H. R. 3630

To amend title XXVII of the Public Health Service Act to protect health care consumers from surprise billing practices, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES
July 9, 2019

Mr. PALLONE introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title XXVII of the Public Health Service 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) COVERAGE OF EMERGENCY SERVICES.—Section
7 2719A(b) of the Public Health Service Act (42 U.S.C.
8 300gg–19a(b)) is amended—
(1) in paragraph (1)—

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

(i) by striking “a group health plan, or a health insurance issuer offering group or individual health insurance issuer,” and inserting “a health plan (as defined in subsection (e)(2)(A))”;

(ii) by inserting “or, for plan year 2021 or a subsequent plan year, with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D))” after “emergency department of a hospital”;

(iii) by striking “the plan or issuer” and inserting “the plan”; and

(iv) by striking “paragraph (2)(B)” and inserting “paragraph (3)(C)”;

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

(C) in subparagraph (C)—

(i) by inserting “by a nonparticipating pro-
vider or a nonparticipating emergency fa-
cility” 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 rela-
tionship with the plan for the providing of
services”;

(v) by striking “emergency depart-
ment services received from providers who
do have such a contractual relationship
with the plan; and” and inserting “emer-
gency services received from participating
providers and participating emergency fa-
cilities with respect to such plan;”;

(vi) by striking “(II) if such services”
and all that follows through “were pro-
vided in-network” and inserting the fol-
lowing:

“(ii) the cost-sharing requirement (ex-
pressed as a copayment amount or coinsur-
ance rate) is not greater than the require-
ment 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 fol-
lowing new clauses:
“(iii) such requirement is calculated
as if the total amount that would have
been charged for such services by such
participating provider or participating
emergency facility were equal to—
“(I) in the case of such services
furnished in a State described in
paragraph (3)(H)(ii), the median con-
tracted rate (as defined in paragraph
(3)(E)(i)) for such services; and
“(II) in the case of such services
furnished in a State described in
paragraph (3)(H)(i), the lesser of—
“(aa) the amount deter-
mined by such State for such
services in accordance with the
method described in such para-
graph; and
“(bb) the median contracted
rate (as so defined) for such
services;
“(iv) the health plan pays to such provider or facility, respectively, the amount by which the recognized amount (as defined in paragraph (3)(H)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

“(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan 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”;

(2) by redesignating paragraph (2) as paragraph (3);

(3) by inserting after paragraph (1) the following new paragraph:

“(2) Audit process for median contracted rates.—Not later than July 1, 2020, the Secretary shall, in consultation with appropriate State agencies, establish through rulemaking a proc-
ess under which sponsors and issuers of health plans
are audited to ensure that such sponsors and issuers
are in compliance with the requirement of applying
a median contracted rate under this section that sat-
mifies the definition under paragraph (3)(E).”;
and
(4) in paragraph (3), as redesignated by para-
graph (2) of this subsection—
(A) in the matter preceding subparagraph
(A), by inserting “and subsections (e) and (f)”
after “this subsection”;
(B) by redesignating subparagraphs (A)
through (C) as subparagraphs (B) through (D),
respectively;
(C) by inserting before subparagraph (B),
as redesignated by subparagraph (B) of this
paragraph, the following new subparagraph:
“(A) EMERGENCY DEPARTMENT OF A HOS-
PITAL.—The term ‘emergency department of a
hospital’ includes a hospital outpatient depart-
ment that provides emergency services.”;
(D) by amending subparagraph (C), as re-
designated by subparagraph (B) of this para-
graph, to read as follows:
“(C) EMERGENCY SERVICES.—
“(i) IN GENERAL.—The term ‘emergency services’, with respect to an emergency medical condition means—

“(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

“(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section
if such section applied to an independent freestanding emergency department, to stabilize the patient.

“(ii) **Inclusion of Poststabilization Services.**—For purposes of this subsection and section 2799, in the case of an individual enrolled in a health plan who is furnished services described in clause (i) by a provider or facility to stabilize such individual with respect to an emergency medical condition, the term ‘emergency services’ shall include such items and services in addition to those described in clause (i) that such a provider or facility determines are needed to be furnished to such individual during the visit in which such individual is so stabilized after such stabilization, unless each of the following conditions are met:

“(I) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.
“(II) Such provider furnishing such additional items and services is in compliance with section 2799A(d) with respect to such items and services.”;

(E) by redesigning subparagraph (D), as redesignated by subparagraph (B) of this paragraph, as subparagraph (I); and

(F) by inserting after subparagraph (C), as redesignated by subparagraph (B) of this paragraph, the following new subparagraphs:

“(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term ‘independent freestanding emergency department’ means a facility that—

“(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

“(ii) provides emergency services.

“(E) MEDIAN CONTRACTED RATE.—

“(i) IN GENERAL.—The term ‘median contracted rate’ means, with respect to an item or service and a health plan (as defined in subsection (e)(2)(A))—
“(I) for 2021, the median of the negotiated rates recognized by the sponsor or issuer of such plan (determined with respect to all such plans of such sponsor or such 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) under such plans in 2019 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, consistent with the methodology established by the Secretary under section 2(e) of the No Surprises Act, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019 and 2020; and
“(II) for 2022 and each subsequent year, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(ii) Special rule; rule of construction.—

“(I) Certain insurers.—The Secretary shall provide pursuant to rulemaking described in clause (ii) that—

“(aa) if the sponsor or issuer of a health plan does not have sufficient information to calculate a median contracted rate for an item or service or provider type, or amount of, claims for items or services (as determined by the Secretary) provided in a particular geographic area (other than in a case described in item (bb)), such sponsor or issuer shall dem-
onstrate that such sponsor or issuer will use any database free of conflicts of interest that has sufficient information reflecting allowed amounts paid to individual health care providers for relevant services provided in the applicable geographic region (such as All Payer Claims Databases (as defined in section 4(d) of the No Surprises Act) of States), and that such sponsor or issuer will use any such database to determine a median contracted rate and cover the cost of accessing any such database; and

“(bb) in the case of a sponsor or issuer offering a health plan in a geographic region that did not offer any health plan in such region during 2019, such sponsor or issuer shall use a methodology established by the Secretary for determining the median contracted rate for items
and services covered by such plan for the first year in which such plan is offered in such region, and that, for each succeeding year, the median contracted rate for such items and services under such plan shall be the median contracted rate for such items and services under such plan for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

“(II) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall prevent the sponsor or issuer of a health plan from establishing separate calculations of a median contracted rate under this subparagraph for items and services delivered in non-hospital facilities, including independent freestanding emergency departments.
“(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 health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

“(ii) Participating emergency facility.—The term ‘participating emergency facility’ means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

“(G) Nonparticipating providers; participating providers.—
“(i) Nonparticipating Provider.—

The term ‘nonparticipating provider’ means, with respect to an item or service and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

“(ii) Participating Provider.—The term ‘participating provider’ means, with respect to an item or service and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider’s license or certification under applicable State law and who has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.
“(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 regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan and receiving such item or service from a nonparticipating provider or facility, not more than the amount determined in accordance with such law plus the cost-sharing amount imposed under the plan 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 rulemaking de-
scribed in subparagraph (E)(ii)) for such item or service.”.

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

“(1) IN GENERAL.—Subject to paragraph (3), 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)(3)(G)(i)) during a visit (as defined by the Secretary in accordance with paragraph (2)(C)) 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 (as defined in subsection (b)(3)(G)(ii));

“(B) shall calculate such cost-sharing amount as if the amount that would have been charged for such items and services by such participating provider were equal to—

“(i) in the case of such items and services furnished in a State described in subsection (b)(3)(H)(ii), the median contracted rate (as defined in subsection (b)(3)(E)(i)) for such items and services; and

“(ii) in the case of such items and services furnished in a State described in subsection (b)(3)(H)(i), the lesser of—

“(I) the amount determined by such State for such items and services in accordance with the method described in such subsection; and

“(II) the median contracted rate (as so defined) for such items and services;
“(C) 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)(3)(H)) for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B));

and

“(D) shall count toward any in-network 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 and subsection (b):

“(A) HEALTH PLAN.—The term ‘health plan’ means a group health plan and health insurance coverage offered by a health insurance issuer in the group or individual market and includes a grandfathered health plan (as defined
in section 1251(e) of the Patient Protection and Affordable Care Act).

“(B) PARTICIPATING HEALTH CARE FACILITY.—

“(i) IN GENERAL.—The term ‘participating health care facility’ means, with respect to an item or service and a health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) 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 facility or imaging center.

“(C) During a visit.—The term ‘during a visit’ shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

“(3) Exception.—Paragraph (1) shall not apply to a health plan 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)(3)(G)(i)) during a visit (as defined by the Secretary in accordance with paragraph (2)(C)) at a participating health care facility (as defined in paragraph (2)(B)) if such provider is in compliance with section 2799A(d) with respect to such items and services.”.

(c) Provider Directory Requirements; Disclosure on Patient Protections.—Section 2719A of the
Public Health Service Act, as amended by subsection (b),
is further amended by adding at the end the following new
subsections:

“(f) PROVIDER DIRECTORY INFORMATION REQUIRE-
MENTS.—

“(1) IN GENERAL.—Not later than 1 year after
the date of the enactment of this subsection, each
group health plan and health insurance issuer offer-
ing group or individual health insurance coverage
shall—

“(A) establish the verification process de-
scribed in paragraph (2);

“(B) establish the response protocol de-
scribed in paragraph (3);

“(C) establish the database described in
paragraph (4); and

“(D) include in any print directory con-
taining provider directory information with re-
spect to such plan or such coverage the infor-
mation described in paragraph (5).

“(2) VERIFICATION PROCESS.—The verification
process described in this paragraph is, with respect
to a group health plan or a health insurance issuer
offering group or individual health insurance cov-
ervation, a process under which—
“(A) not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database; and

“(B) such plan or such issuer removes any such provider or facility with respect to which such plan or such issuer has been unable to verify such information during any 6-month period.

“(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

“(A) responds to such individual as soon as practicable and in no case later than 1 busi-
ness day after such call is received through a written electronic communication; and

“(B) retains such communication in such individual’s file for at least 2 years following such response.

“(4) DATABASE.—The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, a database on the public website of such plan or issuer that contains—

“(A) a list of each health care provider and health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage; and

“(B) provider directory information with respect to each such provider and facility.

“(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of
the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

“(6) DEFINITION.—For purposes of this subsection, the term ‘provider directory information’ includes, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

“(g) DISCLOSE ON PATIENT PROTECTIONS.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, and (if applicable) post on a public website of such plan or issuer—

“(1) information in plain language on—

“(A) the requirements and prohibitions applied under sections 2799 and 2799A (relating
to prohibitions on balance billing in certain circumstances);

“(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

“(C) the requirements applied under subsections (b) and (e); and

“(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.”.

(d) Preventing Certain Cases of Balance Billing.—Title XXVII of the Public Health Service Act is amended by adding at the end the following new part:
“PART D—PREVENTING CERTAIN CASES OF
BALANCE BILLING

“SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

“(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a health plan 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—

“(1) the emergency department of a hospital or independent freestanding emergency department shall not hold the participant, beneficiary, or enrollee 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)); and

“(2) a health care provider shall not hold such participant, beneficiary, or enrollee 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)).

“(b) DEFINITIONS.—In this section:

“(1) The terms ‘emergency department of a hospital’, ‘emergency medical condition’, ‘emergency services’, and ‘independent freestanding emergency department’ have the meanings given such terms, respectively, in section 2719A(b)(3).

“(2) The term ‘health plan’ has the meaning given such term in section 2719A(e).

“(3) The term ‘during a visit’ shall have such meaning as applied to such term for purposes of section 2719A(e).

“SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

“(a) IN GENERAL.—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a health plan (as defined in section 2799(b)) who is furnished on or after January 1, 2021, items or services (other than emergency services to which section 2799 applies) at a participating health care facility by a non-participating provider, such provider shall not hold such participant, beneficiary, or enrollee liable for a payment
amount for such an item or service furnished by such pro-
vider during a visit at such facility that is more than the
cost-sharing amount for such item or service (as deter-
dined in accordance with subparagraphs (A) and (B) of
section 2719A(e)(1)).

“(b) EXCEPTION.—

“(1) IN GENERAL.—Subsection (a) shall not
apply to a nonparticipating provider (other than a
specified provider at a participating health care fa-
cility), with respect to items or services furnished by
the provider to a participant, beneficiary, or enrollee
of a health plan, if the provider is in compliance
with the notice and consent requirements of sub-
section (d).

“(2) SPECIFIED PROVIDER DEFINED.—For pur-
poses of paragraph (1), the term ‘specified provider’,
with respect to a participating health care facility—

“(A) means a facility-based provider, in-
cluding emergency medicine providers, anesthe-
siologists, pathologists, radiologists,
neonatologists, assistant surgeons, hospitalists,
intensivists, or other providers as determined by
the Secretary; and

“(B) includes, with respect to an item or
service, a nonparticipating provider if there is
no participating provider at such facility who
can furnish such item or service.

“(c) CLARIFICATION.—In the case of a nonparticipating provider (other than a specified provider at a participating health care facility) that complies with the notice and consent requirements of subsection (d) with respect to an item or service (referred to in this subsection as a ‘covered item or service’), such notice and consent requirements may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen medical needs that arise at the time such covered item or service is furnished.

“(d) COMPLIANCE WITH NOTICE AND CONSENT REQUIREMENTS.—

“(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility is in compliance with this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a health plan, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

“(A) provides to the participant, beneficiary, or enrollee (or to an authorized 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 or services—

“(i) an oral explanation of the written notice described in clause (ii); and

“(ii) a written notice specified, not later than July 1, 2020, by the Secretary through guidance (which shall be updated as determined necessary by the Secretary) that—

“(I) contains the information required under paragraph (2); and

“(II) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, beneficiary, or en-
rollee being furnished such items or
services by such provider; and

“(B) obtains from the participant, bene-

ficiary, or enrollee (or from such an authorized
representative) the consent described in para-
graph (3).

“(2) INFORMATION REQUIRED UNDER WRITTEN
NOTICE.—For purposes of paragraph (1)(A)(ii)(I),
the information described in this paragraph, with re-
spect to a nonparticipating provider or nonpartici-
pating facility and a participant, beneficiary, or en-
rollee of a health plan, is each of the following:

“(A) Notification, as applicable, that the
health care provider is a nonparticipating pro-
vider with respect to the health plan or the
health care facility is a nonparticipating facility
with respect to the health plan;

“(B) Notification of the estimated amount
that such provider or facility may charge the
participant, beneficiary, or enrollee for such
items and services involved.

“(C) In the case of a nonparticipating fa-
cility, a list of any participating providers at the
facility who are able to furnish such items and
services involved and notification that the par-
participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

“(3) CONSENT DESCRIBED.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a health plan who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary through rulemaking that—

“(A) is signed by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider or facility that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider or facility;

“(B) 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 provider or facility; and

“(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the health plan places on cost-sharing; and

“(C) documents the consent of the participant, beneficiary, or enrollee to—

“(i) be furnished with such items or services by such provider or facility; 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 charged the individual if furnished by a participating provider or participating facility with respect to such items or services and plan.

“(e) RETENTION OF CERTAIN DOCUMENTS.—A non-participating provider (or, in the case of a nonparticipating provider at a participating health care facility, such facility) or nonparticipating facility that obtains from a
participant, beneficiary, or enrollee of a health plan (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (c)(1)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 2-year period after the date on which such item or service is so furnished.

“(f) DEFINITIONS.—In this section:

“(1) The terms ‘nonparticipating provider’ and ‘participating provider’ have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

“(2) The terms ‘participating health care facility’ and ‘health plan’ have the meanings given such terms, respectively, in subsection (e)(2) of section 2719A.

“(3) The term ‘nonparticipating facility’ means—

“(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable,
issuer offering the plan) for furnishing such services under the plan; and

“(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan.

“(4) The term ‘participating facility’ means—

“(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan; and

“(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency de-
part of the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan.

“SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO PROVIDER DIRECTORY INFORMATION.

“No later than 1 year after the date of the enactment of this section, each health care provider and health care facility shall establish a process under which such provider or facility transmits, to each health insurance issuer offering group or individual health insurance coverage and group health plan with which such provider or facility has in effect a contractual relationship for furnishing items and services under such coverage or such plan, provider directory information (as defined in section 2719A(f)(6)) with respect to such provider or facility, as applicable. Such provider or facility shall so transmit such information to such issuer offering such coverage or such group health plan—

“(1) when the provider or facility enters into such a relationship with respect to such coverage offered by such issuer or with respect to such plan;

“(2) when the provider or facility terminates such relationship with respect to such coverage offered by such issuer or with respect to such plan;
“(3) when there are any other material changes to such provider directory information of the provider or facility with respect to such coverage offered by such issuer or with respect to such plan; and

“(4) at any other time determined appropriate by the provider, facility, or the Secretary.

“SEC. 2799C. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

“Each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility—

“(1) information in plain language on—

“(A) the requirements and prohibitions of such provider or facility under sections 2799 and 2799A (relating to prohibitions on balance billing in certain circumstances); and

“(B) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a health plan (as defined in section 2719A(e)(2)) with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service.
under the plan after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

“(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

“SEC. 2799D. ENFORCEMENT.

“(a) STATE ENFORCEMENT.—

“(1) STATE AUTHORITY.—Each State may require a provider or health care facility subject to the requirements of sections 2799, 2799A, 2799B, or 2799C to satisfy such requirements applicable to the provider or facility.

“(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to applicable providers and facilities in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to actions prohibited under this part occurring in such State.

“(b) SECRETARIAL ENFORCEMENT AUTHORITY.—
“(1) In General.—If a provider or facility is found to be in violation of this part by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility in an amount not to exceed $10,000 per violation. The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

“(2) Limitation.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) of this part only as provided under subsection (a)(2).

“(3) Complaint Process.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of this part and resolve such complaints within 60 days of receipt of such complaints.

“(4) Exception.—The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider who does not knowingly violate, and should not have reasonably known it violated, a provision of this part with respect to
a participant, beneficiary, or enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of such provision, and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

“(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

“(c) CONTINUED APPLICABILITY OF STATE LAW.—This part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of this part.”.

(e) RULEMAKING FOR MEDIAN CONTRACTED RATES.—Not later than July 1, 2020, the Secretary of Health and Human Services, jointly with the Secretary of Labor, shall establish through rulemaking the methodology the sponsor or issuer of a health plan (as defined in subsection (e) of section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by sub-
section (b) of this section) shall use to determine the median contracted rate (as defined in section 2719A(b) of such Act, as amended by subsection (a) of this section), the information such sponsor or issuer shall share with the nonparticipating provider (as defined in such section) involved when making such a determination, and the geographic regions applied for purposes of this subparagraph (E) of section 2719A(b)(3), as amended by subsection (a) of this section.

(f) Effective Date.—The amendments made by subsections (a) and (b) shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 3. GOVERNMENT ACCOUNTABILITY OFFICE STUDY ON PROFIT- AND REVENUE-SHARING IN HEALTH CARE.

(a) Study.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study to—

1. describe what is known about profit- and revenue-sharing relationships in the commercial health care markets, including those relationships that—

   (A) involve one or more—

   (i) physician groups that practice within a hospital included in the profit-
revenue-sharing relationship, or refer patients to such hospital;

(ii) laboratory, radiology, or pharmacy services that are delivered to privately insured patients of such hospital;

(iii) surgical services;

(iv) hospitals or group purchasing organizations; or

(v) rehabilitation or physical therapy facilities or services; and

(B) include revenue- or profit-sharing whether through a joint venture, management or professional services agreement, or other form of gain-sharing contract;

(2) describe Federal oversight of such relationships, including authorities of the Department of Health and Human Services and the Federal Trade Commission to review such relationships and their potential to increase costs for patients, and identify limitations in such oversight; and

(3) as appropriate, make recommendations to improve Federal oversight of such relationships.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report on the
study conducted under subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and Committee on Energy and Commerce of the House of Representatives.

SEC. 4. STATE ALL PAYER CLAIMS DATABASES.

(a) In General.—The Secretary of Health and Human Services shall make one-time grants to eligible States for the purposes described in subsection (b).

(b) Uses.—A State may use a grant received under subsection (a) for one of the following purposes:

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

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

(e) Eligibility.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary 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.
(d) **All Payer Claims Database.**—For purposes of this section, 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.

(e) **Authorization of Appropriations.**—To carry out this section, there are authorized to be appropriated $50,000,000, to remain available until expended.

**SEC. 5. SIMPLIFYING EMERGENCY AIR AMBULANCE BILLING.**

(a) **In General.**—Providers of emergency air medical services shall submit to a group health plan or health insurance issuer offering group or individual health insurance coverage, together with an electronic claims transaction with respect to an enrollee in such plan or coverage, a description of charges for such services that are separated by—

(1) the cost of air travel; and

(2) the cost of emergency medical services and supplies.

(b) **Rulemaking.**—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall determine the form and manner
for submitting the description of charges in subsection (a)
through notice and comment rulemaking.

(c) Civil Monetary Penalties.—

(1) In general.—A provider of emergency air
medical services who violates the requirement of sub-
section (a) shall be subject to a civil monetary pen-
alty of not more than $10,000 for each act constit-
tuting such violation.

(2) Procedure.—The provisions of section
1128A of the Social Security Act (42 U.S.C. 1320a–
7a), other than subsections (a) and (b) and the first
sentence of subsection (c)(1) of such section, shall
apply to civil money penalties under this subsection
in the same manner as such provisions apply to a
penalty or proceeding under section 1128A of the
Social Security Act.

(d) Definitions.—In this section, the terms “group
health plan”, “health insurance coverage”, and “health in-
surance issuer” have the meanings given such terms in
section 2791 of the Public Health Service Act (42 U.S.C.
300gg–91).

(e) Effective Date.—The requirement under sub-
section (a) shall take effect 6 months after the rules de-
scribed in subsection (b) are finalized.
SEC. 6. REPORT BY SECRETARY OF LABOR.

Not later than one year after the date of the enactment of this Act, and annually thereafter for each of the following 5 years, the Secretary of Labor shall—

(1) conduct a study of—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs in group health plans, including out-of-pocket costs that are permitted by reason of compliance with section 2799A(d) of the Public Health Service Act, as added by section 2(d);

(B) the adequacy of provider networks in group health plans; and

(C) such other effects of such provisions, and amendments, as the Secretary deems relevant; and

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and the Committee on Energy and Commerce of the House of Representatives.