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, the median of the negotiated rates recognized by the plan or issuer as the total maximum payment (including the cost-sharing amount imposed for such services (as determined in accordance with paragraph (1)(C)(ii) or subsection (e)(1)(A), as applicable) and the amount to be paid by the plan or issuer) for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished.

''(ii) RULEMAKING.—Not later than July 1, 2020, the Secretary shall through rulemaking determine the methodology the plan or issuer shall use to determine the median contracted rate, the information the plan or issuer shall share with the nonparticipating provider involved when making such a determination, and the geographic regions applied for purposes of this subparagraph.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who does not have a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who has a contractual relationship with the plan or coverage for furnishing such item or service.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service—

''(i) in the case of such item or service furnished in a State that has in effect a State law that provides for a method for determining the amount of payment that is required to be covered by a health plan or health insurance issuer offering group or individual health insurance coverage regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from a nonparticipating provider, not more than the amount deter-

mined in accordance with such law plus the cost-sharing amount imposed for such item or service (as determined in accordance with paragraph (1)(C)(ii) or subsection (e)(1)(A), as applicable); or

''(ii) in the case of such item or service furnished in a State that does not have in effect such a law, an amount that is at least the median contracted rate (as defined in subparagraph (E)(i) and determined in accordance with the regulations promulgated pursuant to subparagraph (E)(ii)) for such item or service.''.

(b) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

(1) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

''(e) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which

subsection (b) applies) furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (2)(A)) by a nonparticipating provider (as defined in subsection (b)(2)(G)) during a visit at a participating health care facility (as defined in paragraph (2)(B)), with respect to such plan, the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a participating provider;

''(B) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in subsection (b)(2)(H)) for such services exceeds the cost-sharing amount imposed for such services (as determined in accordance with subparagraph (A)); and

''(C) shall count toward any deductible or out-of-pocket maximums applied under the plan

any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this subsection:

''(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market.

''(B) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a health care facility described in clause (ii) that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

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

"(II) A critical access hospital (as defined in section 1861(mm) of such Act).

"(III) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

"(IV) A laboratory.

"(V) A radiology or imaging center.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2021.

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

"(t)(1) In the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent

freestanding emergency department (as defined in section 2719A(b)(2) of the Public Health Service Act)—

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

''(B) if any health care provider holds such individual liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with section 2719A(b)(1)(C)(ii) of the Public Health Service Act);

the hospital, emergency department, independent freestanding emergency department, or health care provider, respectively, shall be subject, in addition to any other penalties that may be prescribed by law,

to a civil money penalty of not more than $[____] for each specified claim.

''(2) The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) shall apply to a civil money penalty or assessment under paragraph (1) or subsection (u) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a).

''(3) In this subsection and subsection (u):

''(A) The terms 'emergency medical condition' and 'emergency services' have the meanings given such terms, respectively, in section 2719A(b)(2) of the Public Health Service Act.

''(B) The terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

''(u)(1) Subject to paragraph (2), in the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, items or services (other than emergency services to which subsection (t) applies) at a participating health care facility by a nonparticipating provider, if such provider holds such individual liable for a payment amount for such an item or service furnished by such provider during a visit at such

facility that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A) of the Public Health Service Act), such provider shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $[____] for each specified claim.

''(2) Paragraph (1) shall not apply to a nonparticipating provider (other than a facility-based provider), with respect to items or services furnished by the provider at a participating health care facility to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if the provider is in compliance with the requirement of paragraph (3). For purposes of the previous sentence, the term 'facility-based provider' means emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary.

''(3) (A) For purposes of paragraph (2) a nonparticipating provider is in compliance with this paragraph, with respect to items or services furnished by the provider at a participating health care facility to a participant, beneficiary, or enrollee of a health plan or health insurance

coverage offered by a health insurance issuer, if the provider—

''(i)(I) provides to the participant, beneficiary, or enrollee (or to a representative of the participant, beneficiary, or enrollee), on the date on which the participant, beneficiary, or enrollee 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—

''(aa) an oral explanation of the written notice described in item (bb) and such documentation of the provision of such explanation, as the Secretary determines appropriate; and

''(bb) a written notice specified, not later than July 1, 2020, by the Secretary through rulemaking that—

''(AA) contains the information required under subparagraph (B); and

''(BB) is signed and dated by the participant, beneficiary, or enrollee; and

''(II) retain, for a period specified through rulemaking by the Secretary, a copy of the documenta-

tion described in subclause (I)(aa) and the written notice described in subclause (I)(bb); and

''(ii) obtains from the participant, beneficiary, or enrollee (or representative) the consent described in subparagraph (C).

''(B) For purposes of subparagraph (A)(i), the information described in this subparagraph, with respect to a nonparticipating provider and a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, is a notification of each of the following:

''(i) That the health care provider is a nonparticipating provider with respect to the group health plan or health insurance coverage.

''(ii) The estimated amount that such provider will charge the participant, beneficiary, or enrollee for such items and services involved.

''(C) For purposes of subparagraph (A)(ii), the consent described in this subparagraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer, who is to be furnished items or services by a nonparticipating provider, is a document specified by the Secretary through rulemaking that—

''(i) is signed by the participant, beneficiary, or enrollee (or by a representative of the participant, beneficiary, or enrollee) not less than 24 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider;

''(ii) acknowledges that the participant, beneficiary, or enrollee has been—

''(I) provided with a written estimate and an oral explanation of the charge that the participant, beneficiary, or enrollee will be assessed for the items or services anticipated to be furnished to the participant, beneficiary, or enrollee by such nonparticipating provider; and

''(II) informed that the payment of such charge by the participant, beneficiary, or enrollee will not accrue toward meeting any limitation that the group health plan or health insurance coverage places on cost-sharing; and

''(iii) documents the consent of the participant, beneficiary, or enrollee to—

''(I) be furnished with such items or services by such nonparticipating provider; and

''(II) in the case that the individual is so furnished such items or services, be charged an amount that may be greater than the amount

that would otherwise be changed the individual if furnished by a participating provider with respect to such items or services and plan or coverage.

''(4) For purposes of this subsection, the terms 'nonparticipating provider' and 'participating health care facility' have such meanings given such terms under subsections (b)(2) and (e)(2), respectively, of section 2719A of the Public Health Service Act.''.

(d) STATE ALL PAYER CLAIMS DATABASES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall make one-time grants to eligible States for the purposes described in paragraph (2).

(2) USES.—A State may use a grant received under paragraph (1) for one of the following purposes:

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

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

(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Sec-

retary specifies. Such information shall include, with respect to an All Payer Claims Database for the State, at least specifics on how the State will ensure uniform data collection through the database and the security of such data submitted to and maintained in the database.

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

(5) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are appropriated $50,000,000, to remain available until expended.