

116TH CONGRESS
1ST SESSION

S. 1266

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

IN THE SENATE OF THE UNITED STATES

MAY 1, 2019

Mr. SCOTT of Florida introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

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

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 “Protecting Patients
5 from Surprise Medical Bills Act”.

6 **SEC. 2. PROHIBITION ON SURPRISE MEDICAL BILLING.**

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

1 **“SEC. 716. PROHIBITION ON SURPRISE MEDICAL BILLING.**

2 “(a) DEFINITIONS.—In this section:

3 “(1) BALANCE BILL.—The term ‘balance bill’
4 means the collection or attempted collection from a
5 participant or beneficiary of any amount in excess of
6 the applicable copayments, coinsurance, or deduct-
7 ible for services covered under the participant or
8 beneficiary’s group health plan.

9 “(2) EMERGENCY MEDICAL CONDITION.—The
10 term ‘emergency medical condition’ means the condi-
11 tion described in section 2719A(b)(2)(A) of the Pub-
12 lic Health Service Act.

13 “(3) EMERGENCY SERVICES.—The term ‘emer-
14 gency services’ means the services described in sec-
15 tion 2719A(b)(2)(B) of the Public Health Service
16 Act.

17 “(4) EMERGENCY SERVICES PROVIDER.—The
18 term ‘emergency services provider’ means a facility
19 or facility-based provider that bills a participant or
20 beneficiary for emergency services.

21 “(5) FACILITY.—The term ‘facility’ means an
22 entity providing health care services, as licensed or
23 authorized by a State.

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

1 agreement with a facility to provide health care serv-
2 ices to patients of that facility.

3 “(b) EMERGENCY SERVICES.—

4 “(1) PROHIBITION ON BALANCE BILLING.—A
5 self-insured group health plan shall be solely liable
6 for making payments to an emergency services pro-
7 vider for emergency services covered under the plan
8 that are provided to a participant or beneficiary, and
9 such participant or beneficiary shall not be liable to
10 the emergency services provider for any amount for
11 such services other than the applicable copayment,
12 coinsurance, or deductible amount required under
13 the plan for covered emergency services. Emergency
14 service providers shall not balance bill a participant
15 or beneficiary under a self-insured group health plan
16 for any covered emergency services provided to such
17 participant or beneficiary.

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

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

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

6 “(B) prior authorization shall not be re-
 7 quired for pre-hospital transport or treatment;
 8 and

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

11 “(c) COVERED NON-EMERGENCY SERVICES.—Facil-
 12 ity-based providers shall not balance bill a patient for cov-
 13 ered non-emergency services if the services are provided
 14 at an in-network facility and the participant or beneficiary
 15 did not have the ability or opportunity to select to receive
 16 such services from an in-network provider.

17 “(d) REIMBURSEMENTS FOR OUT-OF-NETWORK
 18 PAYMENTS.—A self-insured group health plan shall reim-
 19 burse a health care provider for out-of-network emergency
 20 and non-emergency services described in subsections (b)
 21 and (c) based on one of the following payment methodolo-
 22 gies:

23 “(1) The amount of the claim made by the pro-
 24 vider for such services.

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

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

7 “(e) VOLUNTARY BINDING ARBITRATION.—

8 “(1) IN GENERAL.—If a self-insured group
9 health plan and health care provider are unable to
10 resolve a dispute with respect to billing for services
11 described in subsection (b) or (c), such provider may
12 voluntarily initiate binding arbitration with such
13 plan under this subsection. The Secretary shall es-
14 tablish by rule methods of aggregation for claim dis-
15 putes submitted to voluntary binding arbitration
16 under this subsection.

17 “(2) ARBITRATION ORGANIZATIONS.—

18 “(A) IN GENERAL.—The Secretary shall
19 enter into contracts with outside organizations
20 to conduct timely, voluntary binding arbitration
21 proceedings under this subsection. To be eligi-
22 ble for such a contract, an organization shall
23 have at least 5 years of experience serving as a
24 neutral party in complex dispute resolution pro-
25 ceedings.

1 “(B) LIMITATION.—An organization shall
2 not be eligible to enter into a contract under
3 subparagraph (A) if the organization has been
4 employed by, consulted for, or otherwise had a
5 business relationship (other than the receipt of
6 arbitration fees) with a health plan, health in-
7 surance issuer, facility, or health care profes-
8 sional during the 3-year period immediately
9 preceding the effective date of the contract with
10 the Secretary or during the term of such con-
11 tract.

12 “(C) ARBITRATOR.—An arbitrator may
13 not be assigned by an organization to resolve a
14 dispute under this paragraph if the arbitrator
15 has been employed by, consulted for, or other-
16 wise had a business relationship (other than the
17 receipt of arbitration fees) with a health plan,
18 health insurance issuer, facility, or health care
19 professional during the 3-year period imme-
20 diately preceding the request for arbitration.

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

1 “(A) in the case of a claim relating to fa-
2 cility health care services, be not less than
3 \$3,000; and

4 “(B) in the case of a claim relating to pro-
5 fessional services, be not less than \$500.

6 Such amounts shall be adjusted by the Secretary
7 each year by the percentage increase in the con-
8 sumer price index.

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

12 “(A) The plan or provider involved may
13 make an offer to settle the disputed claim. The
14 party to whom such an offer is directed shall
15 respond to such offer within 15 days after re-
16 ceipt of the offer.

17 “(B) If the party receiving an offer to set-
18 tle under paragraph (A) does not accept such
19 offer, and the arbitrator issues a final order
20 with respect to the disputed claim that is more
21 than 90 percent or less than 110 percent of the
22 offer amount, the party receiving the offer is
23 deemed a non-prevailing party for purpose of
24 paragraph (5).

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

3 “(D) All parties to a dispute that is sub-
4 ject to arbitration under this subsection may
5 agree to settle claim at any time, for any
6 amount, regardless of whether an offer to settle
7 was made or rejected.

8 “(5) REVIEW COSTS.—

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

13 “(B) APPORTIONMENT OF COSTS.—In the
14 case that both parties to voluntary binding arbi-
15 tration under this subsection prevail in part,
16 the review costs shall be apportioned among the
17 parties in proportion to the final judgment. The
18 apportionment shall be based on the disputed
19 claim amount.

20 “(C) FAILURE TO PAY.—If a party to vol-
21 untary binding arbitration under this subsection
22 fails to pay any amount of the ordered review
23 costs within 35 days after the arbitrator’s final
24 order, the party shall be subject to a penalty of

1 \$500 for each day that such amount is not
2 paid.

3 “(f) NETWORK TRANSPARENCY.—A self-insured
4 group health plan shall—

5 “(1) not later than 1 year after the date of en-
6 actment of this section, publish on their Internet
7 website a list of network providers, and update such
8 list on a monthly basis; and

9 “(2) not later than 1 year after the date of en-
10 actment of this section, and annually thereafter, pro-
11 vide an annual notification to participants and bene-
12 ficiaries concerning the potential for balance billing
13 when using out-of-network providers.”.

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