116TH CONGRESS
1ST SESSION

S. ______

To amend the Public Health Service Act to provide protections for health insurance consumers from surprise billing.

IN THE SENATE OF THE UNITED STATES

Mr. CASSIDY (for himself, Mr. BENNET, Mr. YOUNG, Ms. HASSAN, Ms. MURKOWSKI, Mr. CARPER, Mr. SULLIVAN, Mr. BROWN, and Mr. CRAMER) introduced the following bill; which was read twice and referred to the Committee on ______________

A BILL

To amend the Public Health Service Act to provide protections for health insurance consumers from surprise billing.

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 ‘‘Stopping the Out-
5 rageous Practice of Surprise Medical Bills Act of 2019’’
6 or the ‘‘STOP Surprise Medical Bills Act of 2019’’.

7 **SEC. 2. FINDINGS.**

8 Congress makes the following findings:

1 (1) Consumers frequently struggle to determine
2 when and how much they will pay for a medical
3 service or procedure. A majority of consumers say
4 health care providers rarely, if ever, discuss costs of
5 recommended treatments and whether these treat-
6 ments are covered by health insurance. Almost 70
7 percent of patients who receive bills from out-of-net-
8 work providers did not realize the provider was out-
9 of-network at the time of treatment. Patients using
10 in-network facilities still receive claims from out-of-
11 network providers at high rates, over 15 percent of
12 inpatient admissions and 5 percent of outpatient
13 service days. Even when patients try to schedule an
14 in-network procedure at an in-network hospital and
15 try to ensure that all providers who administer
16 treatment will be in-network, they may be sent a
17 balance bill by an out-of-network provider after re-
18 ceiving care. If providers accepted the same health
19 plans as the facilities at which they practice and ad-
20 minister care, out-of-network surprise medical bills
21 would not be a complication for consumers sched-
22 uling elective procedures.
23 (2) Surprise medical bills affect a sizeable por-
24 tion of the insured population. Approximately 30
25 percent of individuals covered by private health in-

1 surance have received a surprise medical bill within
2 the past year. Almost 20 percent of inpatient admis-
3 sions by enrollees in large employer plans include at
4 least 1 claim from an out-of-network provider, while
5 8 percent of outpatient service days include an out-
6 of-network claim.
7 (3) Surprise medical bills are an issue of par-
8 ticular concern to consumers. A majority of Ameri-
9 cans feel that softening the impact of surprise med-
10 ical bills should be a priority for the current Con-
11 gress. Eighty-six percent of Americans think it is
12 important to protect individuals from surprise med-
13 ical bills.
14 (4) Surprise medical bills for emergency care
15 are frequently unavoidable due to the emergent and
16 serious nature of the patient's condition at the time
17 of treatment. One in 5 cases of inpatient hospital
18 admissions that originate within the emergency de-
19 partment result in a surprise medical bill. For inpa-
20 tient admissions, those that include an emergency
21 room claim are much more likely to include a claim
22 from an out-of-network provider than admissions
23 without an emergency room claim. This is true
24 whether or not enrollees use in-network facilities.
25 Most cases of surprise medical billing occur when

1 privately insured individuals involuntarily see out-of-
2 network providers during medical emergencies.
3 (5) The financial implications of surprise med-
4 ical bills can be devastating for American consumers
5 and can prevent them from seeking timely follow-up
6 care or from accessing necessary services. Approxi-
7 mately 20 percent of insured Americans struggle to
8 pay their medical bills. Almost a third of consumers
9 who report they are struggling to pay a medical bill
10 also report this bill was due to charges from an out-
11 of-network provider that were not covered or were
12 only partially covered by their insurer. Consumers
13 with outstanding medical bills report delaying or
14 skipping needed health care at rates 2 to 3 times
15 higher than consumers without outstanding bills.
16 Over 60 percent of consumers with outstanding
17 medical bills report difficulties paying other bills (in-
18 cluding necessities such as food, heat, or housing
19 costs) as a result of their medical bills.

1 **SEC. 3. PROHIBITION ON SURPRISE BALANCE BILLING AND**
2 **INDEPENDENT DISPUTE RESOLUTION WITH**
3 **RESPECT TO OUT-OF-NETWORK HEALTH**
4 **CARE SERVICES.**

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

8 **"SEC. 2729A. GENERAL PROHIBITION ON SURPRISE BAL-**
9 **ANCE BILLING.**

10 "(a) SURPRISE MEDICAL BILL.—In this title, the
11 term 'surprise medical bill' means a balance bill, as de-
12 scribed in subsection (b), that an enrollee receives for serv-
13 ices provided to the enrollee where such services were—
14 "(1) emergency services provided by an out-of-
15 network health care professional or at an out-of-net-
16 work facility;
17 "(2) health care services that were provided—
18 "(A) at an in-network facility (including
19 the use of equipment, devices, telemedicine serv-
20 ices, or other treatments or services); and
21 "(B) by an out-of-network health care pro-
22 fessional; or
23 "(3) additional health care services required in
24 the case of an enrollee who initially enters a hospital
25 through the emergency room for emergency services,
26 and then receives nonemergency services from an

1 out-of-network health care professional or at an out-
2 of-network hospital or facility after the enrollee has
3 been stabilized (as defined in section
4 2719A(b)(2)(C)), as determined by the treating phy-
5 sician.

6 Paragraph (3) shall not apply in the case of an enrollee
7 who is stabilized and able to travel in nonmedical trans-
8 port, and the enrollee (or designee of the enrollee where
9 the enrollee is not able to comprehend the information to
10 be provided or make related decisions) has been provided
11 with clear, written notification that the professional or fa-
12 cility is an out-of-network health care professional or facil-
13 ity, has been given a cost estimate for services provided
14 by the out-of-network professional or facility, and has as-
15 sumed, in writing, full responsibility for out-of-pocket
16 costs associated with such out-of-network care.

17 ''(b) BALANCE BILL.—In subsection (a), the term
18 'balance bill' refers to a claim for payment for services
19 provided to an enrollee that is in an amount equal to the
20 difference between the actual amount charged with respect
21 to services or care described in subsection (a) and the ex-
22 pected in-network cost-sharing required by the enrollee
23 under the plan or coverage involved.

24 ''(c) PROHIBITION ON BALANCE BILLING.—

25 ''(1) PROHIBITION.—

1 "(A) IN GENERAL.—A group health plan,
2 a health insurance issuer in connection with
3 group or individual health insurance coverage,
4 or a health care provider shall not engage in
5 balance billing practices prohibited under this
6 section.

7 "(B) APPLICATION OF PROVISIONS.—Sub-
8 paragraph (A) shall apply—

9 "(i) to all services provided at hos-
10 pitals, emergency rooms, State-accredited
11 free-standing emergency departments, hos-
12 pital outpatient departments, and ambula-
13 tory surgery centers; and

14 "(ii) with respect to subsection (a)(2),
15 to the health care provider's offices and re-
16 lated services (including laboratory and im-
17 aging services ordered by an in-network
18 provider and provided by an out-of-network
19 provider or laboratory).

20 "(2) ENROLLEE LIABILITY.—With respect to
21 the services and care described in subsection (a), an
22 enrollee shall only be liable for the in-network cost-
23 sharing amount provided for in their plan or cov-
24 erage. For purposes of this section, such payments
25 by the enrollee shall count toward the in-network de-

1 ductible under the plan or coverage as well as to-
2 ward the enrollee's out-of-pocket maximum limita-
3 tion.

4 "(3) PENALTY.—Violations of this section shall
5 subject the violator to a civil monetary penalty as
6 provided for in this title. Such provisions shall not
7 apply to a health care provider, group health plan,
8 or health insurance issuer that unknowingly balance
9 bills an enrollee and reimburses such enrollee within
10 30 calendar days of such billing.

11 **"SEC. 2729B. OUT-OF-NETWORK BILLING.**

12 "(a) PROHIBITION.—

13 "(1) IN GENERAL.—An enrollee may not be
14 billed in excess of the in-network cost-sharing
15 amount for services or care provided under section
16 2729A (a surprise medical bill situation).

17 "(2) AUTOMATIC PAYMENT.—

18 "(A) IN GENERAL.—A group health plan,
19 or health insurance issuer in connection with
20 group or individual health insurance coverage,
21 shall pay the median in-network rate under the
22 plan or coverage, less the applicable enrollee in-
23 network cost-sharing, directly to the health care
24 provider as provided for in this section.

1 "(B) REQUEST FOR ALTERNATIVE RATE.—
2 Upon payment under subparagraph (A), the
3 plan or issuer shall provide to the health care
4 provider information about how the provider
5 may initiate independent dispute resolution
6 under such subsection with respect to such pay-
7 ment. The plan, issuer, or provider may nego-
8 tiate an alternative amount or initiate inde-
9 pendent dispute resolution under subsection (b)
10 during the 30-day period beginning on the date
11 on which the automatic payment is made under
12 this subsection.

13 "(b) ESTABLISHMENT OF IDR PROCESS; CERTIFI-
14 CATION OF ENTITIES.—

15 "(1) ESTABLISHMENT.—Not later than 1 year
16 after the date of enactment of this section, the Sec-
17 retary, in consultation with the Secretary of Labor,
18 shall establish a process for resolving payment dis-
19 putes between group health plans, or health insur-
20 ance issuers offering health insurance coverage in
21 the group market, and out-of-network health care
22 providers in surprise medical bill situations in ac-
23 cordance with this section (referred to in this section
24 as the 'IDR process').

1 “(2) CERTIFICATION OF ENTITIES.—An entity
2 wishing to participate in the IDR process under this
3 subsection shall request certification from the Sec-
4 retary. The Secretary, in consultation with the Sec-
5 retary of Labor, shall determine eligibility of appli-
6 cant entities, taking into consideration whether the
7 entity is unbiased and unaffiliated with health plans
8 and providers and free of conflicts of interest, in ac-
9 cordance with the Secretary’s rulemaking on deter-
10 mining criteria for conflicts of interest.
11 “(3) IDR ENTITY.—Under the process estab-
12 lished under paragraph (1), the parties in the inde-
13 pendent dispute resolution process shall jointly agree
14 upon an independent dispute resolution entity. In
15 the event that parties cannot agree, one will be se-
16 lected at random jointly by the Department of
17 Health and Human Services and the Department of
18 Labor.
19 “(c) APPLICABLE CLAIMS.—
20 “(1) IN GENERAL.—The IDR process shall be
21 with respect to one or more Current Procedural Ter-
22 minology (‘CPT’) codes.
23 “(2) BATCHING OF CLAIMS.—Health care facili-
24 ties and providers and group health plans or health
25 insurance issuers may batch claims if such claims—

1 "(A) involve identical plan or issuer and
2 provider or facility parties;
3 "(B) involve claims with the same or re-
4 lated current procedural terminology codes rel-
5 evant to a particular procedure; and
6 "(C) involve claims that occur within 30
7 days of each other.
8 "(d) INDEPENDENT DISPUTE RESOLUTION PROC-
9 ESS.—
10 "(1) TIMING.—An independent dispute resolu-
11 tion entity that receives a request under this section
12 shall, not later than 30 days after receiving such re-
13 quest, determine the amount the group health plan,
14 or health insurance issuer offering health insurance
15 coverage in the group market, is required to pay the
16 out-of-network health care provider. Such amount
17 shall be—
18 "(A) the amount determined by the parties
19 through a settlement under paragraph (2); or
20 "(B) the amount determined reasonable by
21 the entity in accordance with paragraph (3).
22 "(2) SETTLEMENT.—
23 "(A) IN GENERAL.—If the independent
24 dispute resolution entity determines, based on
25 the amounts indicated in the request under this

1 section, that a settlement between the group
2 health plan, or health insurance issuer offering
3 health insurance coverage in the group market,
4 and the out-of-network health care provider is
5 likely, the independent dispute resolution entity
6 may direct the parties to attempt, for a period
7 not to exceed 10 days, a good faith negotiation
8 for a settlement.

9 ''(B) TIMING.—The period for a settlement
10 described in subparagraph (A) shall accrue to-
11 wards the 30-day period required under para-
12 graph (1).

13 ''(3) DETERMINATION OF AMOUNT.—

14 ''(A) FINAL OFFERS.—In the absence of a
15 settlement under paragraph (2), the group
16 health plan, or health insurance issuer offering
17 health insurance coverage in the group market,
18 and the out-of-network health care provider
19 shall each submit to the independent dispute
20 resolution entity their final offer. Such entity
21 shall determine which of the 2 amounts is more
22 reasonable based on the factors described in
23 subparagraph (D).

24 ''(B) FINAL DECISIONS.—The amount that
25 is determined to be the more reasonable amount

1 under subparagraph (A) shall be the final deci-
2 sion of the independent dispute resolution entity
3 as to the amount the group health plan, or
4 health insurance issuer offering health insur-
5 ance coverage in the group market, is required
6 to pay the out-of-network health care provider.

7 ''(C) SERVICE UNITS.—A final determina-
8 tion under subparagraph (B) may include the
9 resolution of disputes for multiple items or serv-
10 ices, if such determination is in regard to items
11 or services that are eligible for independent dis-
12 pute resolution under subsection (c)(2).

13 ''(D) FACTORS.—In determining which
14 final offer to select as the more reasonable
15 amount under subparagraph (A), the inde-
16 pendent dispute resolution entity shall consider
17 relevant factors including—

18 ''(i) commercially reasonable rates for
19 comparable services or items in the same
20 geographic area (which shall take into con-
21 sideration in-network rates for that geo-
22 graphic area and not charges); and

23 ''(ii) other factors that may be sub-
24 mitted at the discretion of either party,
25 which may include—

1 "(I) the level of training, edu-
2 cation, experience, and quality and
3 outcomes measurements of the out-of-
4 network health care provider;
5 "(II) the circumstances and com-
6 plexity of the particular dispute, in-
7 cluding the time and place of the serv-
8 ice;
9 "(III) the market share held by
10 the out-of-network health care pro-
11 vider or that of the plan or issuer;
12 "(IV) demonstration of good
13 faith efforts (or lack of good faith ef-
14 forts) made by the out-of-network
15 provider or the plan to contract and
16 prior negotiated rates, if applicable;
17 and
18 "(V) other relevant economic as-
19 pects of provider reimbursement for
20 the same specialty within the same ge-
21 ographic area.
22 "(E) EFFECT OF DETERMINATION.—A
23 final determination of an independent dispute
24 resolution entity under subparagraph (B)—
25 "(i) shall be binding; and

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

9 "(4) PRIVACY LAWS.—An independent dispute
10 resolution entity shall, in conducting an independent
11 dispute resolution process under this subsection,
12 comply with all applicable Federal and State privacy
13 laws.

14 "(5) PUBLIC AVAILABILITY.—The reasonable
15 amount determined by an independent dispute reso-
16 lution entity under this subsection with respect to
17 any claim shall not be confidential, except that infor-
18 mation submitted to the independent dispute entity
19 shall be kept confidential. Independent dispute enti-
20 ties may consider past decisions awarded by inde-
21 pendent dispute entities during the independent dis-
22 pute resolution process.

23 "(6) COSTS OF INDEPENDENT DISPUTE RESO-
24 LUTION PROCESS.—The nonprevailing party shall be
25 responsible for paying all fees charged by the inde-

1 pendent dispute resolution entity. If the parties
2 reach a settlement prior to completion of the inde-
3 pendent dispute resolution process, the costs of the
4 independent dispute resolution process shall be di-
5 vided equally between the parties.

6 "(7) PAYMENT.—Group health plans and
7 health insurance issuers with respect to group health
8 coverage shall pay directly to the health care pro-
9 vider amounts determined by the independent dis-
10 pute resolution entity within 30 days of the date on
11 which the entity makes a determination with respect
12 to such amount. A plan or issuer that fails to com-
13 ply with this paragraph shall be subject to the pen-
14 alties described in section 2729A(c)(3).".

15 (b) EMERGENCY SERVICES.—Section
16 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act
17 (42 U.S.C. 300gg–19a(b)(1)(C)(ii)(II)) is amended by in-
18 serting ", deductible amount," after "copayment amount

19 **SEC. 4. NOTIFICATION OF NEW INSURANCE PRODUCTS TO**
20 **IN-NETWORK PROVIDERS.**

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

"SEC. 2729C. NOTIFICATION OF NEW INSURANCE PRODUCTS TO IN-NETWORK PROVIDERS.

"If a health care provider has a contract to provide in-network services to enrollees in a group health plan or health insurance coverage offered by a health insurance issuer, the plan or issuer shall notify the in-network provider within 7 days of offering any new insurance product for which the in-network provider would be eligible to enroll as an in-network provider.".

SEC. 5. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES.

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

"SEC. 2729D. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES.

"(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to enrollees in the plan or coverage the amount of the in-network and out-of-network deductibles and the out-of-pocket maximum limitation that apply to such plan or coverage.

1 ‘‘(b) GUIDANCE.—The Secretary, in consultation
2 with the Secretary of Labor, shall issue guidance to imple-
3 ment subsection (a).’’.

4 **SEC. 6. ENSURING ENROLLEE ACCESS TO COST-SHARING**
5 **INFORMATION.**

6 (a) IN GENERAL.—Subpart II of part A of title
7 XXVII of the Public Health Service Act (42 U.S.C.
8 300gg–11 et seq.), as amended by section 5, is further
9 amended by adding at the end the following:

10 **‘‘SEC. 2729E. PROVISION OF COST-SHARING INFORMATION.**

11 ‘‘(a) COST-SHARING DISCLOSURE FOR MEDICAL
12 SERVICES.—
13 ‘‘(1) PROVIDER DISCLOSURES.—A group health
14 plan or a health insurance issuer offering group or
15 individual health insurance coverage shall not con-
16 tract with a health care provider with respect to the
17 plan or coverage unless the provider agrees to pro-
18 vide an enrollee in the plan or coverage, at the time
19 of scheduling an elective health care service, or not
20 later than 48 hours of the enrollee requesting such
21 information, the expected enrollee cost-sharing for
22 the provision of a particular health care service in-
23 volved (including any service that is reasonably ex-
24 pected to be provided in conjunction with such spe-

1 cific service, such as expected cost-sharing of labora-
2 tory services).
3 "(2) INSURER DISCLOSURES.—A group health
4 plan or a health insurance issuer offering group or
5 individual health insurance coverage shall provide an
6 enrollee in the plan or coverage with a good faith es-
7 timate of the enrollee's cost-sharing (including
8 deductibles, copayments, and coinsurance) for which
9 the enrollee would be responsible for paying with re-
10 spect to a specific elective health care service (in-
11 cluding any service that is reasonably expected to be
12 provided in conjunction with such specific service
13 such as expected cost-sharing of laboratory services),
14 not later than 48 hours after receiving a request for
15 such information by an enrollee.
16 "(b) ELECTRONICALLY AVAILABLE PRICE INFORMA-
17 TION.—A group health plan or a health insurance issuer
18 offering group or individual health insurance coverage
19 shall provide to enrollees the out-of-pocket costs and bene-
20 fits information at all sites of care and for all providers
21 included in the plan network. Such information shall be
22 made available to enrollees through an internet website or
23 an application. Information about the availability of such
24 price information through such means shall be provided

1 to each enrollee upon enrollment, or renewal, in the health
2 plan or health insurance coverage.''.
3 (b) EFFECTIVE DATES.—
4 (1) COST-SHARING DISCLOSURES.—Subsection
5 (a)(1) of section 2729E of the Public Health Service
6 Act, as added by subsection (a), shall apply with re-
7 spect to plan years beginning on or after January 1,
8 2020.
9 (2) AVAILABILITY OF INFORMATION.—Sub-
10 section (b) of section 2729E of the Public Health
11 Service Act, as added by subsection (a), shall apply
12 with respect to plan years beginning on or after Jan-
13 uary 1, 2021.

14 **SEC. 7. MEDICAL LOSS RATIO.**

15 Section 2718(a)(1) of the Public Health Service Act
16 (42 U.S.C. 300gg-18(a)(1)) is amended by inserting be-
17 fore the period the following: ''(including, in the case of
18 group health plans, the amount of independent dispute
19 process expenses incurred by the plan)''.

20 **SEC. 8. TRANSPARENCY REQUIREMENTS ON HOSPITALS.**

21 Section 2718 of the Public Health Service Act (42
22 U.S.C. 300gg-18) is amended by adding at the end the
23 following:
24 ''(f) TRANSPARENCY REQUIREMENTS ON HOS-
25 PITALS.—

1 "(1) REQUIREMENTS FOR HOSPITALS AND PHY-
2 SICIAN GROUPS.—Each hospital operating within the
3 United States shall for each year disclose on its
4 internet website and in printed materials, any finan-
5 cial relationship or profit-sharing agreement the hos-
6 pital maintains with a physician group.
7 "(2) REQUIRED INFORMATION.—
8 "(A) IN GENERAL.—Each hospital oper-
9 ating within the United States shall include an-
10 cillary services provided by individuals such as
11 phlebotomists, laboratory technicians, and echo-
12 cardiogram technicians within each hospital bill
13 that is provided to patients.
14 "(B) STUDY.—Not later than 1 year after
15 the date of enactment of this Act, the Secretary
16 shall conduct a study on the feasibility of hos-
17 pitals and hospital-based provider groups pro-
18 viding to patients a single, unified bill for all
19 services provided within an episode of care.".
20 **SEC. 9. TRANSPARENCY REQUIREMENTS ON INSURANCE.**
21 (a) GROUP HEALTH PLAN REPORTING.—Part C of
22 title XXVII of the Public Health Service Act (42 U.S.C.
23 300gg–91 et seq.) is amended by adding at the end the
24 following:

1 **"SEC. 2795. TRANSPARENCY REQUIREMENTS FOR GROUP**
2 **HEALTH PLANS.**
3 "(a) IN GENERAL.—Each group health plan and
4 health insurance issuer offering group or individual health
5 insurance coverage shall annually report to the Secretary
6 of Health and Human Services and the Secretary of
7 Labor, with respect to the applicable plan or coverage for
8 the applicable plan year—
9 "(1) the total claims that were submitted by in-
10 network health care providers with respect to enroll-
11 ees under the plan or coverage, and the number of
12 such claims that were paid and the number of such
13 claims that were denied;
14 "(2) the total claims that were submitted by
15 out-of-network health care providers with respect to
16 enrollees under the plan or coverage, and the num-
17 ber of such claims that were paid and the number
18 of such claims that were denied;
19 "(3) with respect to each out-of-network claim,
20 the out-of-pocket costs, including applicable cost-
21 sharing amounts, to the enrollee for the services,
22 and the difference between the billed charge and the
23 amount the plan pays, adjusted by any balance bill-
24 ing limitation through State and Federal regulatory
25 and statutory requirements that might apply;

1 "(4) the number of out-of-network claims re-
2 ported under paragraph (2) that are for emergency
3 services; and
4 "(5) the number of out-of-network claims re-
5 ported under paragraph (2) that relate to care at in-
6 network hospitals or facilities provided by out-of-net-
7 work providers.
8 "(b) CLARIFICATION.—The information required to
9 be submitted under this section shall be in addition to the
10 information required to be submitted under section
11 2715A.".

12 **SEC. 10. APPLICABILITY TO STATES WITH SURPRISE BILL-**
13 **ING LAWS.**

14 (a) GENERAL APPLICATION.—
15 (1) IN GENERAL.—Nothing in this Act, or the
16 amendments made by this Act, shall be construed to
17 prohibit a State from enacting patient protections
18 that are greater than those provided for in such
19 amendments.
20 (2) APPLICATION TO ALL PLANS.—In the case
21 of a group health plan, individual health plan, and
22 non-Federal governmental health plan offered in a
23 State that has not enacted a law to determine the
24 payment resolution between enrollees and health
25 care facilities or professionals relating to surprise

1 medical bills, the procedures applicable to self-in-
2 sured group health plans for the resolution of sur-
3 prise medical bills under this Act (including the
4 amendments made by this Act), shall apply to deter-
5 mine compensation with respect to a surprise med-
6 ical bill, until such time as the State enacts a law
7 providing for such a resolution methodology.
8 (b) PROVISIONS APPLICABLE TO ERISA.—Section
9 715 of the Employee Retirement Income Security Act of
10 1974 (29 U.S.C. 1185d) is amended by adding at the end
11 the following:
12 ''(c) PROHIBITIONS ON BALANCE BILLING.—
13 ''(1) FULLY INSURED PLANS.—In the case of a
14 fully insured group health plan—
15 ''(A) a State may establish procedures for
16 determining the appropriate compensation ap-
17 plicable to surprise medical bills between a par-
18 ticipant or beneficiary and a health care facility
19 or professional so long as the methodology used
20 relies on the definition of 'surprise medical bill'
21 and the prohibitions contained in section 2729A
22 of the Public Health Service Act; and
23 ''(B) a State may enact laws relating to
24 rate-setting, independent dispute resolution, an

1 in-network guarantee, or an alternative method-
2 ology that complies with paragraph (1).
3 "(2) SELF-INSURED PLANS.—In the of a self-
4 insured group health plan, the resolution method-
5 ology provided for under section 2729A of the Public
6 Health Service Act, shall be used to determine com-
7 pensation with respect to a surprise medical bill.".
8 (c) FEHBP.—In the case of a health plan under
9 chapter 89 of title 5, United States Code, the resolution
10 methodology provided for under this Act (including the
11 amendments made by this Act), shall be used to determine
12 compensation with respect to a surprise medical bill.

13 **SEC. 11. BALANCE BILLING STUDY.**

14 (a) IN GENERAL.—Not later than 3 years after the
15 date of enactment of this Act, the Secretary of Health and
16 Human Services, in consultation with the Secretary of
17 Labor, shall conduct a study of the effects of this Act (in-
18 cluding the amendments made by this Act), and submit
19 to Congress a report on the findings of such study, which
20 shall include information and analysis 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 out-of-network health care services;

1 (3) the adequacy of provider networks offered
2 by health plans and health insurance issuers (as
3 such terms are defined in section 2791 of the Public
4 Health Service Act (42 U.S.C. 300gg–91));
5 (4) the impact of connecting reimbursement to
6 different claims databases;
7 (5) the number of bills that go to the inde-
8 pendent dispute resolution process; and
9 (6) the administrative cost of the independent
10 dispute resolution process and estimated impact on
11 health insurance premiums and deductibles.
12 (b) INFORMATION REQUIREMENTS.—The informa-
13 tion provided in the report under subsection (a) shall be—
14 (1) disaggregated by State and according to the
15 fully insured and the self-insured markets; and
16 (2) with respect to paragraphs (1) through (3)
17 of such subsection, made available to the public elec-
18 tronically in a searchable database.