S 1266

Protecting Patients from Surprise Medical Bills Act

Congress: 116 (2019–2021, Ended)
Chamber: Senate
Policy Area: Health
Introduced: May 1, 2019
Current Status: Read twice and referred to the Committee on Health, Education, Labor, and Pensions.
Latest Action: Read twice and referred to the Committee on Health, Education, Labor, and Pensions. (May 1, 2019)
Official Text: https://www.congress.gov/bill/116th-congress/senate-bill/1266

Sponsor

Name: Sen. Scott, Rick [R-FL]
Party: Republican • **State:** FL • **Chamber:** Senate

Cosponsors

No cosponsors are listed for this bill.

Committee Activity

Committee	Chamber	Activity	Date
Health, Education, Labor, and Pensions Committee	Senate	Referred To	May 1, 2019

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
116 HR 4223	Identical bill	**Sep 10, 2019:** Sponsor introductory remarks on measure. (CR H7587-7588)

Summary (as of May 1, 2019)

Protecting Patients from Surprise Medical Bills Act

This bill prohibits balance billing the holder of a self-insured group health plan (plans in which an employer pays claims to providers for health benefits offered to employees) for emergency and specified nonemergency services. Balance billing is the practice of charging a plan holder for the difference between a provider's rate for a service and the in-network rate.

First, the bill requires self-insured group health plans that cover emergency services to comply with the requirements for other types of group health plans. This includes the requirement to bill a plan holder no more than the in-network cost-sharing amount for covered emergency services, even if the provider is out-of-network. Second, the bill prohibits emergency services providers from billing a self-insured group plan holder for any remaining balance for covered services not paid to the provider by the employer.

Further, unless a plan holder has the option to select an in-network provider, an out-of-network provider of covered, nonemergency services is prohibited from billing plan holders for the difference in rates for such services when provided at an in-network facility.

Employers must pay out-of-network providers for services subject to the requirements of this bill (1) the amount the provider claims, (2) the usual and customary amount for such services in that community, or (3) an amount agreed to within 60 days of when the claim is submitted. Otherwise the parties may enter voluntary binding arbitration.

Actions Timeline

- **May 1, 2019:** Introduced in Senate
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