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116TH CONGRESS
1ST SESSION

H. R. 4223

To amend the Employee Retirement Income Security Act of 1974 to protect patients from surprise medical bills.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 30, 2019

Mr. SPANO introduced the following bill; which was referred to the Committee on Education and Labor

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A BILL

To amend the Employee Retirement Income Security Act of 1974 to protect patients from surprise medical bills.

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. PROHIBITION ON SURPRISE MEDICAL BILLING.

Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

"SEC. 716. PROHIBITION ON SURPRISE MEDICAL BILLING.

''(a) DEFINITIONS.—In this section:

''(1) BALANCE BILL.—The term 'balance bill' means the collection or attempted collection from a participant or beneficiary of any amount in excess of the applicable copayments, coinsurance, or deductible for services covered under the participant or beneficiary's group health plan.

''(2) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means the condition described in section 2719A(b)(2)(A) of the Public Health Service Act.

''(3) EMERGENCY SERVICES.—The term 'emergency services' means the services described in section 2719A(b)(2)(B) of the Public Health Service Act.

''(4) EMERGENCY SERVICES PROVIDER.—The term 'emergency services provider' means a facility or facility-based provider that bills a participant or beneficiary for emergency services.

''(5) FACILITY.—The term 'facility' means an entity providing health care services, as licensed or authorized by a State.

''(6) FACILITY-BASED PROVIDER.—The term 'facility-based provider' means a physician, health care professional, or entity that has entered into an

agreement with a facility to provide health care services to patients of that facility.

''(b) EMERGENCY SERVICES.—

''(1) PROHIBITION ON BALANCE BILLING.—A self-insured group health plan shall be solely liable for making payments to an emergency services provider for emergency services covered under the plan that are provided to a participant or beneficiary, and such participant or beneficiary shall not be liable to the emergency services provider for any amount for such services other than the applicable copayment, coinsurance, or deductible amount required under the plan for covered emergency services. Emergency service providers shall not balance bill a participant or beneficiary under a self-insured group health plan for any covered emergency services provided to such participant or beneficiary.

''(2) COST SHARING LIMITATION AND PRIOR AUTHORIZATION.—If a self-insured group health plan provides coverage for any benefits with respect to emergency services, such coverage shall be in accordance with the provisions of section 2719A(b) of the Public Health Service Act and—

''(A) if such services are provided by an out-of-network provider, the cost-sharing re-

quirements (including any deductible amount and the out-of-pocket limit) applicable to such services shall be the same as the cost-sharing requirement that would apply if such services were provided by an in-network provider;

"(B) prior authorization shall not be required for pre-hospital transport or treatment; and

"(C) payment by the plan shall be made directly to the emergency services provider.

"(c) COVERED NON-EMERGENCY SERVICES.—Facility-based providers shall not balance bill a patient for covered non-emergency services if the services are provided at an in-network facility and the participant or beneficiary did not have the ability or opportunity to select to receive such services from an in-network provider.

"(d) REIMBURSEMENTS FOR OUT-OF-NETWORK PAYMENTS.—A self-insured group health plan shall reimburse a health care provider for out-of-network emergency and non-emergency services described in subsections (b) and (c) based on one of the following payment methodologies:

"(1) The amount of the claim made by the provider for such services.

''(2) The usual and customary amount charged by the provider for similar services in the community where the services were provided.

''(3) The amount mutually agreed to by the plan and the provider during the 60-day period after the date on which the claim is submitted.

''(e) VOLUNTARY BINDING ARBITRATION.—

''(1) IN GENERAL.—If a self-insured group health plan and health care provider are unable to resolve a dispute with respect to billing for services described in subsection (b) or (c), such provider may voluntarily initiate binding arbitration with such plan under this subsection. The Secretary shall establish by rule methods of aggregation for claim disputes submitted to voluntary binding arbitration under this subsection.

''(2) ARBITRATION ORGANIZATIONS.—

''(A) IN GENERAL.—The Secretary shall enter into contracts with outside organizations to conduct timely, voluntary binding arbitration proceedings under this subsection. To be eligible for such a contract, an organization shall have at least 5 years of experience serving as a neutral party in complex dispute resolution proceedings.

''(B) LIMITATION.—An organization shall not be eligible to enter into a contract under subparagraph (A) if the organization has been employed by, consulted for, or otherwise had a business relationship (other than the receipt of arbitration fees) with a health plan, health insurance issuer, facility, or health care professional during the 3-year period immediately preceding the effective date of the contract with the Secretary or during the term of such contract.

''(C) ARBITRATOR.—An arbitrator may not be assigned by an organization to resolve a dispute under this paragraph if the arbitrator has been employed by, consulted for, or otherwise had a business relationship (other than the receipt of arbitration fees) with a health plan, health insurance issuer, facility, or health care professional during the 3-year period immediately preceding the request for arbitration.

''(3) ELIGIBILITY.—To be eligible for voluntary binding arbitration under this subsection the claim involved shall—

"(A) in the case of a claim relating to facility health care services, be not less than $3,000; and

"(B) in the case of a claim relating to professional services, be not less than $500.

Such amounts shall be adjusted by the Secretary each year by the percentage increase in the consumer price index.

"(4) PROCEDURES.—The following procedures shall apply during a voluntary arbitration proceeding under this subsection:

"(A) The plan or provider involved may make an offer to settle the disputed claim. The party to whom such an offer is directed shall respond to such offer within 15 days after receipt of the offer.

"(B) If the party receiving an offer to settle under paragraph (A) does not accept such offer, and the arbitrator issues a final order with respect to the disputed claim that is more than 90 percent or less than 110 percent of the offer amount, the party receiving the offer is deemed a non-prevailing party for purpose of paragraph (5).

''(C) A final order under this paragraph is subject to judicial review under this Act.

''(D) All parties to a dispute that is subject to arbitration under this subsection may agree to settle claim at any time, for any amount, regardless of whether an offer to settle was made or rejected.

''(5) REVIEW COSTS.—

''(A) IN GENERAL.—The entity that does not prevail under an arbitrator's final order under voluntary binding arbitration under this subsection shall pay the review costs.

''(B) APPORTIONMENT OF COSTS.—In the case that both parties to voluntary binding arbitration under this subsection prevail in part, the review costs shall be apportioned among the parties in proportion to the final judgment. The apportionment shall be based on the disputed claim amount.

''(C) FAILURE TO PAY.—If a party to voluntary binding arbitration under this subsection fails to pay any amount of the ordered review costs within 35 days after the arbitrator's final order, the party shall be subject to a penalty of

$500 for each day that such amount is not paid.

''(f) NETWORK TRANSPARENCY.—A self-insured group health plan shall—

''(1) not later than 1 year after the date of enactment of this section, publish on their internet website a list of network providers, and update such list on a monthly basis; and

''(2) not later than 1 year after the date of enactment of this section, and annually thereafter, provide an annual notification to participants and beneficiaries concerning the potential for balance billing when using out-of-network providers.''.

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