115TH CONGRESS
2D SESSION

# S. _____

To prohibit surprise medical billing of patients.

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IN THE SENATE OF THE UNITED STATES

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Mr. CASSIDY introduced the following bill; which was read twice and referred to the Committee on _____

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# A BILL

To prohibit surprise medical billing of patients.

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Protecting Patients from Surprise Medical Bills Act''.

**SEC. 2. STOPPING SURPRISE MEDICAL BILLS.**

(a) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b), by adding at the end the following:

''(3) RESOLUTION OF PROVIDER BILLING.—Any difference between the amount billed with respect to

emergency services provided by an out-of-network provider and the cost-sharing amount under paragraph (1)(C)(ii)(II) shall be paid by the health plan or health insurance issuer. The provider may not balance bill the patient for amounts beyond the cost-sharing amount allowed under this subsection.

''(4) COST-SHARING AMOUNT TO BE PAID BY PLAN OR ISSUER.—

''(A) IN GENERAL.—The amount of any cost-sharing or coinsurance applied with respect to an enrollee under paragraph (1)(C)(ii)(II) for emergency services provided by an out-of-network provider shall not exceed the cost-sharing requirement imposed with respect to the enrollee if the services were provided in-network.

''(B) EXCESS AMOUNTS.—A health plan or health insurance issuer shall pay to an out-of-network provider that provides emergency services to an enrollee, the excess of the amount the out-of-network provider charges for such services above the amount the enrollee is required to pay under subparagraph (A), as determined in accordance with this subparagraph. The amount the plan or issuer is required to pay under this subparagraph shall be—

"(i) an amount determined, and payable in such manner, in accordance with the law of the applicable State, county, parish, or tribal government; or

"(ii) in the case of State for which the applicable State law does not provide for determining such amount and manner of such payment, in such amount that is at least equal to the greater of the amount determined under clause (i) or (ii) of subparagraph (C), less the cost-sharing amount under subparagraph (A).

"(C) AMOUNTS DETERMINED.—The amounts determined under this subparagraph are as follows with respect to the service involved:

"(i) AVERAGE AMOUNT.—The average amount for the service involved as determined under this clause shall be equal to the median in-network amount negotiated by health plans and health insurance issuers for the service provided by a provider in the same or similar specialty and provided in the same geographical area (as determined by the insurance commissioner

of the applicable State or, if such State does not determine a geographic area, as determined by the Secretary).

"(ii) USUAL, CUSTOMARY, AND REASONABLE RATE.—The usual, customary, and reasonable rate for the service involved as determined under this clause, with respect to any calendar year, shall be equal to 125 percent of the average allowed amount for all private health plans and health insurance issuers for the service provided by a provider in the same or similar specialty and provided in the same geographical area (as determined by the insurance commissioner of the applicable State using a database selected by such State, or, if such State does not select a database, selected by the Secretary) for the applicable calendar year or the most recent calendar year that is available, as reported in a statistically significant benchmarking database maintained by a nonprofit organization specified by the insurance commissioner or the applicable State, so long as such organization involved is not affiliated

with any plan or issuer and is transparent with the plan, issuer, provider, and insurance commissioner of the applicable State as to how the average amount negotiated is determined.

''(5) SUBSEQUENT NON-EMERGENCY SERVICES.—In the case of an enrollee who receives emergency services from a nonparticipating health care provider or facility as described in this subsection, for whom additional health care services after the enrollee has been stabilized that are not emergency services, the health care facility or hospital shall notify, in writing, prior to providing additional services, the enrollee or the enrollee's designee that the provider or facility is a nonparticipating health care provider. Such notice shall include—

''(A) information about the potential for higher cost-sharing if such enrollee receives services at the out-of-network facility;

''(B) a written acknowledgement of such notice that the patient is required to sign and return to the hospital or health care facility in advance of the additional services; and

''(C) the option to transfer to an in-network facility.''; and

(2) by adding at the end the following:

''(e) NON-EMERGENCY SERVICES PERFORMED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK FACILITY.—

''(1) IN GENERAL.—Notwithstanding subsection (b), a group health plan or health insurance issuer with respect to group or individual health insurance coverage shall not impose cost-sharing on an enrollee, with respect to services provided by an out-of-network provider at an in-network facility for non-emergency services, that is greater than the cost-sharing that would apply under such plan or coverage had such services been provided by an in-network provider at such facility.

''(2) RESOLUTION OF PROVIDER BILLING.—Any difference between the amount billed with respect to services provided by an out-of-network provider described in paragraph (1) and the cost-sharing amount under paragraph (1) shall be paid by the health plan or health insurance issuer—

''(A) in such amount and in such manner as determined in accordance with the law of the applicable State, county, or parish; or

''(B) in the case of State for which the applicable State law does not provide for deter-

mining such amount and manner of such payment, in an amount that is at least equal to the greatest of the amounts specified in subsection (b)(4)(C) (which are adjusted for in-network cost-sharing requirements), less the cost-sharing amount under paragraph (1).

The provider may not balance bill the patient for amounts beyond the cost-sharing amount allowed under this subsection.''.

(b) APPLICATION.—The amendments made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2020.

**SEC. 3. HHS STUDY ON IMPACT OF THIS ACT.**

The Secretary of Health and Human Services shall—

(1) conduct a comprehensive study on the impacts of this Act (including the amendments made by this Act), including the impacts on patient cost-sharing, access to care, quality of care, insurance premiums, health care costs, emergency care use, network adequacy, and access to new and improved drugs and technology; and

(2) not later than December 31, 2025, issue a publicly available report based on such study that includes recommendations to Congress regarding po-

tential changes to the law with respect to the issues described in paragraph (1).