

116TH CONGRESS
1ST SESSION

S. 967

To amend the Public Health Service Act to establish limitations on cost-sharing for out-of-network services in the individual market, to prohibit balance billing for such services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 1, 2019

Mrs. SHAHEEN (for herself, Ms. BALDWIN, and Mr. MERKLEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to establish limitations on cost-sharing for out-of-network services in the individual market, to prohibit balance billing for such services, 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.**

4 This Act may be cited as the “Reducing Costs for
5 Out-of-Network Services Act of 2019”.

1 **SEC. 2. LIMITATIONS ON COST-SHARING FOR OUT-OF-NET-**
 2 **WORK SERVICES.**

3 (a) IN GENERAL.—Subpart 2 of part B of title
 4 XXVII of the Public Health Service Act (42 U.S.C.
 5 300gg–51 et seq.) is amended by adding at the end the
 6 following:

7 **“SEC. 2754. LIMITATIONS ON COST-SHARING FOR OUT-OF-**
 8 **NETWORK SERVICES.**

9 “(a) HEALTH INSURANCE ISSUER REQUIREMENT.—
 10 A health insurance issuer offering health insurance cov-
 11 erage, in the individual market in a State, that offers ben-
 12 efits with respect to a health care service provided in the
 13 State by a participating provider shall ensure that the
 14 cost-sharing requirement with respect to such service pro-
 15 vided in the State by a nonparticipating provider does not
 16 exceed the rate selected by the applicable State authority
 17 under subsection (c)(1) for such service.

18 “(b) LIMITATION ON CHARGES BY HEALTH CARE
 19 PROVIDERS.—

20 “(1) IN GENERAL.—A health care provider may
 21 not charge a patient for a health care service at a
 22 rate in excess of the following:

23 “(A) In the case of a patient who is en-
 24 rolled in health insurance coverage in the indi-
 25 vidual market that does not provide out-of-net-
 26 work benefits for such service, the health care

1 provider may charge such patient no more than
2 the rate selected by the applicable State author-
3 ity under subsection (c)(1).

4 “(B) In the case of a patient enrolled in
5 health insurance coverage in the individual mar-
6 ket that provides out-of-network benefits for
7 such service, the health care provider may
8 charge such patient no more than—

9 “(i) the rate selected by the applicable
10 State authority under subsection (c)(1);
11 minus

12 “(ii) the sum of—

13 “(I) the payment made by the
14 health insurance issuer to the health
15 care provider pursuant to such cov-
16 erage; and

17 “(II) the out-of-network cost-
18 sharing amount required under such
19 coverage.

20 “(C) In the case of an uninsured indi-
21 vidual, the health care provider may charge
22 such patient no more than the lower of—

23 “(i) the rate selected by the applicable
24 State authority under subsection (c)(2); or

1 “(ii) the rate otherwise allowed to be
2 charged to such an individual for such a
3 service under an applicable law in the
4 State.

5 “(2) ENFORCEMENT.—A health care provider
6 that violates the requirement under paragraph (1)
7 shall be subject to the same civil monetary penalties
8 described in paragraph (1) of section 922(f), includ-
9 ing the provisions described in paragraph (2) of such
10 section, as a person who commits a violation de-
11 scribed in paragraph (1) of such section.

12 “(c) RATE.—

13 “(1) INDIVIDUALS ENROLLED IN HEALTH IN-
14 SURANCE COVERAGE.—An applicable State authority
15 shall select for the State as applicable for purposes
16 of subsection (a) and subparagraphs (A) and (B) of
17 subsection (b)(1) one of the following as a maximum
18 rate for a health care service for individuals enrolled
19 in health insurance coverage in the individual mar-
20 ket in the State:

21 “(A) 125 percent (or, in a case described
22 in paragraph (3) and at the discretion of the
23 applicable State authority, 200 percent) of the
24 allowed charges determined for the item or
25 service under the original Medicare fee-for-serv-

1 ice program under parts A and B of title XVIII
2 of the Social Security Act.

3 “(B) The 80th percentile of usual, cus-
4 tomary, and reasonable charge rates for the
5 service for the geographic area, as determined
6 by a database of usual, customary, and reason-
7 able charges selected by the applicable State au-
8 thority and approved as appropriate by the Sec-
9 retary.

10 “(C) 100 percent of the allowed charges
11 for the service if the service were provided by
12 a participating provider, which shall be deter-
13 mined based upon the average actual allowed
14 rate under the coverage for all participating
15 providers for such service in the health insur-
16 ance issuer’s participating provider network.

17 “(2) UNINSURED INDIVIDUALS.—An applicable
18 State authority shall select for the State as applica-
19 ble for purposes of subsection (b)(1)(C) one of the
20 following as a maximum rate for a health care serv-
21 ice for uninsured individuals:

22 “(A) The rate described in subparagraph
23 (A) of paragraph (1).

24 “(B) The rate described in subparagraph
25 (B) of paragraph (1).

1 “(3) SERVICES PROVIDED IN RURAL AREAS.—
2 A case described in this paragraph is a case in which
3 the item or service is furnished by a provider of
4 services (as defined in subsection (u) of section 1861
5 of the Social Security Act) or supplier (as defined in
6 subsection (d) of such section) in a rural area (as
7 defined in section 1886(d)(2)(D) of such Act).

8 “(4) DEFAULT RATE.—In the case in which an
9 applicable State authority does not select a rate
10 under paragraph (1) or (2) for a service, the max-
11 imum rate applicable in the State for the service for
12 purposes of subsections (a) and (b) shall—

13 “(A) be the rate described in subparagraph
14 (A) of paragraph (1), if the service is covered
15 under the original Medicare fee-for-service pro-
16 gram under parts A and B of title XVIII of the
17 Social Security Act; or

18 “(B) be a rate established by the Sec-
19 retary, if the service is not covered under such
20 program.

21 “(5) CLARIFICATION.—In selecting a rate under
22 paragraph (1) or (2) for a health care service, the
23 applicable State may select a rate that differs from
24 the rate selected under such paragraph for a dif-
25 ferent health care service.

1 “(d) DEFINITIONS.—For purposes of this section:

2 “(1) HEALTH CARE PROVIDER.—The term
3 ‘health care provider’ includes a hospital (as defined
4 in section 1861(e) of the Social Security Act), a crit-
5 ical access hospital (as defined in section 1861(mm)
6 of such Act), a physician (as defined in section
7 1861(r) of such Act), and other providers as deter-
8 mined by the Secretary.

9 “(2) UNINSURED INDIVIDUAL.—The term ‘un-
10 insured individual’, with respect to an individual re-
11 ceiving a health care service, means an individual
12 who, at the time at which the service was furnished,
13 was not enrolled in a plan that provides medical care
14 benefits, including any Federal health benefit pro-
15 gram, as determined by the Secretary.

16 **“SEC. 2755. REPORTS TO CONGRESS ON NETWORK ADE-**
17 **QUACY.**

18 “Not later than January 1, 2022, and every year
19 thereafter, the Secretary shall prepare and submit to the
20 Committee on Health, Education, Labor, and Pensions of
21 the Senate and the Committee on Energy and Commerce
22 of the House of Representatives a report on—

23 “(1) how State network adequacy laws, section
24 2702(c), and any other network adequacy require-
25 ments for qualified health plans under the Patient

1 Protection and Affordable Care Act ensure that pro-
2 vider networks are broad enough to meet the needs
3 of enrolled patients;

4 “(2) the impact of section 2754 on network
5 adequacy; and

6 “(3) any recommendations for Congress, as
7 necessary, on how to improve network adequacy.”.

8 (b) EFFECTIVE DATE.—Section 2754 of the Public
9 Health Service Act, as added by subsection (a), shall take
10 effect on January 1, 2021.

11 **SEC. 3. GRANTS FOR GROUP MARKET.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall award grants to States for the pur-
14 pose of studying the potential for imposing limitations on
15 charges for health care services provided to individuals en-
16 rolled in group health plans or group health insurance cov-
17 erage that are similar to the limitations that apply under
18 section 2754 of the Public Health Service Act, as added
19 by section 2.

20 (b) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section.

23 (c) DEFINITIONS.—In this section, the terms “group
24 health plan” and “group health insurance coverage” have

- 1 the meanings given such terms in section 2791 of the Pub-
- 2 lic Health Service Act (42 U.S.C. 300gg-91).

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