

[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.

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IN THE HOUSE OF REPRESENTATIVES

Mr. PALLONE (for himself and Mr. WALDEN) introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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**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.**

4 This Act may be cited as the “No Surprises Act”.

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

6 (a) **EMERGENCY SERVICES PERFORMED BY NON-**  
7 **PARTICIPATING PROVIDERS.**—Section 2719A of the Pub-

1 lic Health Service Act (42 U.S.C. 300gg–19a) is amend-  
2 ed—

3 (1) in subsection (b)—

4 (A) in paragraph (1)—

5 (i) in the matter preceding subpara-  
6 graph (A)—

7 (I) by striking “offering group or  
8 individual health insurance issuer”  
9 and inserting “offering group or indi-  
10 vidual health insurance coverage”;  
11 and

12 (II) by inserting “or, for plan  
13 year 2021 or a subsequent plan year,  
14 with respect to services in an inde-  
15 pendent freestanding emergency de-  
16 partment (as defined in paragraph  
17 (2)(C))” after “emergency department  
18 of a hospital”; and

19 (III) by striking “paragraph  
20 (2)(B)” and inserting “paragraph  
21 (2)”;

22 (ii) in subparagraph (B), by inserting  
23 “or a participating emergency facility, as  
24 applicable,” after “participating provider”;  
25 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;”;

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, the  
13          amount by which the recognized amount  
14          (as defined in paragraph (2)(H)) for such  
15          services exceeds the cost-sharing amount  
16          for such services (as determined in accord-  
17          ance with clause (ii)); and

18          “(iv) there shall be counted toward  
19          any deductible or out-of-pocket maximums  
20          applied under the plan any cost-sharing  
21          payments made by the participant, bene-  
22          ficiary, or enrollee with respect to such  
23          emergency services so furnished in the  
24          same manner as if such cost-sharing pay-  
25          ments were with respect to emergency

1 services furnished by a participating pro-  
2 vider and a participating emergency facil-  
3 ity.”; and

4 (B) in paragraph (2)—

5 (i) in the matter preceding subpara-  
6 graph (A), by inserting “and subsection  
7 (e)” after “this subsection”;

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

11 (iii) by inserting before subparagraph  
12 (B), as redesignated by clause (ii), the fol-  
13 lowing new subparagraph:

14 “(A) EMERGENCY DEPARTMENT OF A HOS-  
15 PITAL.—The term ‘emergency department of a  
16 hospital’ includes a hospital outpatient depart-  
17 ment that provides emergency services.”.

18 (iv) in subparagraph (C), as redesign-  
19 ated by clause (ii)—

20 (I) in clause (i)—

21 (aa) by inserting “, or as  
22 would be required under such  
23 section if such section applied to  
24 an independent freestanding  
25 emergency department” after

1 “section 1867 of the Social Secu-  
2 rity Act”; and

3 (bb) by inserting “or of the  
4 independent freestanding emer-  
5 gency department, as applicable”  
6 after “of a hospital”; and

7 (II) in clause (ii)—

8 (aa) by inserting “or the  
9 independent freestanding emer-  
10 gency department, as applicable”  
11 after “at the hospital”; and

12 (bb) by inserting “, or as  
13 would be required under such  
14 section if such section applied to  
15 an independent freestanding  
16 emergency department,” after  
17 “section 1867 of such Act”;

18 (v) by redesignating subparagraph  
19 (D), as redesignated by clause (ii), as sub-  
20 paragraph (I); and

21 (vi) by inserting after subparagraph  
22 (C), as redesignated by clause (ii), the fol-  
23 lowing subparagraphs:

24 “(D) INDEPENDENT FREESTANDING  
25 EMERGENCY DEPARTMENT.—The term ‘inde-

1           pendent freestanding emergency department’  
2           means a facility that provides emergency or un-  
3           scheduled outpatient services to patients whose  
4           conditions require immediate care in a setting  
5           that is geographically separate and distinct  
6           from a hospital and independently licensed.

7           “(E) MEDIAN CONTRACTED RATE.—

8                   “(i) IN GENERAL.—The term ‘median  
9                   contracted rate’ means, with respect to an  
10                  item or service and a group health plan or  
11                  health insurance coverage offered by a  
12                  health insurance issuer, the median of the  
13                  negotiated rates recognized by the plan or  
14                  issuer as the total maximum payment (in-  
15                  cluding the cost-sharing amount imposed  
16                  for such services (as determined in accord-  
17                  ance with paragraph (1)(C)(ii) or sub-  
18                  section (e)(1)(A), as applicable) and the  
19                  amount to be paid by the plan or issuer)  
20                  for the same or a similar item or service  
21                  that is provided by a provider in the same  
22                  or similar specialty and provided in the ge-  
23                  ographic region in which the item or serv-  
24                  ice is furnished.

1                   “(ii) RULEMAKING.—Not later than  
2                   July 1, 2020, the Secretary shall through  
3                   rulemaking determine the methodology the  
4                   plan or issuer shall use to determine the  
5                   median contracted rate, the information  
6                   the plan or issuer shall share with the non-  
7                   participating provider involved when mak-  
8                   ing such a determination, and the geo-  
9                   graphic regions applied for purposes of this  
10                  subparagraph.

11                  “(F) NONPARTICIPATING EMERGENCY FA-  
12                  CILITY; PARTICIPATING EMERGENCY FACIL-  
13                  ITY.—

14                  “(i) NONPARTICIPATING EMERGENCY  
15                  FACILITY.—The term ‘nonparticipating  
16                  emergency facility’ means, with respect to  
17                  an item or service and a group health plan  
18                  or health insurance coverage offered by a  
19                  health insurance issuer, an emergency de-  
20                  partment of a hospital or an independent  
21                  freestanding emergency department, that  
22                  does not have a contractual relationship  
23                  with the plan or coverage for furnishing  
24                  such item or service.



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

12                  “(G) NONPARTICIPATING PROVIDERS; PAR-  
13                  TICIPATING PROVIDERS.—

14                  “(i) NONPARTICIPATING PROVIDER.—  
15                  The term ‘nonparticipating provider’  
16                  means, with respect to an item or service  
17                  and a group health plan or health insur-  
18                  ance coverage offered by a health insur-  
19                  ance issuer, a physician or other health  
20                  professional who is licensed by the State  
21                  involved to furnish such item or service  
22                  and who does not have a contractual rela-  
23                  tionship with the plan or coverage for fur-  
24                  nishing such item or service.

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

11                  “(H) RECOGNIZED AMOUNT.—The term  
12                  ‘recognized amount’ means, with respect to an  
13                  item or service—

14                         “(i) in the case of such item or service  
15                         furnished in a State that has in effect a  
16                         State law that provides for a method for  
17                         determining the amount of payment that is  
18                         required to be covered by a health plan or  
19                         health insurance issuer offering group or  
20                         individual health insurance coverage regu-  
21                         lated by such State in the case of a partici-  
22                         pant, beneficiary, or enrollee covered under  
23                         such plan or coverage and receiving such  
24                         item or service from a nonparticipating  
25                         provider, not more than the amount deter-

1           mined in accordance with such law plus  
2           the cost-sharing amount imposed for such  
3           item or service (as determined in accord-  
4           ance with paragraph (1)(C)(ii) or sub-  
5           section (e)(1)(A), as applicable); or

6                   “(ii) in the case of such item or serv-  
7           ice furnished in a State that does not have  
8           in effect such a law, an amount that is at  
9           least the median contracted rate (as de-  
10          fined in subparagraph (E)(i) and deter-  
11          mined in accordance with the regulations  
12          promulgated pursuant to subparagraph  
13          (E)(ii) for such item or service.”.

14          (b) NON-EMERGENCY SERVICES PERFORMED BY  
15          NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-  
16          PATING FACILITIES.—

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

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

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

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

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

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

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

1 any cost-sharing payments made by the partici-  
2 pant, beneficiary, or enrollee with respect to  
3 such items and services so furnished in the  
4 same manner as if such cost-sharing payments  
5 were with respect to items and services fur-  
6 nished by a participating provider.

7 “(2) DEFINITIONS.—In this subsection:

8 “(A) HEALTH PLAN.—The term ‘health  
9 plan’ means a group health plan and health in-  
10 surance coverage offered by a health insurance  
11 issuer in the group or individual market.

12 “(B) PARTICIPATING HEALTH CARE FACIL-  
13 ITY.—

14 “(i) IN GENERAL.—The term ‘partici-  
15 pating health care facility’ means, with re-  
16 spect to an item or service and a group  
17 health plan or health insurance coverage  
18 offered by a health insurance issuer, a  
19 health care facility described in clause (ii)  
20 that has a contractual relationship with  
21 the plan or coverage for furnishing such  
22 item or service.

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

1                   “(I) A hospital (as defined in  
2                   1861(e) of the Social Security Act).

3                   “(II) A critical access hospital  
4                   (as defined in section 1861(mm) of  
5                   such Act).

6                   “(III) An ambulatory surgical  
7                   center (as defined in section  
8                   1833(i)(1)(A) of such Act).

9                   “(IV) A laboratory.

10                   “(V) A radiology or imaging cen-  
11                   ter.”.

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

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

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

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

3           “(A) if the emergency department of a hospital  
4           or independent freestanding emergency department  
5           holds the individual liable for a payment amount for  
6           such emergency services so furnished that is more  
7           than the cost-sharing amount for such services (as  
8           determined in accordance with section  
9           2719A(b)(1)(C)(ii) of the Public Health Service  
10          Act); or

11           “(B) if any health care provider holds such in-  
12          dividual liable for a payment amount for an emer-  
13          gency service furnished to such individual by such  
14          provider with respect to such emergency medical  
15          condition and visit for which the individual receives  
16          emergency services at the hospital or emergency de-  
17          partment that is more than the cost-sharing amount  
18          for such services furnished by the provider (as deter-  
19          mined in accordance with section 2719A(b)(1)(C)(ii)  
20          of the Public Health Service Act);  
21          the hospital, emergency department, independent  
22          freestanding emergency department, or health care  
23          provider, respectively, shall be subject, in addition to  
24          any other penalties that may be prescribed by law,

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

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

8 “(3) In this subsection and subsection (u):

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

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

17 “(u)(1) Subject to paragraph (2), in the case of an  
18 individual with benefits under a health plan or health in-  
19 surance coverage offered in the group or individual market  
20 who is furnished on or after January 1, 2021, items or  
21 services (other than emergency services to which sub-  
22 section (t) applies) at a participating health care facility  
23 by a nonparticipating provider, if such provider holds such  
24 individual liable for a payment amount for such an item  
25 or service furnished by such provider during a visit at such



1 facility that is more than the cost-sharing amount for such  
2 item or service (as determined in accordance with section  
3 2719A(e)(1)(A) of the Public Health Service Act), such  
4 provider shall be subject, in addition to any other penalties  
5 that may be prescribed by law, to a civil money penalty  
6 of not more than \$【\_\_\_\_】 for each specified claim.

7 “(2) Paragraph (1) shall not apply to a nonpartici-  
8 pating provider (other than a facility-based provider), with  
9 respect to items or services furnished by the provider at  
10 a participating health care facility to a participant, bene-  
11 ficiary, or enrollee of a health plan or health insurance  
12 coverage offered by a health insurance issuer, if the pro-  
13 vider is in compliance with the requirement of paragraph  
14 (3). For purposes of the previous sentence, the term ‘facil-  
15 ity-based provider’ means emergency medicine providers,  
16 anesthesiologists, pathologists, radiologists,  
17 neonatologists, assistant surgeons, hospitalists,  
18 intensivists, or other providers as determined by the Sec-  
19 retary.

20 “(3) (A) For purposes of paragraph (2) a nonpartici-  
21 pating provider is in compliance with this paragraph, with  
22 respect to items or services furnished by the provider at  
23 a participating health care facility to a participant, bene-  
24 ficiary, or enrollee of a health plan or health insurance

1 coverage offered by a health insurance issuer, if the pro-  
2 vider—

3 “(i)(I) provides to the participant, beneficiary,  
4 or enrollee (or to a representative of the participant,  
5 beneficiary, or enrollee), on the date on which the  
6 participant, beneficiary, or enrollee makes an ap-  
7 pointment to be furnished such items or services, if  
8 applicable, and on the date on which the individual  
9 is furnished such items and services—

10 “(aa) an oral explanation of the writ-  
11 ten notice described in item (bb) and such  
12 documentation of the provision of such ex-  
13 planation, as the Secretary determines ap-  
14 propriate; and

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

18 “(AA) contains the information  
19 required under subparagraph (B); and

20 “(BB) is signed and dated by the  
21 participant, beneficiary, or enrollee;  
22 and

23 “(II) retain, for a period specified through rule-  
24 making by the Secretary, a copy of the documenta-

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

3             “(ii) obtains from the participant, beneficiary,  
4       or enrollee (or representative) the consent described  
5       in subparagraph (C).

6       “(B) For purposes of subparagraph (A)(i), the infor-  
7       mation described in this subparagraph, with respect to a  
8       nonparticipating provider and a participant, beneficiary,  
9       or enrollee of a health plan or health insurance coverage  
10      offered by a health insurance issuer, is a notification of  
11      each of the following:

12            “(i) That the health care provider is a non-  
13      participating provider with respect to the group  
14      health plan or health insurance coverage.

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

18       “(C) For purposes of subparagraph (A)(ii), the con-  
19      sent described in this subparagraph, with respect to a par-  
20      ticipant, beneficiary, or enrollee of a group health plan or  
21      health insurance coverage offered by a health insurance  
22      issuer, who is to be furnished items or services by a non-  
23      participating provider, is a document specified by the Sec-  
24      retary through rulemaking that—

1           “(i) is signed by the participant, beneficiary, or  
2           enrollee (or by a representative of the participant,  
3           beneficiary, or enrollee) not less than 24 hours prior  
4           to the participant, beneficiary, or enrollee being fur-  
5           nished such items or services by such provider;

6           “(ii) acknowledges that the participant, bene-  
7           ficiary, or enrollee has been—

8                   “(I) provided with a written estimate and  
9                   an oral explanation of the charge that the par-  
10                  ticipant, beneficiary, or enrollee will be assessed  
11                  for the items or services anticipated to be fur-  
12                  nished to the participant, beneficiary, or en-  
13                  rollee by such nonparticipating provider; and

14                   “(II) informed that the payment of such  
15                  charge by the participant, beneficiary, or en-  
16                  rollee will not accrue toward meeting any limi-  
17                  tation that the group health plan or health in-  
18                  surance coverage places on cost-sharing; and

19           “(iii) documents the consent of the participant,  
20           beneficiary, or enrollee to—

21                   “(I) be furnished with such items or serv-  
22                  ices by such nonparticipating provider; and

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

1           that would otherwise be changed the individual  
2           if furnished by a participating provider with re-  
3           spect to such items or services and plan or cov-  
4           erage.

5           “(4) For purposes of this subsection, the terms ‘non-  
6 participating provider’ and ‘participating health care facil-  
7 ity’ have such meanings given such terms under sub-  
8 sections (b)(2) and (e)(2), respectively, of section 2719A  
9 of the Public Health Service Act.”.

10          (d) STATE ALL PAYER CLAIMS DATABASES.—

11           (1) IN GENERAL.—The Secretary of Health and  
12 Human Services shall make one-time grants to eligi-  
13 ble States for the purposes described in paragraph  
14 (2).

15           (2) USES.—A State may use a grant received  
16 under paragraph (1) for one of the following pur-  
17 poses:

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

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

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

1       retary specifies. Such information shall include, with  
2       respect to an All Payer Claims Database for the  
3       State, at least specifics on how the State will ensure  
4       uniform data collection through the database and  
5       the security of such data submitted to and main-  
6       tained in the database.

7               (4) ALL PAYER CLAIMS DATABASE.—For pur-  
8       poses of this subsection, the term “All Payer Claims  
9       Database” means, with respect to a State, a State  
10      database that may include medical claims, pharmacy  
11      claims, dental claims, and eligibility and provider  
12      files, which are collected from private and public  
13      payers.

14              (5) AUTHORIZATION OF APPROPRIATIONS.—To  
15      carry out this subsection, there are appropriated  
16      \$50,000,000, to remain available until expended.