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116TH CONGRESS
1ST SESSION

H. R. 3502

To amend the Public Health Service Act and title XI of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2019

Mr. RUIZ (for himself, Mr. BUCSHON, Mr. MORELLE, Mr. BERA, Mr. WENSTRUP, Ms. SHALALA, Mr. TAYLOR, Mr. DAVID P. ROE of Tennessee, Mr. BANKS, Mr. HIGGINS of New York, Mr. GRIJALVA, Mr. CISNEROS, Mr. SOTO, Mr. HARRIS, Mr. HUDSON, Ms. SCHRIER, Mr. MARSHALL, Mr. DUNN, Mr. STIVERS, Mr. DESJARLAIS, Mr. BURCHETT, Mr. RIGGLEMAN, Mr. WATKINS, Mr. JOYCE of Pennsylvania, Mr. SMUCKER, Ms. STEFANIK, Mr. THOMPSON of Pennsylvania, Mr. WRIGHT, Mr. NORCROSS, Mrs. LOWEY, Mr. CÁRDENAS, Mr. DESAULNIER, and Ms. KELLY of Illinois) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Oversight and Reform, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act and title XI of the Social Security Act to protect health care consumers from surprise billing practices, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Protecting People From Surprise Medical Bills Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

(a) EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking ''offering group or individual health insurance issuer'' and inserting ''offering group or individual health insurance coverage''; and

(II) by striking ''paragraph (2)(B)'' and inserting ''paragraph (2)'';

(ii) in subparagraph (B), by inserting ''or a participating emergency facility, as applicable,'' after ''participating provider''; and

(iii) in subparagraph (C)—

(I) in the matter preceding clause (i), by inserting ''by a nonparticipating provider or a nonparticipating emergency facility'' after ''enrollee'';

(II) by striking clause (i);

(III) by striking ''(ii)(I) such services'' and inserting ''(i) such services'';

(IV) by striking ''where the provider of services does not have a contractual relationship with the plan for the providing of services'';

(V) by striking ''emergency department services received from providers who do have such a contractual relationship with the plan; and'' and inserting ''emergency services received

from participating providers and participating emergency facilities with respect to such plan;'';

(VI) by striking ''(II) if such services'' and all that follows through ''were provided in-network'' and inserting the following:

''(ii) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;''; and

(VII) by adding at the end the following new clauses:

''(iii) the group health plan or health insurance issuer offering group or individual health insurance coverage pays to such provider or facility, respectively, subject to subsection (f), the amount by which the commercially reasonable rate, as determined by the plan or issuer, for such services exceeds the cost-sharing amount for such services (as determined in accordance

with clause (ii) and, if applicable, any amount to reconcile the difference between such rate so paid and the specified rate determined under subsection (f)(1)) for such services; and

''(iv) there shall be counted toward any deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished in the same manner as if such cost-sharing payments were with respect to emergency services furnished by a participating provider and a participating emergency facility.''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ''and subsection (e)'' after ''this subsection'';

(ii) by redesignating subparagraph (C) as subparagraph (H); and

(iii) by inserting after subparagraph (C) the following subparagraphs:

"(D) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

"(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or coverage for furnishing such item or service.

"(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, an emergency department of a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(E) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who does not have a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a physician or other health professional who is licensed by the State involved to furnish such item or service and who has a contractual relationship with the plan or coverage for furnishing such item or service.''.

(b) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICI-

PATING FACILITIES.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

"(e) NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

"(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (2)(A)) by a nonparticipating provider (as defined in subsection (b)(2)(G)) during a visit at a participating health care facility (as defined in paragraph (2)(B)) (including imaging or laboratory services so furnished by a nonparticipating provider when ordered by a participating provider or after-emergency care furnished by a nonparticipating provider in the case that the participant, beneficiary, or enrollee cannot travel without medical transport), with respect to such plan, the plan—

"(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing

amount that would apply under such plan had such items or services been furnished by a participating provider;

''(B) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee, subject to subsection (f), the amount by which the commercially reasonable rate, as determined by the plan or issuer, for such services exceeds the cost-sharing amount imposed for such services (as determined in accordance with subparagraph (A)) and, if applicable, any amount to reconcile the difference between such rate so paid and the specified rate (determined under subsection (f)(1)) for such services; and

''(C) shall count toward any deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this subsection and subsection (f):

''(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market.

''(B) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer, a health care facility described in clause (ii) that has a contractual relationship with the plan or coverage for furnishing such item or service.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

''(I) A hospital (as defined in 1861(e) of the Social Security Act).

''(II) A critical access hospital (as defined in section 1861(mm) of such Act).

"(III) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

"(IV) A laboratory.

"(V) A radiology or imaging center.

"(VI) Any other facility that provides services that are covered under a group health plan or health insurance coverage.

"(VII) Any other facility specified by the Secretary.".

(c) NEGOTIATION AND ARBITRATION PROCESS FOR DETERMINING PRICES.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as amended by subsection (b), is further amended by adding at the end the following new subsection:

"(f) NEGOTIATION AND ARBITRATION PROCESS.—

"(1) SPECIFIED AMOUNT.—For purposes of subsections (b) and (e) and this subsection, the specified amount determined under this subsection, with respect to a health plan and nonparticipating provider for an item or service, is—

"(A) in the case the plan and provider enter into negotiations pursuant to paragraph

(2) and such negotiations are successful, the amount determined for such item or service pursuant to such negotiations; or

''(B) in the case the plans and provider enter into such negotiations but such negotiations are not successful, the reasonable amount determined for such item or service pursuant to the independent dispute resolution process under paragraph (3).

''(2) NEGOTIATIONS.—For purposes of subsections (b)(1)(C)(iii) and (e)(1)(B), in the case of a payment of a commercially reasonable rate made by a health plan to a nonparticipating provider pursuant to such respective subsection for an item or service, the provider and plan may, not later than 30 days after the date of such payment, negotiate an amount of payment (other than the commercially reasonable rate specified in such subsection) to be made for such item or service.

''(3) INDEPENDENT DISPUTE RESOLUTION.—

''(A) IN GENERAL.—If, by the end of such 30-day period specified in paragraph (2), the plan and provider have not determined a negotiated amount for the payment involved, the plan or provider may initiate an independent

dispute resolution process under this paragraph to determine the amount of payment.

''(B) ESTABLISHMENT OF IDR.—

''(i) IN GENERAL.—Not later than January 1, 2021, the Secretary, in consultation with the Secretary of Labor, shall establish a process for resolving payment disputes between health plans and nonparticipating providers for purposes of determining amounts of payments to be made by the plans to the providers pursuant to subsections (b) and (e) (referred to in this section as the 'IDR process').

''(ii) ENTITIES.—An entity wishing to participate in the IDR process under this subsection shall request certification from the Secretary. The Secretary, in consultation with the Secretary of Labor, shall determine eligibility of applicant entities, taking into consideration whether the entity is unbiased and unaffiliated with health plans and providers and free of conflicts of interest, in accordance with the Secretary's rulemaking on determining criteria for conflicts of interest.

"(iii) APPLICABLE CLAIMS.—

"(I) IN GENERAL.—The IDR process shall be with respect to one or more Current Procedural Terminology ('CPT') codes.

"(II) BATCHING OF CLAIMS.—Claims may be batched if such claims—

"(aa) involve identical plan or issuer and provider or facility parties;

"(bb) involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

"(cc) involve claims that occur within 60 days of each other.

"(C) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(i) TIMING.—In the case of an IDR entity that receives a request under this paragraph, with respect to a payment amount to be paid by a health plan to a nonparticipating provider—

"(I) the plan and provider may, during the 30-day period following the date of receipt of such request, submit any information or supporting documentation to the IDR entity; and

"(II) the IDR entity shall, not later than 60 days after receiving such request, determine such amount.

"(ii) DETERMINATION OF AMOUNT.—

"(I) IN GENERAL.—The amount determined by the IDR entity under clause (i), with respect to a payment amount to be paid by a health plan to a nonparticipating provider for an item or service shall be—

"(aa) the initial charge for the item or service made by the provider or the commercially reasonable rate paid by the plan for the item or service under subsections (b)(1)(C)(iii) or (e)(1)(B), respectively, whichever is determined reasonable by the entity based on the factors described in subclause (III); or

"(bb) in the case neither such charge or such rate is determined by the entity to be reasonable, the final offer submitted under subclause (II) that is determined more reasonable in accordance with such subclause.

"(II) FINAL OFFERS.—For purposes of subclause (I)(bb), the health plan and the nonparticipating provider party to the independent dispute resolution under this paragraph shall each submit to the IDR entity their final offer for an amount for the payment that is subject to the dispute not later than 30 days after the IDR entity determines under such subclause that neither the charge or rate described in subclause (I)(aa) were reasonable. Not later than 60 days after such date of such determination, such entity shall determine which of the 2 final offers is more reasonable based on the factors described in subclause (III).

"(III) FACTORS.—For purposes of subclauses (I) and (II), the factors described in this subclause include, as relevant—

"(aa) commercially reasonable rates for comparable services or items in the same geographic area (which shall take into consideration in-network rates for that geographic area and not charges);

"(bb) the usual and customary cost of the item or service involved, determined as the 80th percentile of charges for comparable items and services for the specialty involved in the geographical area in which the item or service was furnished, as determined through reference to a medical claims database;

"(cc) other factors that may be submitted at the discretion of either party, which may include—

"(dd) the level of training, education, experience, and quality and outcomes measurements of the nonparticipating provider;

"(ee) the circumstances and complexity of the particular dispute, including the time and place of the service;

"(ff) the provider's quality and outcome metrics;

"(gg) the provider's usual charge for comparable services with regard to patients in health care plans in which the provider is not participating;

"(hh) the individual patient characteristics; and

"(ii) other relevant economic and clinical factors.

"(IV) FINAL DECISIONS.—The amount that is determined to be the more reasonable amount under item (aa) or (bb) of subclause (I), as applicable, shall be the final decision of the IDR entity as to the amount the

health plan is required to pay the provider.

"(V) EFFECT OF DETERMINATION.—A final determination of an IDR entity under subclause (IV)—

"(aa) shall be binding; and

"(bb) shall not be subject to judicial review, except in cases comparable to those described in section 10(a) of title 9, United States Code, as determined by the Secretary in consultation with the Secretary of Labor, and cases in which information submitted by one party was determined to be fraudulent.

"(iii) PRIVACY LAWS.—An IDR entity shall, in conducting an independent dispute resolution process under this paragraph, comply with all applicable Federal and State privacy laws.

"(iv) PUBLIC AVAILABILITY.—The reasonable amount determined by an IDR entity under this paragraph with respect to any claim shall not be confidential, except

that information submitted to the IDR entity shall be kept confidential. IDR entities may consider past decisions awarded by independent dispute entities during the independent dispute resolution process.

''(v) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The nonprevailing party shall be responsible for paying all fees charged by the IDR entity. If the parties reach a settlement prior to completion of the IDR process, the costs of the independent dispute resolution process shall be divided equally between the parties.

''(vi) PAYMENT.—Any difference between—

''(I) the amount determined to be paid by one party of the dispute resolution to another pursuant to this paragraph; and

''(II) the amounts already paid under subsection (b) or (e) before entering into the process under this paragraph,

shall be paid not later than 15 days after the date on which the entity makes a determination with respect to such amount.

''(D) PUBLICATION.—The Secretary shall publish aggregated results of the independent dispute resolution by geographic region in order to give more guidance to providers and health plans.''.

(d) PREVENTING CERTAIN CASES OF BALANCE BILLING.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsections:

''(t)(1) Subject to paragraph (3), in the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital—

''(A) if the emergency department of a hospital holds the individual liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with section 2719A(b)(1)(C)(ii) of the Public Health Service Act); or

''(B) if any health care provider holds such individual liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with section 2719A(b)(1)(C)(ii) of the Public Health Service Act),

the hospital, emergency department or health care provider, respectively, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than an amount determined appropriate by the Secretary for each specified claim.

''(2) The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) shall apply to a civil money penalty or assessment under paragraph (1) or subsection (u) in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a).

''(3) Paragraph (1) shall not apply to an emergency department of a hospital or a provider, with respect to items or services furnished to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if the emergency de-

partment of the hospital or the provider, respectively, reimburses such participant, beneficiary, or enrollee any amount for such an item or service that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A)) not later than 30 days after the date the emergency department of the hospital or provider, respectively, knew or should have known such excess payment was in violation of this subsection.

''(4) In this subsection and subsection (u):

''(A) The terms 'emergency medical condition' and 'emergency services' have the meanings given such terms, respectively, in section 2719A(b)(2) of the Public Health Service Act.

''(B) The terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

''(u)(1) Subject to paragraph (2), in the case of an individual with benefits under a health plan or health insurance coverage offered in the group or individual market who is furnished on or after January 1, 2021, items or services (other than emergency services to which subsection (t) applies) during an episode of care (as defined by the Secretary) at a participating health care facility

by a nonparticipating provider (including imaging or laboratory services so furnished by a nonparticipating provider when ordered by a participating provider or after-emergency care furnished by a nonparticipating provider in the case that the participant, beneficiary, or enrollee cannot travel without medical transport), if such nonparticipating provider holds such individual liable for a payment amount for such an item or service furnished by such provider that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A) of the Public Health Service Act), such provider shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than an amount determined appropriate by the Secretary for each specified claim.

''(2) Paragraph (1) shall not apply to a nonparticipating provider, with respect to items or services furnished by the provider to a participant, beneficiary, or enrollee of a health plan or health insurance coverage offered by a health insurance issuer, if the provider reimburses such participant, beneficiary, or enrollee any amount for such an item or service that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e)(1)(A)) not later than 30 days

after the date the provider knew or should have known such excess payment was in violation of this subsection.

''(3) For purposes of this subsection, the terms 'non-participating provider' and 'participating health care facility' have such meanings given such terms under subsections (b)(2) and (e)(2), respectively, of section 2719A of the Public Health Service Act.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 3. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES.

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

''SEC. 2729A. 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.

''(b) GUIDANCE.—The Secretary, in consultation with the Secretary of Labor, shall issue guidance to implement subsection (a).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to plan years beginning on or after the date that is one year after the date of the enactment of this Act.

SEC. 4. TRANSPARENCY FOR IN-NETWORK PATIENTS.

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 3, is further amended by adding at the end the following:

''SEC. 2729B. TRANSPARENCY FOR IN-NETWORK PATIENTS.

''(a) STANDARDS.—Not later than January 1, 2021, the Secretary shall, through rulemaking, establish transparency standards to provide better information to individuals who are enrolled in group health plans or health insurance coverage offered in the individual or group market (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) about which health care providers are participating in the network of the plan or coverage in which such an individual is enrolled. Such standards shall at a minimum provide for the following:

''(1) Such plans and coverage offer provider directories online and in print.

''(2) Annual audits of such provider directories, as specified by the Secretary.

''(3) Monthly updates of such online directories.

''(b) GUIDANCE.—Beginning January 1, 2022, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall be in compliance with the standards established pursuant to subsection (a).''.

SEC. 5. REPORTING REQUIREMENTS.

Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by sections 3 and 4, is further amended by adding at the end the following:

''SEC. 2729C. TRANSPARENCY REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually report (beginning for plan year 2021) to the Secretary and the Secretary of Labor, with respect to the applicable plan or coverage for the applicable plan year—

''(1) the total claims that were submitted by in-network health care providers with respect to enrollees under the plan or coverage, and the number of

such claims that were paid and the number of such claims that were denied;

''(2) the total claims that were submitted by out-of-network health care providers with respect to enrollees under the plan or coverage, and the number of such claims that were paid and the number of such claims that were denied;

''(3) with respect to each out-of-network claim, the out-of-pocket costs to the enrollee for the services;

''(4) the number of out-of-network claims reported under paragraph (2) that are for emergency services; and

''(5) the number of out-of-network claims reported under paragraph (2) that relate to care at in-network hospitals or facilities provided by out-of-network providers.

''(b) CLARIFICATION.—The information required to be submitted under this section shall be in addition to the information required to be submitted under section 2715A.''.

SEC. 6. BILLING STATUTE OF LIMITATIONS.

Notwithstanding any other provision of law, a health care provider may not seek reimbursement from an individual for a service furnished by such provider to such in-

dividual more than a year after such date of service. Any provider that bills an individual in violation of the previous sentence shall be subject to a civil monetary penalty in such amount as specified by the Secretary of Health and Human Services.

SEC. 7. APPLICATION.

(a) NON-APPLICATION IN CASES OF STATES WITH CERTAIN BALANCE BILLING LAWS.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsection:

''(g) In any case in which a State has in effect a law or regulation that prohibits balance billing or otherwise provides an alternate method for resolving a dispute between a health plan and provider for determining compensation for services described in subsections (b), (e), or (f), the provisions of such law and not the provisions of this Act shall apply to health plans (except self-insured group health plans that are not subject to State insurance regulation), health care providers, and individuals in such State so long as such law does not require an individual to pay more in cost-sharing than the amount that would otherwise be required of such individual under this section.''.

(b) APPLICATION TO FEHB.—

(1) IN GENERAL.—Section 8902 of title 5, United States Code, is amended by adding at the end the following new subsection:

''(p) Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of subsections (b), (e), and (f) of section 2719A of the Public Health Service Act and sections 2729A and 2729B of such Act in the same manner as those provisions apply to a groups health plan or health insurance issuer offering health insurance coverage, as described in such sections.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply with respect to contracts entered into or renewed for contract years beginning at least one year after the date of enactment of this Act.

SEC. 8. STUDIES BY SECRETARIES OF HEALTH AND HUMAN SERVICES AND OF LABOR.

(a) IMPACT STUDY.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study of the effects of this Act (including the amendments made by this Act), and submit to Congress (and make public) a report on the findings

of such study, which shall include information and analysis on—

(1) the financial impact on patient responsibility for health care spending and overall health care spending;

(2) the incidence and prevalence of the delivery of unanticipated out-of-network health care services, in the cases of emergency services and in the cases of care at in-network hospitals or facilities provided by out-of-network providers;

(3) the adequacy of provider networks offered by health plans and health insurance issuers (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91));

(4) a comparison of the different claims databases used and the impact of using such databases on reimbursement rates;

(5) the number of bills that are settled through negotiations pursuant to subsection (f)(2) of section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by section 2, and the number of bills that go to the independent dispute resolution process under subsection (f)(3) of such section, as so added;

(6) the administrative cost of such independent dispute resolution process; and

(7) the estimated impact of such independent dispute resolution process on health insurance premiums and deductibles.

(b) BILLING FEASIBILITY STUDY.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct, and submit to Congress (and make public), a feasibility study on the provision of a single bill for all services provided for a single episode of care, as defined by the Secretary.

SEC. 9. REGULATIONS.

Not later than one year after the date of the enactment of this Act, the Secretary of Labor and the Secretary of Health and Human Services shall promulgate regulations pertaining to carry out the provisions (including amendments made by) this Act.

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