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(Original Signature of Member)

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. RUIZ 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.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Protecting People From Surprise Medical Bills Act”.

6 (b) TABLE OF CONTENTS.—The table of contents for  
7 this Act is as follows:

Sec. 1. Short title; table of contents.

- Sec. 2. Preventing surprise medical bills.
- Sec. 3. Transparency regarding in-network and out-of-network deductibles.
- Sec. 4. Transparency for In-Network Patients.
- Sec. 5. Reporting requirements.
- Sec. 6. Billing statute of limitations.
- Sec. 7. Application.
- Sec. 8. Studies by Secretaries of Health and Human Services and of Labor.
- Sec. 9. Regulations.

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

2 (a) EMERGENCY SERVICES PERFORMED BY NON-  
3 PARTICIPATING PROVIDERS.—Section 2719A of the Pub-  
4 lic Health Service Act (42 U.S.C. 300gg–19a) is amend-  
5 ed—

6 (1) in subsection (b)—

7 (A) in paragraph (1)—

8 (i) in the matter preceding subpara-  
9 graph (A)—

10 (I) by striking “offering group or  
11 individual health insurance issuer”  
12 and inserting “offering group or indi-  
13 vidual health insurance coverage”;  
14 and

15 (II) by striking “paragraph  
16 (2)(B)” and inserting “paragraph  
17 (2)”;

18 (ii) in subparagraph (B), by inserting  
19 “or a participating emergency facility, as  
20 applicable,” after “participating provider”;  
21 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, coinsur-  
3           ance rate, or deductible) is not greater  
4           than the requirement that would apply if  
5           such services were provided by a partici-  
6           pating provider or a participating emer-  
7           gency facility;” and

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

10           “(iii) the group health plan or health  
11           insurance issuer offering group or indi-  
12           vidual health insurance coverage pays to  
13           such provider or facility, respectively, sub-  
14           ject to subsection (f), the amount by which  
15           the commercially reasonable rate, as deter-  
16           mined by the plan or issuer, for such serv-  
17           ices exceeds the cost-sharing amount for  
18           such services (as determined in accordance  
19           with clause (ii)) and, if applicable, any  
20           amount to reconcile the difference between  
21           such rate so paid and the specified rate de-  
22           termined under subsection (f)(1)) for such  
23           services; and

24           “(iv) there shall be counted toward  
25           any deductible or out-of-pocket maximums

1 applied under the plan any cost-sharing  
2 payments made by the participant, bene-  
3 ficiary, or enrollee with respect to such  
4 emergency services so furnished in the  
5 same manner as if such cost-sharing pay-  
6 ments were with respect to emergency  
7 services furnished by a participating pro-  
8 vider and a participating emergency facil-  
9 ity.”; and

10 (B) in paragraph (2)—

11 (i) in the matter preceding subpara-  
12 graph (A), by inserting “and subsection  
13 (e)” after “this subsection”;

14 (ii) by redesignating subparagraph  
15 (C) as subparagraph (H); and

16 (iii) by inserting after subparagraph  
17 (C) the following subparagraphs:

18 “(D) NONPARTICIPATING EMERGENCY FA-  
19 CILITY; PARTICIPATING EMERGENCY FACIL-  
20 ITY.—

21 “(i) NONPARTICIPATING EMERGENCY  
22 FACILITY.—The term ‘nonparticipating  
23 emergency facility’ means, with respect to  
24 an item or service and a group health plan  
25 or health insurance coverage offered by a

1 health insurance issuer, an emergency de-  
2 partment of a hospital or an independent  
3 freestanding emergency department, that  
4 does not have a contractual relationship  
5 with the plan or coverage for furnishing  
6 such item or service.

7 “(ii) PARTICIPATING EMERGENCY FA-  
8 CILITY.—The term ‘participating emer-  
9 gency facility’ 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, an emergency de-  
13 partment of a hospital or an independent  
14 freestanding emergency department, that  
15 has a contractual relationship with the  
16 plan or coverage for furnishing such item  
17 or service.

18 “(E) NONPARTICIPATING PROVIDERS; PAR-  
19 TICIPATING PROVIDERS.—

20 “(i) NONPARTICIPATING PROVIDER.—  
21 The term ‘nonparticipating provider’  
22 means, with respect to an item or service  
23 and a group health plan or health insur-  
24 ance coverage offered by a health insur-  
25 ance issuer, a physician or other health

1 professional who is licensed by the State  
2 involved to furnish such item or service  
3 and who does not have a contractual rela-  
4 tionship with the plan or coverage for fur-  
5 nishing such item or service.

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

16 (b) NON-EMERGENCY SERVICES PERFORMED BY  
17 NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-  
18 PATING FACILITIES.—Section 2719A of the Public Health  
19 Service Act (42 U.S.C. 300gg–19a) is amended by adding  
20 at the end the following new 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)) (including imaging or laboratory  
7 services so furnished by a nonparticipating provider  
8 when ordered by a participating provider or after-  
9 emergency care furnished by a nonparticipating pro-  
10 vider in the case that the participant, beneficiary, or  
11 enrollee cannot travel without medical transport),  
12 with respect to such plan, the plan—

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

21 “(B) shall pay to such provider furnishing  
22 such items and services to such participant,  
23 beneficiary, or enrollee, subject to subsection  
24 (f), the amount by which the commercially rea-  
25 sonable rate, as determined by the plan or

1 issuer, for such services exceeds the cost-shar-  
2 ing amount imposed for such services (as deter-  
3 mined in accordance with subparagraph (A))  
4 and, if applicable, any amount to reconcile the  
5 difference between such rate so paid and the  
6 specified rate determined under subsection  
7 (f)(1)) for such services; and

8 “(C) shall count toward any deductible or  
9 out-of-pocket maximums applied under the plan  
10 any cost-sharing payments made by the partici-  
11 pant, beneficiary, or enrollee with respect to  
12 such items and services so furnished in the  
13 same manner as if such cost-sharing payments  
14 were with respect to items and services fur-  
15 nished by a participating provider.

16 “(2) DEFINITIONS.—In this subsection and  
17 subsection (f):

18 “(A) HEALTH PLAN.—The term ‘health  
19 plan’ means a group health plan and health in-  
20 surance coverage offered by a health insurance  
21 issuer in the group or individual market.

22 “(B) PARTICIPATING HEALTH CARE FACIL-  
23 ITY.—

24 “(i) IN GENERAL.—The term ‘partici-  
25 pating health care facility’ means, with re-

1 spect to an item or service and a group  
2 health plan or health insurance coverage  
3 offered by a health insurance issuer, a  
4 health care facility described in clause (ii)  
5 that has a contractual relationship with  
6 the plan or coverage for furnishing such  
7 item or service.

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

11 “(I) A hospital (as defined in  
12 1861(e) of the Social Security Act).

13 “(II) A critical access hospital  
14 (as defined in section 1861(mm) of  
15 such Act).

16 “(III) An ambulatory surgical  
17 center (as defined in section  
18 1833(i)(1)(A) of such Act).

19 “(IV) A laboratory.

20 “(V) A radiology or imaging cen-  
21 ter.

22 “(VI) Any other facility that pro-  
23 vides services that are covered under  
24 a group health plan or health insur-  
25 ance coverage.

1                                   “(VII) Any other facility speci-  
2                                   fied by the Secretary.”.

3           (c) NEGOTIATION AND ARBITRATION PROCESS FOR  
4 DETERMINING PRICES.—Section 2719A of the Public  
5 Health Service Act (42 U.S.C. 300gg–19a), as amended  
6 by subsection (b), is further amended by adding at the  
7 end the following new subsection:

8           “(f) NEGOTIATION AND ARBITRATION PROCESS.—

9                   “(1) SPECIFIED AMOUNT.—For purposes of  
10 subsections (b) and (e) and this subsection, the spec-  
11 ified amount determined under this subsection, with  
12 respect to a health plan and nonparticipating pro-  
13 vider for an item or service, is—

14                           “(A) in the case the plan and provider  
15 enter into negotiations pursuant to paragraph  
16 (2) and such negotiations are successful, the  
17 amount determined for such item or service  
18 pursuant to such negotiations; or

19                           “(B) in the case the plans and provider  
20 enter into such negotiations but such negotia-  
21 tions are not successful, the reasonable amount  
22 determined for such item or service pursuant to  
23 the independent dispute resolution process  
24 under paragraph (3).

1           “(2) NEGOTIATIONS.—For purposes of sub-  
2           sections (b)(1)(C)(iii) and (e)(1)(B), in the case of  
3           a payment of a commercially reasonable rate made  
4           by a health plan to a nonparticipating provider pur-  
5           suant to such respective subsection for an item or  
6           service, the provider and plan may, not later than 30  
7           days after the date of such payment, negotiate an  
8           amount of payment (other than the commercially  
9           reasonable rate specified in such subsection) to be  
10          made for such item or service.

11          “(3) INDEPENDENT DISPUTE RESOLUTION.—

12                 “(A) IN GENERAL.—If, by the end of such  
13                 30-day period specified in paragraph (2), the  
14                 plan and provider have not determined a nego-  
15                 tiated amount for the payment involved, the  
16                 plan or provider may initiate an independent  
17                 dispute resolution process under this paragraph  
18                 to determine the amount of payment.

19                 “(B) ESTABLISHMENT OF IDR.—

20                         “(i) IN GENERAL.—Not later than  
21                         January 1, 2021, the Secretary, in con-  
22                         sultation with the Secretary of Labor, shall  
23                         establish a process for resolving payment  
24                         disputes between health plans and non-  
25                         participating providers for purposes of de-

1           termining amounts of payments to be  
2           made by the plans to the providers pursu-  
3           ant to subsections (b) and (e) (referred to  
4           in this section as the ‘IDR process’).

5           “(ii) ENTITIES.—An entity wishing to  
6           participate in the IDR process under this  
7           subsection shall request certification from  
8           the Secretary. The Secretary, in consulta-  
9           tion with the Secretary of Labor, shall de-  
10          termine eligibility of applicant entities, tak-  
11          ing into consideration whether the entity is  
12          unbiased and unaffiliated with health plans  
13          and providers and free of conflicts of inter-  
14          est, in accordance with the Secretary’s  
15          rulemaking on determining criteria for con-  
16          flicts of interest.

17          “(iii) APPLICABLE CLAIMS.—

18                 “(I) IN GENERAL.—The IDR  
19                 process shall be with respect to one or  
20                 more Current Procedural Terminology  
21                 (‘CPT’) codes.

22                 “(II) BATCHING OF CLAIMS.—  
23                 Claims may be batched if such  
24                 claims—

1           “(aa) involve identical plan  
2           or issuer and provider or facility  
3           parties;

4           “(bb) involve claims with the  
5           same or related current proce-  
6           dural terminology codes relevant  
7           to a particular procedure; and

8           “(cc) involve claims that  
9           occur within 60 days of each  
10          other.

11           “(C) INDEPENDENT DISPUTE RESOLUTION  
12          PROCESS.—

13           “(i) TIMING.—In the case of an IDR  
14          entity that receives a request under this  
15          paragraph, with respect to a payment  
16          amount to be paid by a health plan to a  
17          nonparticipating provider—

18           “(I) the plan and provider may,  
19          during the 30-day period following the  
20          date of receipt of such request, submit  
21          any information or supporting docu-  
22          mentation to the IDR entity; and

23           “(II) the IDR entity shall, not  
24          later than 60 days after receiving  
25          such request, determine such amount.

1 “(ii) DETERMINATION OF AMOUNT.—

2 “(I) IN GENERAL.—The amount  
3 determined by the IDR entity under  
4 clause (i), with respect to a payment  
5 amount to be paid by a health plan to  
6 a nonparticipating provider for an  
7 item or service shall be—

8 “(aa) the initial charge for  
9 the item or service made by the  
10 provider or the commercially rea-  
11 sonable rate paid by the plan for  
12 the item or service under sub-  
13 sections (b)(1)(C)(iii) or  
14 (e)(1)(B), respectively, whichever  
15 is determined reasonable by the  
16 entity based on the factors de-  
17 scribed in subclause (III); or

18 “(bb) in the case neither  
19 such charge or such rate is deter-  
20 mined by the entity to be reason-  
21 able, the final offer submitted  
22 under subclause (II) that is de-  
23 termined more reasonable in ac-  
24 cordance with such subclause.

1                   “(II) FINAL OFFERS.—For pur-  
2                   poses of subclause (I)(bb), the health  
3                   plan and the nonparticipating pro-  
4                   vider party to the independent dispute  
5                   resolution under this paragraph shall  
6                   each submit to the IDR entity their  
7                   final offer for an amount for the pay-  
8                   ment that is subject to the dispute not  
9                   later than 30 days after the IDR enti-  
10                  ty determines under such subclause  
11                  that neither the charge or rate de-  
12                  scribed in subclause (I)(aa) were rea-  
13                  sonable. Not later than 60 days after  
14                  such date of such determination, such  
15                  entity shall determine which of the 2  
16                  final offers is more reasonable based  
17                  on the factors described in subclause  
18                  (III).

19                  “(III) FACTORS.—For purposes  
20                  of subclauses (I) and (II), the factors  
21                  described in this subclause include, as  
22                  relevant—

23                                 “(aa) commercially reason-  
24                                 able rates for comparable services  
25                                 or items in the same geographic

1 area (which shall take into con-  
2 sideration in-network rates for  
3 that geographic area and not  
4 charges);

5 “(bb) the usual and cus-  
6 tomary cost of the item or service  
7 involved, determined as the 80th  
8 percentile of charges for com-  
9 parable items and services for the  
10 specialty involved in the geo-  
11 graphical area in which the item  
12 or service was furnished, as de-  
13 termined through reference to a  
14 medical claims database;

15 “(cc) other factors that may  
16 be submitted at the discretion of  
17 either party, which may in-  
18 clude—

19 “(dd) the level of training,  
20 education, experience, and quality  
21 and outcomes measurements of  
22 the nonparticipating provider;

23 “(ee) the circumstances and  
24 complexity of the particular dis-

1           pute, including the time and  
2           place of the service;

3                   “(ff) the provider’s quality  
4           and outcome metrics;

5                   “(gg) the provider’s usual  
6           charge for comparable services  
7           with regard to patients in health  
8           care plans in which the provider  
9           is not participating;

10                   “(hh) the individual patient  
11           characteristics; and

12                   “(ii) other relevant economic  
13           and clinical factors.

14                   “(IV) FINAL DECISIONS.—The  
15           amount that is determined to be the  
16           more reasonable amount under item  
17           (aa) or (bb) of subclause (I), as appli-  
18           cable, shall be the final decision of the  
19           IDR entity as to the amount the  
20           health plan is required to pay the pro-  
21           vider.

22                   “(V) EFFECT OF DETERMINA-  
23           TION.—A final determination of an  
24           IDR entity under subclause (IV)—

25                   “(aa) shall be binding; and

1                   “(bb) shall not be subject to  
2                   judicial review, except in cases  
3                   comparable to those described in  
4                   section 10(a) of title 9, United  
5                   States Code, as determined by  
6                   the Secretary in consultation  
7                   with the Secretary of Labor, and  
8                   cases in which information sub-  
9                   mitted by one party was deter-  
10                  mined to be fraudulent.

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

16                  “(iv) PUBLIC AVAILABILITY.—The  
17                  reasonable amount determined by an IDR  
18                  entity under this paragraph with respect to  
19                  any claim shall not be confidential, except  
20                  that information submitted to the IDR en-  
21                  tity shall be kept confidential. IDR entities  
22                  may consider past decisions awarded by  
23                  independent dispute entities during the  
24                  independent dispute resolution process.

1           “(v) COSTS OF INDEPENDENT DIS-  
2           PUTE RESOLUTION PROCESS.—The non-  
3           prevailing party shall be responsible for  
4           paying all fees charged by the IDR entity.  
5           If the parties reach a settlement prior to  
6           completion of the IDR process, the costs of  
7           the independent dispute resolution process  
8           shall be divided equally between the par-  
9           ties.

10           “(vi) PAYMENT.—Any difference be-  
11           tween—

12                   “(I) the amount determined to be  
13                   paid by one party of the dispute reso-  
14                   lution to another pursuant to this  
15                   paragraph; and

16                   “(II) the amounts already paid  
17                   under subsection (b) or (e) before en-  
18                   tering into the process under this  
19                   paragraph,

20           shall be paid not later than 15 days after  
21           the date on which the entity makes a de-  
22           termination with respect to such amount.

23           “(D) PUBLICATION.—The Secretary shall  
24           publish aggregated results of the independent  
25           dispute resolution by geographic region in order

1 to give more guidance to providers and health  
2 plans.”.

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

7 “(t)(1) Subject to paragraph (3), in the case of an  
8 individual with benefits under a health plan or health in-  
9 surance coverage offered in the group or individual market  
10 who is furnished on or after January 1, 2021, emergency  
11 services with respect to an emergency medical condition  
12 during a visit at an emergency department of a hospital—

13 “(A) if the emergency department of a hospital  
14 holds the individual liable for a payment amount for  
15 such emergency services so furnished that is more  
16 than the cost-sharing amount for such services (as  
17 determined in accordance with section  
18 2719A(b)(1)(C)(ii) of the Public Health Service  
19 Act); or

20 “(B) if any health care provider holds such in-  
21 dividual liable for a payment amount for an emer-  
22 gency service furnished to such individual by such  
23 provider with respect to such emergency medical  
24 condition and visit for which the individual receives  
25 emergency services at the hospital or emergency de-

1       partment that is more than the cost-sharing amount  
2       for such services furnished by the provider (as deter-  
3       mined in accordance with section 2719A(b)(1)(C)(ii)  
4       of the Public Health Service Act);  
5       the hospital, emergency department or health care  
6       provider, respectively, shall be subject, in addition to  
7       any other penalties that may be prescribed by law,  
8       to a civil money penalty of not more than an amount  
9       determined appropriate by the Secretary for each  
10      specified claim.

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

16      “(3) Paragraph (1) shall not apply to an emergency  
17 department of a hospital or a provider, with respect to  
18 items or services furnished to a participant, beneficiary,  
19 or enrollee of a health plan or health insurance coverage  
20 offered by a health insurance issuer, if the emergency de-  
21 partment of the hospital or the provider, respectively, re-  
22 imburses such participant, beneficiary, or enrollee any  
23 amount for such an item or service that is more than the  
24 cost-sharing amount for such item or service (as deter-  
25 mined in accordance with section 2719A(e)(1)(A)) not

1 later than 30 days after the date the emergency depart-  
2 ment of the hospital or provider, respectively, knew or  
3 should have known such excess payment was in violation  
4 of this subsection.

5 “(4) In this subsection and subsection (u):

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

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

14 “(u)(1) Subject to paragraph (2), in the case of an  
15 individual with benefits under a health plan or health in-  
16 surance coverage offered in the group or individual market  
17 who is furnished on or after January 1, 2021, items or  
18 services (other than emergency services to which sub-  
19 section (t) applies) during an episode of care (as defined  
20 by the Secretary) at a participating health care facility  
21 by a nonparticipating provider (including imaging or lab-  
22 oratory services so furnished by a nonparticipating pro-  
23 vider when ordered by a participating provider or after-  
24 emergency care furnished by a nonparticipating provider  
25 in the case that the participant, beneficiary, or enrollee

1 cannot travel without medical transport), if such non-  
2 participating provider holds such individual liable for a  
3 payment amount for such an item or service furnished by  
4 such provider that is more than the cost-sharing amount  
5 for such item or service (as determined in accordance with  
6 section 2719A(e)(1)(A) of the Public Health Service Act),  
7 such provider shall be subject, in addition to any other  
8 penalties that may be prescribed by law, to a civil money  
9 penalty of not more than \$an amount determined appro-  
10 priate by the Secretary for each specified claim.

11 “(2) Paragraph (1) shall not apply to a nonpartici-  
12 pating provider, with respect to items or services furnished  
13 by the provider to a participant, beneficiary, or enrollee  
14 of a health plan or health insurance coverage offered by  
15 a health insurance issuer, if the provider reimburses such  
16 participant, beneficiary, or enrollee any amount for such  
17 an item or service that is more than the cost-sharing  
18 amount for such item or service (as determined in accord-  
19 ance with section 2719A(e)(1)(A) not later than 30 days  
20 after the date the provider knew or should have known  
21 such excess payment was in violation of this subsection.

22 “(3) For purposes of this subsection, the terms ‘non-  
23 participating provider’ and ‘participating health care facil-  
24 ity’ have such meanings given such terms under sub-

1 sections (b)(2) and (e)(2), respectively, of section 2719A  
2 of the Public Health Service Act.”.

3 (e) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply with respect to plan years begin-  
5 ning on or after January 1, 2021.

6 **SEC. 3. TRANSPARENCY REGARDING IN-NETWORK AND**  
7 **OUT-OF-NETWORK DEDUCTIBLES.**

8 (a) IN GENERAL.—Subpart II of part A of title  
9 XXVII of the Public Health Service Act (42 U.S.C. 300gg  
10 et seq.) is amended by adding at the end the following:

11 **“SEC. 2729A. TRANSPARENCY REGARDING IN-NETWORK**  
12 **AND OUT-OF-NETWORK DEDUCTIBLES.**

13 “(a) IN GENERAL.—A group health plan or a health  
14 insurance issuer offering group or individual health insur-  
15 ance coverage and providing or covering any benefit with  
16 respect to items or services shall include, in clear writing,  
17 on any plan or insurance identification card issued to en-  
18 rollees in the plan or coverage the amount of the in-net-  
19 work and out-of-network deductibles and the out-of-pocket  
20 maximum limitation that apply to such plan or coverage.

21 “(b) GUIDANCE.—The Secretary, in consultation  
22 with the Secretary of Labor, shall issue guidance to imple-  
23 ment subsection (a).”.

24 (b) EFFECTIVE DATE.—The amendment made by  
25 subsection (a) shall apply with respect to plan years begin-

1 ning on or after the date that is one year after the date  
2 of the enactment of this Act.

3 **SEC. 4. TRANSPARENCY FOR IN-NETWORK PATIENTS.**

4 Subpart II of part A of title XXVII of the Public  
5 Health Service Act (42 U.S.C. 300gg et seq.), as amended  
6 by section 3, is further amended by adding at the end the  
7 following:

8 **“SEC. 2729B. TRANSPARENCY FOR IN-NETWORK PATIENTS.**

9 “(a) STANDARDS.—Not later than January 1, 2021,  
10 the Secretary shall, through rulemaking, establish trans-  
11 parency standards to provide better information to individ-  
12 uals who are enrolled in group health plans or health in-  
13 surance coverage offered in the individual or group market  
14 (as such terms are defined in section 2791 of the Public  
15 Health Service Act (42 U.S.C. 300gg–91)) about which  
16 health care providers are participating in the network of  
17 the plan or coverage in which such an individual is en-  
18 rolled. Such standards shall at a minimum provide for the  
19 following:

20 “(1) Such plans and coverage offer provider di-  
21 rectories online and in print.

22 “(2) Annual audits of such provider directories,  
23 as specified by the Secretary.

24 “(3) Monthly updates of such online directories.

1 “(b) GUIDANCE.—Beginning January 1, 2022, a  
2 group health plan or a health insurance issuer offering  
3 group or individual health insurance coverage shall be in  
4 compliance with the standards established pursuant to  
5 subsection (a).”.

6 **SEC. 5. REPORTING REQUIREMENTS.**

7 Subpart II of part A of title XXVII of the Public  
8 Health Service Act (42 U.S.C. 300gg et seq.), as amended  
9 by sections 3 and 4, is further amended by adding at the  
10 end the following:

11 **“SEC. 2729C. TRANSPARENCY REQUIREMENTS.**

12 “(a) IN GENERAL.—Each group health plan and  
13 health insurance issuer offering group or individual health  
14 insurance coverage shall annually report (beginning for  
15 plan year 2021) to the Secretary and the Secretary of  
16 Labor, with respect to the applicable plan or coverage for  
17 the applicable plan year—

18 “(1) the total claims that were submitted by in-  
19 network health care providers with respect to enroll-  
20 ees under the plan or coverage, and the number of  
21 such claims that were paid and the number of such  
22 claims that were denied;

23 “(2) the total claims that were submitted by  
24 out-of-network health care providers with respect to  
25 enrollees under the plan or coverage, and the num-

1       ber of such claims that were paid and the number  
2       of such claims that were denied;

3           “(3) with respect to each out-of-network claim,  
4       the out-of-pocket costs to the enrollee for the serv-  
5       ices;

6           “(4) the number of out-of-network claims re-  
7       ported under paragraph (2) that are for emergency  
8       services; and

9           “(5) the number of out-of-network claims re-  
10      ported under paragraph (2) that relate to care at in-  
11      network hospitals or facilities provided by out-of-net-  
12      work providers.

13       “(b) CLARIFICATION.—The information required to  
14      be submitted under this section shall be in addition to the  
15      information required to be submitted under section  
16      2715A.”.

17   **SEC. 6. BILLING STATUTE OF LIMITATIONS.**

18       Notwithstanding any other provision of law, a health  
19      care provider may not seek reimbursement from an indi-  
20      vidual for a service furnished by such provider to such in-  
21      dividual more than a year after such date of service. Any  
22      provider that bills an individual in violation of the previous  
23      sentence shall be subject to a civil monetary penalty in  
24      such amount as specified by the Secretary of Health and  
25      Human Services.

1 **[SEC. 7. APPLICATION.**

2 (a) NON-APPLICATION IN CASES OF STATES WITH  
3 CERTAIN BALANCE BILLING LAWS.—Section 2719A of  
4 the Public Health Service Act (42 U.S.C. 300gg–19a) is  
5 amended by adding at the end the following new sub-  
6 section:

7 “(g) In any case in which a State has in effect a law  
8 or regulation that prohibits balance billing or otherwise  
9 provides an alternate method for resolving a dispute be-  
10 tween a health plan and provider for determining com-  
11 pensation for services described in subsections (b), (e), or  
12 (f), the provisions of such law and not the provisions of  
13 this Act shall apply to health plans (except self-insured  
14 group health plans that are not subject to State insurance  
15 regulation), health care providers, and individuals in such  
16 State so long as such law does not require an individual  
17 to pay more in cost-sharing than the amount that would  
18 otherwise be required of such individual under this sec-  
19 tion.”.

20 (b) APPLICATION TO FEHB.—

21 (1) IN GENERAL.—Section 8902 of title 5,  
22 United States Code, is amended by adding at the  
23 end the following new subsection:

24 “(p) Each contract under this chapter shall require  
25 the carrier to comply with requirements described in the  
26 provisions of subsections (b), (e), and (f) of section 2719A

1 of the Public Health Service Act and sections 2729A and  
2 2729B of such Act in the same manner as those provisions  
3 apply to a groups health plan or health insurance issuer  
4 offering health insurance coverage, as described in such  
5 sections.”.

6 (2) EFFECTIVE DATE.—The amendment made  
7 by this subsection shall apply with respect to con-  
8 tracts entered into or renewed for contract years be-  
9 ginning at least one year after the date of enactment  
10 of this Act.

11 **SEC. 8. STUDIES BY SECRETARIES OF HEALTH AND HUMAN**  
12 **SERVICES AND OF LABOR.**

13 (a) IMPACT STUDY.—Not later than 3 years after the  
14 date of enactment of this Act, the Secretary of Health and  
15 Human Services, in consultation with the Secretary of  
16 Labor, shall conduct a study of the effects of this Act (in-  
17 cluding the amendments made by this Act), and submit  
18 to Congress (and make public) a report on the findings  
19 of such study, which shall include information and anal-  
20 ysis on—

21 (1) the financial impact on patient responsi-  
22 bility for health care spending and overall health  
23 care spending;

24 (2) the incidence and prevalence of the delivery  
25 of unanticipated out-of-network health care services,

1 in the cases of emergency services and in the cases  
2 of care at in-network hospitals or facilities provided  
3 by out-of-network providers;

4 (3) the adequacy of provider networks offered  
5 by health plans and health insurance issuers (as  
6 such terms are defined in section 2791 of the Public  
7 Health Service Act (42 U.S.C. 300gg–91));

8 (4) a comparison of the different claims data-  
9 bases used and ;the impact of using such databases  
10 on reimbursement rates;

11 (5) the number of bills that are settled through  
12 negotiations pursuant to subsection (f)(2) of section  
13 2719A of the Public Health Service Act (42 U.S.C.  
14 300gg–19a), as added by section 2, and the number  
15 of bills that go to the independent dispute resolution  
16 process under subsection (f)(3) of such section, as so  
17 added; and

18 (6) the administrative cost of such independent  
19 dispute resolution process; and

20 (7) the estimated impact of such independent  
21 dispute resolution process on health insurance pre-  
22 miums and deductibles.

23 (b) BILLING FEASIBILITY STUDY.—Not later than 3  
24 years after the date of the enactment of this Act, the Sec-  
25 retary of Health and Human Services shall conduct, and

1 submit to Congress (and make public), a feasibility study  
2 on the provision of a single bill for all services provided  
3 for a single episode of care, as defined by the Secretary.

4 **SEC. 9. REGULATIONS.**

5 Not later than one year after the date of the enact-  
6 ment of this Act, the Secretary of Labor and the Secretary  
7 of Health and Human Services shall promulgate regula-  
8 tions pertaining to carry out the provisions (including  
9 amendments made by) this Act.