

116TH CONGRESS
2D SESSION

H. R. 5800

To end surprise medical billing and increase transparency in health coverage.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 7, 2020

Mr. SCOTT of Virginia (for himself and Ms. FOXX of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, Ways and Means, and Oversight and Reform, 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

A BILL

To end surprise medical billing and increase transparency
in health coverage.

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 “Ban Surprise Billing
5 Act”.

1 **SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.**

2 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

3 Section 2719A of the Public Health Service Act (42
4 U.S.C. 300gg–19a) is amended—

5 (1) by amending subsection (b) to read as fol-
6 lows:

7 “(b) COVERAGE OF EMERGENCY SERVICES.—

8 “(1) IN GENERAL.—If a group health plan, or
9 a health insurance issuer offering group or indi-
10 vidual health insurance coverage, provides or covers
11 any benefits with respect to services in an emergency
12 department of a hospital or with respect to emer-
13 gency services in an independent freestanding emer-
14 gency department (as defined in paragraph (3)(D)),
15 the plan or issuer shall cover emergency services (as
16 defined in paragraph (3)(C))—

17 “(A) without the need for any prior au-
18 thorization determination;

19 “(B) whether the health care provider fur-
20 nishing such services is a participating provider
21 or a participating emergency facility, as appli-
22 cable, with respect to such services;

23 “(C) in a manner so that, if such services
24 are provided to a participant, beneficiary, or en-
25 rollee by a nonparticipating provider or a non-
26 participating emergency facility—

1 “(i) such services will be provided
2 without imposing any requirement under
3 the plan or coverage for prior authoriza-
4 tion of services or any limitation on cov-
5 erage that is more restrictive than the re-
6 quirements or limitations that apply to
7 emergency services received from partici-
8 pating providers and participating emer-
9 gency facilities with respect to such plan or
10 coverage, respectively;

11 “(ii) the cost-sharing requirement (ex-
12 pressed as a copayment amount or coinsur-
13 ance rate) is not greater than the require-
14 ment that would apply if such services
15 were provided by a participating provider
16 or a participating emergency facility;

17 “(iii) such cost-sharing requirement is
18 calculated as if the total amount that
19 would have been charged for such services
20 by such participating provider or partici-
21 pating emergency facility were equal to the
22 recognized amount (as defined in para-
23 graph (3)(H)) for such services, plan or
24 coverage, and year;

1 “(iv) the group health plan or health
2 insurance issuer, respectively, pays to such
3 provider or facility, respectively the
4 amount by which the recognized amount
5 for such services and year involved exceeds
6 the cost-sharing amount for such services
7 (as determined in accordance with clauses
8 (ii) and (iii)) and year; and

9 “(v) any cost-sharing payments made
10 by the participant, beneficiary, or enrollee
11 with respect to such emergency services so
12 furnished shall be counted toward any in-
13 network deductible or out-of-pocket maxi-
14 mums applied under the plan or coverage,
15 respectively (and such in-network deduct-
16 ible and out-of-pocket maximums shall be
17 applied) in the same manner as if such
18 cost-sharing payments were made with re-
19 spect to emergency services furnished by a
20 participating provider or a participating
21 emergency facility; and

22 “(D) without regard to any other term or
23 condition of such coverage (other than exclusion
24 or coordination of benefits, or an affiliation or
25 waiting period, permitted under section 2704 of

1 this Act, including as incorporated pursuant to
2 section 715 of the Employee Retirement Income
3 Security Act of 1974 and section 9815 of the
4 Internal Revenue Code of 1986, and other than
5 applicable cost-sharing).

6 “(2) AUDIT PROCESS AND REGULATIONS FOR
7 MEDIAN CONTRACTED RATES.—

8 “(A) AUDIT PROCESS.—

9 “(i) IN GENERAL.—Not later than
10 July 1, 2021, the Secretary, in consulta-
11 tion with appropriate State agencies and
12 the Secretary of Labor and the Secretary
13 of the Treasury, shall establish through
14 rulemaking a process, in accordance with
15 clause (ii), under which group health plans
16 and health insurance issuers offering
17 health insurance coverage in the group or
18 individual market are audited by the Sec-
19 retary or applicable State authority to en-
20 sure that—

21 “(I) such plans and coverage are
22 in compliance with the requirement of
23 applying a median contracted rate
24 under this section; and

1 “(II) such median contracted
2 rate so applied satisfies the definition
3 under paragraph (3)(E) with respect
4 to the year involved, including with re-
5 spect to a group health plan or health
6 insurance issuer described in clause
7 (ii) of such paragraph (3)(E).

8 “(ii) AUDIT SAMPLES.—Under the
9 process established pursuant to clause (i),
10 the Secretary—

11 “(I) shall conduct audits de-
12 scribed in such clause, with respect to
13 a year (beginning with 2022), of a
14 sample with respect to such year of
15 claims data from not more than 25
16 group health plans and health insur-
17 ance issuers offering health insurance
18 coverage in the group or individual
19 market; and

20 “(II) may audit any group health
21 plan or health insurance issuer offer-
22 ing health insurance coverage in the
23 group or individual market if the Sec-
24 retary has received any complaint
25 about such plan or coverage, respec-

1 tively, that involves the compliance of
2 the plan or coverage, respectively,
3 with either of the requirements de-
4 scribed in subclauses (I) and (II) of
5 such clause.

6 “(iii) REPORTS.—Beginning for 2022,
7 the Secretary shall annually submit to
8 Congress a report on the number of plans
9 and issuers with respect to which audits
10 were conducted during such year pursuant
11 to this subparagraph.

12 “(B) RULEMAKING.—Not later than July
13 1, 2021, the Secretary, in consultation with the
14 Secretary of Labor and the Secretary of the
15 Treasury, shall establish through rulemaking—

16 “(i) the methodology the group health
17 plan or health insurance issuer offering
18 health insurance coverage in the group or
19 individual market shall use to determine
20 the median contracted rate, differentiating
21 by line of business;

22 “(ii) the information such plan or
23 issuer, respectively, shall share with the
24 nonparticipating provider or nonpartici-

1 pating facility, as applicable, when making
2 such a determination;

3 “(iii) the geographic regions applied
4 for purposes of this subparagraph, taking
5 into account access to items and services in
6 rural and underserved areas, including
7 health professional shortage areas, as de-
8 fined in section 332; and

9 “(iv) a process to receive complaints
10 of violations of the requirements described
11 in subclauses (I) and (II) of subparagraph
12 (A)(i) by group health plans and health in-
13 surance issuers offering health insurance
14 coverage in the group or individual market.

15 Such rulemaking shall take into account pay-
16 ments that are made by such plan or issuer, re-
17 spectively, that are not on a fee-for-service
18 basis. Such methodology may account for rel-
19 evant payment adjustments that take into ac-
20 count quality or facility type (including higher
21 acuity settings and the case-mix of various fa-
22 cility types) that are otherwise taken into ac-
23 count for purposes of determining payment
24 amounts with respect to participating facilities.

25 In carrying out clause (iii), the Secretary shall

1 consult with the National Association of Insur-
2 ance Commissioners to establish the geographic
3 regions under such clause and shall periodically
4 update such regions, as appropriate.

5 “(3) DEFINITIONS.—In this part:

6 “(A) EMERGENCY DEPARTMENT OF A HOS-
7 PITAL.—The term ‘emergency department of a
8 hospital’ includes a hospital outpatient depart-
9 ment that provides emergency services.

10 “(B) EMERGENCY MEDICAL CONDITION.—
11 The term ‘emergency medical condition’ means
12 a medical condition manifesting itself by acute
13 symptoms of sufficient severity (including se-
14 vere pain) such that a prudent layperson, who
15 possesses an average knowledge of health and
16 medicine, could reasonably expect the absence
17 of immediate medical attention to result in a
18 condition described in clause (i), (ii), or (iii) of
19 section 1867(e)(1)(A) of the Social Security
20 Act.

21 “(C) EMERGENCY SERVICES.—

22 “(i) IN GENERAL.—The term ‘emer-
23 gency services’, with respect to an emer-
24 gency medical condition, means—

1 “(I) a medical screening exam-
2 ination (as required under section
3 1867 of the Social Security Act, or as
4 would be required under such section
5 if such section applied to an inde-
6 pendent freestanding emergency de-
7 partment) that is within the capability
8 of the emergency department of a hos-
9 pital or of an independent free-
10 standing emergency department, as
11 applicable, including ancillary services
12 routinely available to the emergency
13 department to evaluate such emer-
14 gency medical condition; and

15 “(II) within the capabilities of
16 the staff and facilities available at the
17 hospital or the independent free-
18 standing emergency department, as
19 applicable, such further medical exam-
20 ination and treatment as are required
21 under section 1867 of such Act, or as
22 would be required under such section
23 if such section applied to an inde-
24 pendent freestanding emergency de-
25 partment, to stabilize the patient.

1 “(ii) INCLUSION OF CERTAIN SERV-
2 ICES OUTSIDE OF EMERGENCY DEPART-
3 MENT.—

4 “(I) IN GENERAL.—For purposes
5 of this subsection and section 2799A-
6 1, in the case of an individual enrolled
7 in a group health plan or health in-
8 surance coverage offered by a health
9 insurance issuer in the group or indi-
10 vidual market who is furnished serv-
11 ices described in clause (i) by a par-
12 ticipating or nonparticipating provider
13 or a participating or nonparticipating
14 emergency facility to stabilize such in-
15 dividual with respect to an emergency
16 medical condition, the term ‘emer-
17 gency services’ shall include, unless
18 each of the conditions described in
19 subclause (II) are met, in addition to
20 the items and services described in
21 clause (i), items and services for
22 which benefits are provided or covered
23 under the plan or coverage, respec-
24 tively, furnished by a nonparticipating
25 provider or nonparticipating facility,

1 regardless of the department of the
2 hospital in which such individual is
3 furnished such items or services, if,
4 after such stabilization but during
5 such visit in which such individual is
6 so stabilized, the provider or facility
7 determines that such items or services
8 are needed.

9 “(II) CONDITIONS.—For pur-
10 poses of subclause (I), the conditions
11 described in this subclause, with re-
12 spect to an individual who is stabilized
13 and furnished additional items and
14 services described in subclause (I)
15 after such stabilization by a provider
16 or facility described in subclause (I),
17 are the following:

18 “(aa) Such a provider or fa-
19 cility determines such individual
20 is able to travel using nonmedical
21 transportation or nonemergency
22 medical transportation.

23 “(bb) Such provider fur-
24 nishing such additional items and
25 services satisfies the notice and

1 consent criteria of section
2 2799A–2(d) with respect to such
3 items and services.

4 “(cc) Such an individual is
5 in a condition to receive (as de-
6 termined in accordance with
7 guidance issued by the Secretary)
8 the information described in sec-
9 tion 2799A–2 and to provide in-
10 formed consent under such sec-
11 tion, in accordance with applica-
12 ble State law.

13 “(D) INDEPENDENT FREESTANDING
14 EMERGENCY DEPARTMENT.—The term ‘inde-
15 pendent freestanding emergency department’
16 means a facility that—

17 “(i) is geographically separate and
18 distinct and licensed separately from a hos-
19 pital under applicable State law; and

20 “(ii) provides any emergency services
21 (as defined in subparagraph (C)).

22 “(E) MEDIAN CONTRACTED RATE.—

23 “(i) IN GENERAL.—The term ‘median
24 contracted rate’ means, subject to clauses
25 (ii) and (iii), with respect to a sponsor of

1 a group health plan and health insurance
2 issuer offering health insurance coverage in
3 the group or individual market—

4 “(I) for an item or service fur-
5 nished during 2022, the median of the
6 contracted rates recognized by the
7 plan or issuer, respectively (deter-
8 mined with respect to all such plans
9 of such sponsor or all such coverage
10 offered by such issuer that are offered
11 within the same line of business as
12 the plan or coverage) as the total
13 maximum payment (including the
14 cost-sharing amount imposed for such
15 item or service and the amount to be
16 paid by the plan or issuer, respec-
17 tively) under such plans or coverage,
18 respectively, on January 31, 2019, for
19 the same or a similar item or service
20 that is provided by a provider in the
21 same or similar specialty and provided
22 in the geographic region in which the
23 item or service is furnished, consistent
24 with the methodology established by
25 the Secretary under paragraph

1 (2)(B), increased by the percentage
2 increase in the consumer price index
3 for all urban consumers (United
4 States city average) over 2019, such
5 percentage increase over 2020, and
6 such percentage increase over 2021;
7 and

8 “(II) for an item or service fur-
9 nished during 2023 or a subsequent
10 year, the median contracted rate de-
11 termined under this clause for such
12 an item or service furnished in the
13 previous year, increased by the per-
14 centage increase in the consumer price
15 index for all urban consumers (United
16 States city average) over such pre-
17 vious year.

18 “(ii) NEW PLANS AND COVERAGE.—

19 The term ‘median contracted rate’ means,
20 with respect to a sponsor of a group health
21 plan or health insurance issuer offering
22 health insurance coverage in the group or
23 individual market in a geographic region in
24 which such sponsor or issuer, respectively,

1 did not offer any group health plan or
2 health insurance coverage during 2019—

3 “(I) for the first year in which
4 such group health plan or health in-
5 surance coverage, respectively, is of-
6 fered in such region, a rate (deter-
7 mined in accordance with a method-
8 ology established by the Secretary) for
9 items and services that are covered by
10 such plan and furnished during such
11 first year; and

12 “(II) for each subsequent year
13 such group health plan or health in-
14 surance coverage, respectively, is of-
15 fered in such region, the median con-
16 tracted rate determined under this
17 clause for such items and services fur-
18 nished in the previous year, increased
19 by the percentage increase in the con-
20 sumer price index for all urban con-
21 sumers (United States city average)
22 over such previous year.

23 “(iii) INSUFFICIENT INFORMATION;
24 NEWLY COVERED ITEMS AND SERVICES.—
25 In the case of a sponsor of a group health

1 plan or health insurance issuer offering
2 health insurance coverage in the group or
3 individual market that does not have suffi-
4 cient information to calculate the median
5 of the contracted rates described in clause
6 (i)(I) in 2019 (or, in the case of a newly
7 covered item or service (as defined in
8 clause (iv)(III)), in the first coverage year
9 (as defined in clause (iv)(I)) for such item
10 or service with respect to such plan or cov-
11 erage) for an item or service (including
12 with respect to provider type, or amount,
13 of claims for items or services (as deter-
14 mined by the Secretary) provided in a par-
15 ticular geographic region (other than in a
16 case with respect to which clause (ii) ap-
17 plies)) the term ‘median contracted rate’—

18 “(I) for an item or service fur-
19 nished during 2022 (or, in the case of
20 a newly covered item or service, dur-
21 ing the first coverage year for such
22 item or service with respect to such
23 plan or coverage), means such rate for
24 such item or service determined by
25 the sponsor or issuer, respectively,

1 through use of any database that is
2 determined, in accordance with rule-
3 making described in paragraph
4 (2)(B), to not have any conflicts of in-
5 terest and to have sufficient informa-
6 tion reflecting allowed amounts paid
7 to a health care provider or facility for
8 relevant services furnished in the ap-
9 plicable geographic region (such as a
10 State all-payer claims database);

11 “(II) for an item or service fur-
12 nished in a subsequent year (before
13 the first sufficient information year
14 (as defined in clause (iv)(II)) for such
15 item or service with respect to such
16 plan or coverage), means the rate de-
17 termined under subclause (I) or this
18 subclause, as applicable, for such item
19 or service for the year previous to
20 such subsequent year, increased by
21 the percentage increase in the con-
22 sumer price index for all urban con-
23 sumers (United States city average)
24 over such previous year;

1 “(III) for an item or service fur-
2 nished in the first sufficient informa-
3 tion year for such item or service with
4 respect to such plan or coverage, has
5 the meaning given the term median
6 contracted rate in clause (i)(I), except
7 that in applying such clause to such
8 item or service, the reference to ‘fur-
9 nished during 2022’ shall be treated
10 as a reference to furnished during
11 such first sufficient information year,
12 the reference to ‘in 2019’ shall be
13 treated as a reference to such suffi-
14 cient information year, and the in-
15 crease described in such clause shall
16 not be applied; and

17 “(IV) for an item or service fur-
18 nished in any year subsequent to the
19 first sufficient information year for
20 such item or service with respect to
21 such plan or coverage, has the mean-
22 ing given such term in clause (i)(II),
23 except that in applying such clause to
24 such item or service, the reference to
25 ‘furnished during 2023 or a subse-

1 quent year’ shall be treated as a ref-
2 erence to furnished during the year
3 after such first sufficient information
4 year or a subsequent year.

5 “(iv) DEFINITIONS.—For purposes of
6 this subparagraph:

7 “(I) FIRST COVERAGE YEAR.—

8 The term ‘first coverage year’ means,
9 with respect to a group health plan or
10 health insurance coverage offered by a
11 health insurance issuer in the group
12 or individual market and an item or
13 service for which coverage is not of-
14 fered in 2019 under such plan or cov-
15 erage, the first year after 2019 for
16 which coverage for such item or serv-
17 ice is offered under such plan or
18 health insurance coverage.

19 “(II) FIRST SUFFICIENT INFOR-
20 MATION YEAR.—The term ‘first suffi-
21 cient information year’ means, with
22 respect to a group health plan or
23 health insurance coverage offered by a
24 health insurance issuer in the group
25 or individual market—

1 “(aa) in the case of an item
2 or service for which the plan or
3 coverage does not have sufficient
4 information to calculate the me-
5 dian of the contracted rates de-
6 scribed in clause (i)(I) in 2019,
7 the first year subsequent to 2022
8 for which the sponsor or issuer
9 has such sufficient information to
10 calculate the median of such con-
11 tracted rates in the year previous
12 to such first subsequent year;
13 and

14 “(bb) in the case of a newly
15 covered item or service, the first
16 year subsequent to the first cov-
17 erage year for such item or serv-
18 ice with respect to such plan or
19 coverage for which the sponsor or
20 issuer has sufficient information
21 to calculate the median of the
22 contracted rates described in
23 clause (i)(I) in the year previous
24 to such first subsequent year.

1 “(III) NEWLY COVERED ITEM OR
2 SERVICE.—The term ‘newly covered
3 item or service’ means, with respect to
4 a group health plan or health insur-
5 ance issuer offering health insurance
6 coverage in the group or individual
7 market, an item or service for which
8 coverage was not offered in 2019
9 under such plan or coverage, but is
10 offered under such plan or coverage in
11 a year after 2019.

12 “(F) NONPARTICIPATING EMERGENCY FA-
13 CILITY; PARTICIPATING EMERGENCY FACIL-
14 ITY.—

15 “(i) NONPARTICIPATING EMERGENCY
16 FACILITY.—The term ‘nonparticipating
17 emergency facility’ means, with respect to
18 an item or service and a group health plan
19 or health insurance coverage offered by a
20 health insurance issuer in the group or in-
21 dividual market, an emergency department
22 of a hospital, or an independent free-
23 standing emergency department, that does
24 not have a contractual relationship directly
25 or indirectly with the plan or issuer, re-

1 spectively, for furnishing such item or serv-
2 ice under the plan or coverage, respec-
3 tively.

4 “(ii) PARTICIPATING EMERGENCY FA-
5 CILITY.—The term ‘participating emer-
6 gency facility’ means, with respect to an
7 item or service and a group health plan or
8 health insurance coverage offered by a
9 health insurance issuer in the group or in-
10 dividual market, an emergency department
11 of a hospital, or an independent free-
12 standing emergency department, that has
13 a contractual relationship directly or indi-
14 rectly with the plan or issuer, respectively,
15 with respect to the furnishing of such an
16 item or service at such facility.

17 “(G) NONPARTICIPATING PROVIDERS; PAR-
18 TICIPATING PROVIDERS.—

19 “(i) NONPARTICIPATING PROVIDER.—
20 The term ‘nonparticipating provider’
21 means, with respect to an item or service
22 and a group health plan or health insur-
23 ance coverage offered by a health insur-
24 ance issuer in the group or individual mar-
25 ket, a physician or other health care pro-

1 vider who is acting within the scope of
2 practice of that provider’s license or certifi-
3 cation under applicable State law and who
4 does not have a contractual relationship
5 with the plan or issuer, respectively, for
6 furnishing such item or service under the
7 plan or coverage, respectively.

8 “(ii) PARTICIPATING PROVIDER.—The
9 term ‘participating provider’ means, with
10 respect to an item or service and a group
11 health plan or health insurance coverage
12 offered by a health insurance issuer in the
13 group or individual market, a physician or
14 other health care provider who is acting
15 within the scope of practice of that pro-
16 vider’s license or certification under appli-
17 cable State law and who has a contractual
18 relationship with the plan or issuer, respec-
19 tively, for furnishing such item or service
20 under the plan or coverage, respectively.

21 “(H) RECOGNIZED AMOUNT.—The term
22 ‘recognized amount’ means, with respect to an
23 item or service furnished by a nonparticipating
24 provider or emergency facility during a year
25 and a group health plan or health insurance

1 coverage offered by a health insurance issuer in
2 the group or individual market—

3 “(i) subject to clause (iii), in the case
4 of such item or service furnished in a State
5 that has in effect a specified State law
6 with respect to such plan, coverage, or
7 issuer, respectively, such a nonpartici-
8 pating provider or emergency facility, and
9 such an item or service, the amount deter-
10 mined in accordance with such law;

11 “(ii) subject to clause (iii), in the case
12 of such item or service furnished in a State
13 that does not have in effect a specified
14 State law, with respect to such plan, cov-
15 erage, or issuer, respectively, such a non-
16 participating provider or emergency facil-
17 ity, and such an item or service, an
18 amount that is the median contracted rate
19 (as defined in subparagraph (E)) for such
20 year and determined in accordance with
21 rulemaking described in paragraph (2)(B)
22 for such item or service; or

23 “(iii) in the case of such item or serv-
24 ice furnished in a State with an All-Payer
25 Model Agreement under section 1115A of

1 the Social Security Act, the amount that
2 the State approves under such system for
3 such item or service so furnished.

4 “(I) SPECIFIED STATE LAW.—The term
5 ‘specified State law’ means, with respect to a
6 State, an item or service furnished by a non-
7 participating provider or emergency facility dur-
8 ing a year and a group health plan or health in-
9 surance coverage offered by a health insurance
10 issuer in the group or individual market, a
11 State law that provides for a method for deter-
12 mining the amount of payment that is required
13 to be covered by such a plan, coverage, or
14 issuer, respectively (to the extent such State
15 law applies to such plan, coverage, or issuer,
16 subject to section 514 of the Employee Retire-
17 ment Income Security Act of 1974) in the case
18 of a participant, beneficiary, or enrollee covered
19 under such plan or coverage and receiving such
20 item or service from such a nonparticipating
21 provider or emergency facility.

22 “(J) STABILIZE.—The term ‘to stabilize’,
23 with respect to an emergency medical condition
24 (as defined in subparagraph (B)), has the

1 meaning give in section 1867(e)(3) of the Social
2 Security Act (42 U.S.C. 1395dd(e)(3)).”; and
3 (2) by adding at the end the following new sub-
4 sections:

5 “(e) COVERAGE OF NON-EMERGENCY SERVICES
6 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
7 TAIN PARTICIPATING FACILITIES.—

8 “(1) IN GENERAL.—In the case of items or
9 services (other than emergency services to which
10 subsection (b) applies) for which any benefits are
11 provided or covered by a group health plan or health
12 insurance issuer offering health insurance coverage
13 in the group or individual market furnished to a
14 participant, beneficiary, or enrollee of such plan or
15 coverage by a nonparticipating provider (as defined
16 in subsection (b)(3)(G)(i)) (and who, with respect to
17 such items and services, has not satisfied the notice
18 and consent criteria of section 2799A–2(d)) with re-
19 spect to a visit (as defined by the Secretary in ac-
20 cordance with paragraph (2)(B)) at a participating
21 health care facility (as defined in paragraph (2)(A)),
22 with respect to such plan or coverage, respectively,
23 the plan or coverage, respectively—

24 “(A) shall not impose on such participant,
25 beneficiary, or enrollee a cost-sharing amount

1 (expressed as a copayment amount or coinsur-
2 ance rate) for such items and services so fur-
3 nished that is greater than the cost-sharing
4 amount that would apply under such plan or
5 coverage, respectively, had such items or serv-
6 ices been furnished by a participating provider
7 (as defined in subsection (b)(3)(G)(ii));

8 “(B) shall calculate such cost-sharing
9 amount as if the total amount that would have
10 been charged for such items and services by
11 such participating provider were equal to the
12 recognized amount (as defined in subsection
13 (b)(3)(H)) for such items and services, plan or
14 coverage, and year;

15 “(C) shall pay to such provider furnishing
16 such items and services to such participant,
17 beneficiary, or enrollee the amount by which the
18 recognized amount (as defined in subsection
19 (b)(3)(H)) for such items and services and year
20 involved exceeds the cost-sharing amount im-
21 posed under the plan or coverage, respectively,
22 for such items and services (as determined in
23 accordance with subparagraphs (A) and (B));
24 and

“(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) 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 section:

“(A) 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 issuer offering health insurance coverage in the group or individual market, a health care facility described in clause (ii) that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

1 “(ii) HEALTH CARE FACILITY DE-
2 SCRIBED.—A health care facility described
3 in this clause, with respect to a group
4 health plan or health insurance coverage
5 offered in the group or individual market,
6 is each of the following:

7 “(I) A hospital (as defined in
8 1861(e) of the Social Security Act).

9 “(II) A hospital outpatient de-
10 partment.

11 “(III) A critical access hospital
12 (as defined in section 1861(mm) of
13 such Act).

14 “(IV) An ambulatory surgical
15 center (as defined in section
16 1833(i)(1)(A) of such Act).

17 “(V) Any other facility that pro-
18 vides items or services for which cov-
19 erage is provided under the plan or
20 coverage, respectively.

21 “(B) VISIT.—The term ‘visit’ shall, with
22 respect to items and services furnished to an in-
23 dividual at a participating health care facility,
24 include equipment and devices, telemedicine
25 services, imaging services, laboratory services,

1 and such other items and services as the Sec-
2 retary may specify, regardless of whether or not
3 the provider furnishing such items or services is
4 at the facility.

5 “(f) AIR AMBULANCE SERVICES.—

6 “(1) IN GENERAL.—In the case of a partici-
7 pant, beneficiary, or enrollee in a group health plan
8 or health insurance coverage offered in the group or
9 individual market who receives air ambulance serv-
10 ices from a nonparticipating provider (as defined in
11 subsection (b)(3)(G)) with respect to such plan or
12 coverage, if such services would be covered if pro-
13 vided by a participating provider (as defined in such
14 section) with respect to such plan or coverage—

15 “(A) the cost-sharing requirement (ex-
16 pressed as a copayment amount, coinsurance
17 rate, or deductible) with respect to such services
18 shall be the same requirement that would apply
19 if such services were provided by such a partici-
20 pating provider, and any coinsurance or deduct-
21 ible shall be based on rates that would apply for
22 such services if they were furnished by such a
23 participating provider;

24 “(B) such cost-sharing amounts shall be
25 counted toward the in-network deductible and

1 in-network out-of-pocket maximum amount
 2 under the plan or coverage for the plan year
 3 (and such in-network deductible shall be ap-
 4 plied) with respect to such items and services so
 5 furnished in the same manner as if such cost-
 6 sharing payments were with respect to items
 7 and services furnished by a participating pro-
 8 vider; and

9 “(C) the plan or coverage shall pay to such
 10 provider furnishing such services to such partic-
 11 ipant, beneficiary, or enrollee the amount by
 12 which the recognized amount (as defined in and
 13 determined pursuant to subsection
 14 (b)(3)(H)(ii)) for such services and year in-
 15 volved exceeds the cost-sharing amount imposed
 16 under the plan or coverage, respectively, for
 17 such services (as determined in accordance with
 18 subparagraphs (A) and (B)).

19 “(2) AIR AMBULANCE SERVICE DEFINED.—For
 20 purposes of this section, the term ‘air ambulance
 21 service’ means medical transport by helicopter or
 22 airplane for patients.

23 “(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
 24 BASES.—In the case of a sponsor of a group health plan
 25 or health insurance issuer offering health insurance cov-

1 erage in the group or individual market that, pursuant to
 2 subsection (b)(3)(E)(iii), uses a database described in
 3 such subsection to determine a rate to apply under such
 4 subsection for an item or service by reason of having insuf-
 5 ficient information described in such subsection with re-
 6 spect to such item or service, such sponsor or issuer shall
 7 cover the cost for access to such database.”.

8 (b) ERISA AMENDMENTS.—

9 (1) IN GENERAL.—Subpart B of part 7 of sub-
 10 title B of title I of the Employee Retirement Income
 11 Security Act of 1974 (29 U.S.C. 1185 et seq.) is
 12 amended by adding at the end the following:

13 **“SEC. 716. CONSUMER PROTECTIONS.**

14 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
 15 a group health plan or health insurance issuer offering
 16 group health insurance coverage requires or provides for
 17 designation by a participant or beneficiary of a partici-
 18 pating primary care provider, then the plan or issuer shall
 19 permit each participant or beneficiary to designate any
 20 participating primary care provider who is available to ac-
 21 cept such individual.

22 “(b) COVERAGE OF EMERGENCY SERVICES.—

23 “(1) IN GENERAL.—If a group health plan, or
 24 a health insurance issuer offering group health in-
 25 surance coverage, provides or covers any benefits

1 with respect to services in an emergency department
2 of a hospital or with respect to emergency services
3 in an independent freestanding emergency depart-
4 ment (as defined in paragraph (3)(D)), the plan or
5 issuer shall cover emergency services (as defined in
6 paragraph (3)(C))—

7 “(A) without the need for any prior au-
8 thorization determination;

9 “(B) whether the health care provider fur-
10 nishing such services is a participating provider
11 or a participating emergency facility, as appli-
12 cable, with respect to such services;

13 “(C) in a manner so that, if such services
14 are provided to a participant or beneficiary by
15 a nonparticipating provider or a nonparti-
16 cating emergency facility—

17 “(i) such services will be provided
18 without imposing any requirement under
19 the plan for prior authorization of services
20 or any limitation on coverage that is more
21 restrictive than the requirements or limita-
22 tions that apply to emergency services re-
23 ceived from participating providers and
24 participating emergency facilities with re-

1 spect to such plan or coverage, respec-
2 tively;

3 “(ii) the cost-sharing requirement (ex-
4 pressed as a copayment amount or coinsur-
5 ance rate) is not greater than the require-
6 ment that would apply if such services
7 were provided by a participating provider
8 or a participating emergency facility;

9 “(iii) such cost-sharing requirement is
10 calculated as if the total amount that
11 would have been charged for such services
12 by such participating provider or partici-
13 pating emergency facility were equal to the
14 recognized amount (as defined in para-
15 graph (3)(H)) for such services, plan or
16 coverage, and year;

17 “(iv) the group health plan or health
18 insurance issuer, respectively, pays to such
19 provider or facility, respectively, the
20 amount by which the recognized amount
21 for such services and year involved exceeds
22 the cost-sharing amount for such services
23 (as determined in accordance with clauses
24 (ii) and (iii)) and year; and

1 “(v) any cost-sharing payments made
2 by the participant or beneficiary with re-
3 spect to such emergency services so fur-
4 nished shall be counted toward any in-net-
5 work deductible or out-of-pocket maxi-
6 mums applied under the plan or coverage,
7 respectively (and such in-network deduct-
8 ible and out-of-pocket maximums shall be
9 applied) in the same manner as if such
10 cost-sharing payments were made with re-
11 spect to emergency services furnished by a
12 participating provider or a participating
13 emergency facility; and

14 “(D) without regard to any other term or
15 condition of such coverage (other than exclusion
16 or coordination of benefits, or an affiliation or
17 waiting period, permitted under section 2704 of
18 the Public Health Service Act, including as in-
19 corporated pursuant to section 715 of this Act
20 and section 9815 of the Internal Revenue Code
21 of 1986, and other than applicable cost-shar-
22 ing).

23 “(2) AUDIT PROCESS AND REGULATIONS FOR
24 MEDIAN CONTRACTED RATES.—

25 “(A) AUDIT PROCESS.—

1 “(i) IN GENERAL.—Not later than
2 July 1, 2021, the Secretary, in consulta-
3 tion with appropriate State agencies and
4 the Secretary of Health and Human Serv-
5 ices and the Secretary of the Treasury,
6 shall establish through rulemaking a proc-
7 ess, in accordance with clause (ii), under
8 which group health plans and health insur-
9 ance issuers offering health insurance cov-
10 erage in the group market are audited by
11 the Secretary or applicable State authority
12 to ensure that—

13 “(I) such plans and coverage are
14 in compliance with the requirement of
15 applying a median contracted rate
16 under this section; and

17 “(II) such median contracted
18 rate so applied satisfies the definition
19 under paragraph (3)(E) with respect
20 to the year involved, including with re-
21 spect to a group health plan or health
22 insurance issuer described in clause
23 (ii) of such paragraph (3)(E).

1 “(ii) AUDIT SAMPLES.—Under the
2 process established pursuant to clause (i),
3 the Secretary—

4 “(I) shall conduct audits de-
5 scribed in such clause, with respect to
6 a year (beginning with 2022), of a
7 sample with respect to such year of
8 claims data from not more than 25
9 group health plans and health insur-
10 ance issuers offering health insurance
11 coverage in the group market; and

12 “(II) may audit any group health
13 plan or health insurance issuer offer-
14 ing health insurance coverage in the
15 group market if the Secretary has re-
16 ceived any complaint about such plan
17 or coverage, respectively, that involves
18 the compliance of the plan or cov-
19 erage, respectively, with either of the
20 requirements described in subclauses
21 (I) and (II) of such clause.

22 “(iii) REPORTS.—Beginning for 2022,
23 the Secretary shall annually submit to
24 Congress information on the number of
25 plans and issuers with respect to which au-

1 dits were conducted during such year pur-
2 suant to this subparagraph.

3 “(B) RULEMAKING.—Not later than July
4 1, 2021, the Secretary, in consultation with the
5 Secretary of the Treasury and the Secretary of
6 Health and Human Services, shall establish
7 through rulemaking—

8 “(i) the methodology the group health
9 plan or health insurance issuer offering
10 health insurance coverage in the group
11 market shall use to determine the median
12 contracted rate, differentiating by line of
13 business;

14 “(ii) the information such plan or
15 issuer, respectively, shall share with the
16 nonparticipating provider or nonpartici-
17 pating facility, as applicable, when making
18 such a determination;

19 “(iii) the geographic regions applied
20 for purposes of this subparagraph, taking
21 into account access to items and services in
22 rural and underserved areas, including
23 health professional shortage areas, as de-
24 fined in section 332 of the Public Health
25 Service Act; and

1 “(iv) a process to receive complaints
2 of violations of the requirements described
3 in subclauses (I) and (II) of paragraph
4 (2)(A)(i) by group health plans and health
5 insurance issuers offering health insurance
6 coverage in the group market.

7 Such rulemaking shall take into account pay-
8 ments that are made by such plan or issuer, re-
9 spectively, that are not on a fee-for-service
10 basis. Such methodology may account for rel-
11 evant payment adjustments that take into ac-
12 count quality or facility type (including higher
13 acuity settings and the case-mix of various fa-
14 cility types) that are otherwise taken into ac-
15 count for purposes of determining payment
16 amounts with respect to participating facilities.
17 In carrying out clause (iii), the Secretary shall
18 consult with the National Association of Insur-
19 ance Commissioners to establish the geographic
20 regions under such clause and shall periodically
21 update such regions, as appropriate.

22 “(3) DEFINITIONS.—In this section:

23 “(A) EMERGENCY DEPARTMENT OF A HOS-
24 PITAL.—The term ‘emergency department of a

1 hospital' includes a hospital outpatient depart-
2 ment that provides emergency services.

3 “(B) EMERGENCY MEDICAL CONDITION.—

4 The term ‘emergency medical condition’ means
5 a medical condition manifesting itself by acute
6 symptoms of sufficient severity (including se-
7 vere pain) such that a prudent layperson, who
8 possesses an average knowledge of health and
9 medicine, could reasonably expect the absence
10 of immediate medical attention to result in a
11 condition described in clause (i), (ii), or (iii) of
12 section 1867(e)(1)(A) of the Social Security
13 Act.

14 “(C) EMERGENCY SERVICES.—

15 “(i) IN GENERAL.—The term ‘emer-
16 gency services’, with respect to an emer-
17 gency medical condition, means—

18 “(I) a medical screening exam-
19 ination (as required under section
20 1867 of the Social Security Act, or as
21 would be required under such section
22 if such section applied to an inde-
23 pendent freestanding emergency de-
24 partment) that is within the capability
25 of the emergency department of a hos-

1 pital or of an independent free-
2 standing emergency department, as
3 applicable, including ancillary services
4 routinely available to the emergency
5 department to evaluate such emer-
6 gency medical condition; and

7 “(II) within the capabilities of
8 the staff and facilities available at the
9 hospital or the independent free-
10 standing emergency department, as
11 applicable, such further medical exam-
12 ination and treatment as are required
13 under section 1867 of such Act, or as
14 would be required under such section
15 if such section applied to an inde-
16 pendent freestanding emergency de-
17 partment, to stabilize the patient.

18 “(ii) INCLUSION OF CERTAIN SERV-
19 ICES OUTSIDE OF EMERGENCY DEPART-
20 MENT.—

21 “(I) IN GENERAL.—For purposes
22 of this subsection and section 2799A-
23 1, in the case of an individual enrolled
24 in a group health plan or health in-
25 surance coverage offered by a health

1 insurance issuer in the group or indi-
2 vidual market who is furnished serv-
3 ices described in clause (i) by a par-
4 ticipating or nonparticipating provider
5 or a participating or nonparticipating
6 emergency facility to stabilize such in-
7 dividual with respect to an emergency
8 medical condition, the term ‘emer-
9 gency services’ shall include, unless
10 each of the conditions described in
11 subclause (II) are met, in addition to
12 the items and services described in
13 clause (i), items and services for
14 which benefits are provided or covered
15 under the plan or coverage, respec-
16 tively, furnished by a nonparticipating
17 provider or nonparticipating facility,
18 regardless of the department of the
19 hospital in which such individual is
20 furnished such items or services, if,
21 after such stabilization but during
22 such visit in which such individual is
23 so stabilized, the provider or facility
24 determines that such items or services
25 are needed.

1 “(II) CONDITIONS.—For pur-
2 poses of subclause (I), the conditions
3 described in this subclause, with re-
4 spect to an individual who is stabilized
5 and furnished additional items and
6 services described in subclause (I)
7 after such stabilization by a provider
8 or facility described in subclause (I),
9 are the following:

10 “(aa) Such a provider or fa-
11 cility determines such individual
12 is able to travel using nonmedical
13 transportation or nonemergency
14 medical transportation.

15 “(bb) Such provider fur-
16 nishing such additional items and
17 services satisfies the notice and
18 consent criteria of section
19 2799A–2(d) of the Public Health
20 Service Act with respect to such
21 items and services.

22 “(cc) Such an individual is
23 in a condition to receive (as de-
24 termined in accordance with
25 guidance issued by the Secretary)

1 the information described in sec-
2 tion 2799A–2 of the Public
3 Health Service Act and to pro-
4 vide informed consent under such
5 section, in accordance with appli-
6 cable State law.

7 “(D) INDEPENDENT FREESTANDING
8 EMERGENCY DEPARTMENT.—The term ‘inde-
9 pendent freestanding emergency department’
10 means a facility that—

11 “(i) is geographically separate and
12 distinct and licensed separately from a hos-
13 pital under applicable State law; and

14 “(ii) provides any emergency services
15 (as defined in subparagraph (C)).

16 “(E) MEDIAN CONTRACTED RATE.—

17 “(i) IN GENERAL.—The term ‘median
18 contracted rate’ means, subject to clauses
19 (ii) and (iii), with respect to a sponsor of
20 a group health plan and health insurance
21 issuer offering health insurance coverage in
22 the group market—

23 “(I) for an item or service fur-
24 nished during 2022, the median of the
25 contracted rates recognized by the

1 plan or issuer, respectively (deter-
2 mined with respect to all such plans
3 of such sponsor or all such coverage
4 offered by such issuer that are offered
5 within the same line of business as
6 the plan or coverage) as the total
7 maximum payment (including the
8 cost-sharing amount imposed for such
9 item or service and the amount to be
10 paid by such plan or such issuer, re-
11 spectively) under such plans or cov-
12 erage, respectively, on January 31,
13 2019, for the same or a similar item
14 or service that is provided by a pro-
15 vider in the same or similar specialty
16 and provided in the geographic region
17 in which the item or service is fur-
18 nished, consistent with the method-
19 ology established by the Secretary
20 under paragraph (2)(B), increased by
21 the percentage increase in the con-
22 sumer price index for all urban con-
23 sumers (United States city average)
24 over 2019, such percentage increase

1 over 2020, and such percentage in-
2 crease over 2021; and

3 “(II) for an item or service fur-
4 nished during 2023 or a subsequent
5 year, the median contracted rate de-
6 termined under this clause for such
7 an item or service furnished in the
8 previous year, increased by the per-
9 centage increase in the consumer price
10 index for all urban consumers (United
11 States city average) over such pre-
12 vious year.

13 “(ii) NEW PLANS AND COVERAGE.—

14 The term ‘median contracted rate’ means,
15 with respect to a sponsor of a group health
16 plan or health insurance issuer offering
17 health insurance coverage in the group
18 market in a geographic region in which
19 such sponsor or issuer, respectively, did
20 not offer any group health plan or health
21 insurance coverage during 2019—

22 “(I) for the first year in which
23 such group health plan or health in-
24 surance coverage, respectively, is of-
25 fered in such region, a rate (deter-

1 mined in accordance with a method-
2 ology established by the Secretary) for
3 items and services that are covered by
4 such plan and furnished during such
5 first year; and

6 “(II) for each subsequent year
7 such group health plan or health in-
8 surance coverage, respectively, is of-
9 ferred in such region, the median con-
10 tracted rate determined under this
11 clause for such items and services fur-
12 nished in the previous year, increased
13 by the percentage increase in the con-
14 sumer price index for all urban con-
15 sumers (United States city average)
16 over such previous year.

17 “(iii) INSUFFICIENT INFORMATION;
18 NEWLY COVERED ITEMS AND SERVICES.—
19 In the case of a sponsor of a group health
20 plan or health insurance issuer offering
21 health insurance coverage in the group
22 market that does not have sufficient infor-
23 mation to calculate the median of the con-
24 tracted rates described in clause (i)(I) in
25 2019 (or, in the case of a newly covered

1 item or service (as defined in clause
2 (iv)(III)), in the first coverage year (as de-
3 fined in clause (iv)(I)) for such item or
4 service with respect to such plan or cov-
5 erage) for an item or service (including
6 with respect to provider type, or amount,
7 of claims for items or services (as deter-
8 mined by the Secretary) provided in a par-
9 ticular geographic region (other than in a
10 case with respect to which clause (ii) ap-
11 plies)) the term ‘median contracted rate’—

12 “(I) for an item or service fur-
13 nished during 2022 (or, in the case of
14 a newly covered item or service, dur-
15 ing the first coverage year for such
16 item or service with respect to such
17 plan or coverage), means such rate for
18 such item or service determined by
19 the sponsor or issuer, respectively,
20 through use of any database that is
21 determined, in accordance with rule-
22 making described in paragraph
23 (2)(B), to not have any conflicts of in-
24 terest and to have sufficient informa-
25 tion reflecting allowed amounts paid

1 to a health care provider or facility for
2 relevant services furnished in the ap-
3 plicable geographic region (such as a
4 State all-payer claims database);

5 “(II) for an item or service fur-
6 nished in a subsequent year (before
7 the first sufficient information year
8 (as defined in clause (iv)(II)) for such
9 item or service with respect to such
10 plan or coverage), means the rate de-
11 termined under subclause (I) or this
12 subclause, as applicable, for such item
13 or service for the year previous to
14 such subsequent year, increased by
15 the percentage increase in the con-
16 sumer price index for all urban con-
17 sumers (United States city average)
18 over such previous year;

19 “(III) for an item or service fur-
20 nished in the first sufficient informa-
21 tion year for such item or service with
22 respect to such plan or coverage, has
23 the meaning given the term median
24 contracted rate in clause (i)(I), except
25 that in applying such clause to such

1 item or service, the reference to ‘fur-
2 nished during 2022’ shall be treated
3 as a reference to furnished during
4 such first sufficient information year,
5 the reference to ‘in 2019’ shall be
6 treated as a reference to such suffi-
7 cient information year, and the in-
8 crease described in such clause shall
9 not be applied; and

10 “(IV) for an item or service fur-
11 nished in any year subsequent to the
12 first sufficient information year for
13 such item or service with respect to
14 such plan or coverage, has the mean-
15 ing given such term in clause (i)(II),
16 except that in applying such clause to
17 such item or service, the reference to
18 ‘furnished during 2023 or a subse-
19 quent year’ shall be treated as a ref-
20 erence to furnished during the year
21 after such first sufficient information
22 year or a subsequent year.

23 “(iv) DEFINITIONS.—For purposes of
24 this subparagraph:

1 “(I) FIRST COVERAGE YEAR.—

2 The term ‘first coverage year’ means,
3 with respect to a group health plan or
4 health insurance coverage offered by a
5 health insurance issuer in the group
6 market and an item or service for
7 which coverage is not offered in 2019
8 under such plan or coverage, the first
9 year after 2019 for which coverage for
10 such item or service is offered under
11 such plan or health insurance cov-
12 erage.

13 “(II) FIRST SUFFICIENT INFOR-

14 MATION YEAR.—The term ‘first suffi-
15 cient information year’ means, with
16 respect to a group health plan or
17 health insurance coverage offered by a
18 health insurance issuer in the group
19 market—

20 “(aa) in the case of an item
21 or service for which the plan or
22 coverage does not have sufficient
23 information to calculate the me-
24 dian of the contracted rates de-
25 scribed in clause (i)(I) in 2019,

1 the first year subsequent to 2022
2 for which such sponsor or issuer
3 has such sufficient information to
4 calculate the median of such con-
5 tracted rates in the year previous
6 to such first subsequent year;
7 and

8 “(bb) in the case of a newly
9 covered item or service, the first
10 year subsequent to the first cov-
11 erage year for such item or serv-
12 ice with respect to such plan or
13 coverage for which the sponsor or
14 issuer has sufficient information
15 to calculate the median of the
16 contracted rates described in
17 clause (i)(I) in the year previous
18 to such first subsequent year.

19 “(III) NEWLY COVERED ITEM OR
20 SERVICE.—The term ‘newly covered
21 item or service’ means, with respect to
22 a group health plan or health insur-
23 ance issuer offering health insurance
24 coverage in the group market, an item
25 or service for which coverage was not

1 offered in 2019 under such plan or
2 coverage, but is offered under such
3 plan or coverage in a year after 2019.

4 “(F) NONPARTICIPATING EMERGENCY FA-
5 CILITY; PARTICIPATING EMERGENCY FACIL-
6 ITY.—

7 “(i) NONPARTICIPATING EMERGENCY
8 FACILITY.—The term ‘nonparticipating
9 emergency facility’ means, with respect to
10 an item or service and a group health plan
11 or health insurance coverage offered by a
12 health insurance issuer in the group mar-
13 ket, an emergency department of a hos-
14 pital, or an independent freestanding emer-
15 gency department, that does not have a
16 contractual relationship directly or indi-
17 rectly with the plan or issuer, respectively,
18 for furnishing such item or service under
19 the plan or coverage, respectively.

20 “(ii) PARTICIPATING EMERGENCY FA-
21 CILITY.—The term ‘participating emer-
22 gency facility’ means, with respect to an
23 item or service and a group health plan or
24 health insurance coverage offered by a
25 health insurance issuer in the group mar-

1 ket, an emergency department of a hos-
2 pital, or an independent freestanding emer-
3 gency department, that has a contractual
4 relationship directly or indirectly with the
5 plan or issuer, respectively, with respect to
6 the furnishing of such an item or service at
7 such facility.

8 “(G) NONPARTICIPATING PROVIDERS; PAR-
9 TICIPATING PROVIDERS.—

10 “(i) NONPARTICIPATING PROVIDER.—
11 The term ‘nonparticipating provider’
12 means, with respect to an item or service
13 and a group health plan or health insur-
14 ance coverage offered by a health insur-
15 ance issuer in the group market, a physi-
16 cian or other health care provider who is
17 acting within the scope of practice of that
18 provider’s license or certification under ap-
19 plicable State law and who does not have
20 a contractual relationship with the plan or
21 issuer, respectively, for furnishing such
22 item or service under the plan or coverage,
23 respectively.

24 “(ii) PARTICIPATING PROVIDER.—The
25 term ‘participating provider’ means, with

1 respect to an item or service and a group
2 health plan or health insurance coverage
3 offered by a health insurance issuer in the
4 group market, a physician or other health
5 care provider who is acting within the
6 scope of practice of that provider’s license
7 or certification under applicable State law
8 and who has a contractual relationship
9 with the plan or issuer, respectively, for
10 furnishing such item or service under the
11 plan or coverage, respectively.

12 “(H) RECOGNIZED AMOUNT.—The term
13 ‘recognized amount’ means, with respect to an
14 item or service furnished by a nonparticipating
15 provider or emergency facility during a year
16 and a group health plan or health insurance
17 coverage offered by a health insurance issuer in
18 the group market—

19 “(i) subject to clause (iii), in the case
20 of such item or service furnished in a State
21 that has in effect a specified State law
22 with respect to such plan, coverage, or
23 issuer, respectively, such a nonpartici-
24 pating provider or emergency facility, and

1 such an item or service, the amount deter-
2 mined in accordance with such law;

3 “(ii) subject to clause (iii), in the case
4 of such item or service furnished in a State
5 that does not have in effect a specified
6 State law, with respect to such plan, cov-
7 erage, or issuer, respectively, such a non-
8 participating provider or emergency facil-
9 ity, and such an item or service, an
10 amount that is the median contracted rate
11 (as defined in subparagraph (E)) for such
12 year and determined in accordance with
13 rulemaking described in paragraph (2)(B)
14 for such item or service; or

15 “(iii) in the case of such item or serv-
16 ice furnished in a State with an All-Payer
17 Model Agreement under section 1115A of
18 the Social Security Act, the amount that
19 the State approves under such system for
20 such item or service so furnished.

21 “(I) SPECIFIED STATE LAW.—The term
22 ‘specified State law’ means, with respect to a
23 State, an item or service furnished by a non-
24 participating provider or emergency facility dur-
25 ing a year and a group health plan or health in-

1 surance coverage offered by a health insurance
2 issuer in the group market, a State law that
3 provides for a method for determining the
4 amount of payment that is required to be cov-
5 ered by such a plan, coverage, or issuer, respec-
6 tively (to the extent such State law applies to
7 such plan, coverage, or issuer, subject to section
8 514) in the case of a participant or beneficiary
9 covered under such plan or coverage and receiv-
10 ing such item or service from such a nonpartici-
11 pating provider or emergency facility.

12 “(J) STABILIZE.—The term ‘to stabilize’,
13 with respect to an emergency medical condition
14 (as defined in subparagraph (B)), has the
15 meaning give in section 1867(e)(3) of the Social
16 Security Act (42 U.S.C. 1395dd(e)(3)).

17 “(c) ACCESS TO PEDIATRIC CARE.—

18 “(1) PEDIATRIC CARE.—In the case of a person
19 who has a child who is a participant or beneficiary
20 under a group health plan, or health insurance cov-
21 erage offered by a health insurance issuer in the
22 group market, if the plan or issuer requires or pro-
23 vides for the designation of a participating primary
24 care provider for the child, the plan or issuer shall
25 permit such person to designate a physician

1 (allopathic or osteopathic) who specializes in pediat-
2 rics as the child’s primary care provider if such pro-
3 vider participates in the network of the plan or
4 issuer.

5 “(2) CONSTRUCTION.—Nothing in paragraph
6 (1) shall be construed to waive any exclusions of cov-
7 erage under the terms and conditions of the plan or
8 health insurance coverage with respect to coverage
9 of pediatric care.

10 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
11 COLOGICAL CARE.—

12 “(1) GENERAL RIGHTS.—

13 “(A) DIRECT ACCESS.—A group health
14 plan, or health insurance issuer offering group
15 health insurance coverage, described in para-
16 graph (2) may not require authorization or re-
17 ferral by the plan, issuer, or any person (includ-
18 ing a primary care provider described in para-
19 graph (2)(B)) in the case of a female partici-
20 pant or beneficiary who seeks coverage for ob-
21 stetrical or gynecological care provided by a
22 participating health care professional who spe-
23 cializes in obstetrics or gynecology. Such profes-
24 sional shall agree to otherwise adhere to such
25 plan’s or issuer’s policies and procedures, in-

cluding procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group health insurance coverage, described in this paragraph is a group health plan or coverage that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant or beneficiary of a participating primary care provider.

1 “(3) CONSTRUCTION.—Nothing in paragraph
2 (1) shall be construed to—

3 “(A) waive any exclusions of coverage
4 under the terms and conditions of the plan or
5 health insurance coverage with respect to cov-
6 erage of obstetrical or gynecological care; or

7 “(B) preclude the group health plan or
8 health insurance issuer involved from requiring
9 that the obstetrical or gynecological provider
10 notify the primary care health care professional
11 or the plan or issuer of treatment decisions.

12 “(e) COVERAGE OF NON-EMERGENCY SERVICES
13 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
14 TAIN PARTICIPATING FACILITIES.—

15 “(1) IN GENERAL.—In the case of items or
16 services (other than emergency services to which
17 subsection (b) applies) for which any benefits are
18 provided or covered by a group health plan or health
19 insurance issuer offering health insurance coverage
20 in the group market furnished to a participant or
21 beneficiary of such plan or coverage by a nonpartici-
22 pating provider (as defined in subsection
23 (b)(3)(G)(i)) (and who, with respect to such items
24 and services, has not satisfied the notice and consent
25 criteria of section 2799A–2(d) of the Public Health

1 Service Act) with respect to a visit (as defined by
2 the Secretary in accordance with paragraph (2)(B))
3 at a participating health care facility (as defined in
4 paragraph (2)(A)), with respect to such plan or cov-
5 erage, respectively, the plan or coverage, respec-
6 tively—

7 “(A) shall not impose on such participant
8 or beneficiary a cost-sharing amount (expressed
9 as a copayment amount or coinsurance rate) for
10 such items and services so furnished that is
11 greater than the cost-sharing amount that
12 would apply under such plan or coverage, re-
13 spectively, had such items or services been fur-
14 nished by a participating provider (as defined in
15 subsection (b)(3)(G)(ii));

16 “(B) shall calculate such cost-sharing
17 amount as if the total amount that would have
18 been charged for such items and services by
19 such participating provider were equal to the
20 recognized amount (as defined in subsection
21 (b)(3)(H)) for such items and services, plan or
22 coverage, and year;

23 “(C) shall pay to such provider furnishing
24 such items and services to such participant or
25 beneficiary the amount by which the recognized

1 amount (as defined in subsection (b)(3)(H)) for
2 such items and services and year involved ex-
3 ceeds the cost-sharing amount imposed under
4 the plan or coverage, respectively, for such
5 items and services (as determined in accordance
6 with subparagraphs (A) and (B)); and

7 “(D) shall count toward any in-network
8 deductible and in-network out-of-pocket maxi-
9 mums (as applicable) applied under the plan or
10 coverage, respectively, any cost-sharing pay-
11 ments made by the participant or beneficiary
12 (and such in-network deductible and out-of-
13 pocket maximums shall be applied) with respect
14 to such items and services so furnished in the
15 same manner as if such cost-sharing payments
16 were with respect to items and services fur-
17 nished by a participating provider.

18 “(2) DEFINITIONS.—In this section:

19 “(A) PARTICIPATING HEALTH CARE FACIL-
20 ITY.—

21 “(i) IN GENERAL.—The term ‘partici-
22 pating health care facility’ means, with re-
23 spect to an item or service and a group
24 health plan or health insurance issuer of-
25 fering health insurance coverage in the

1 group market, a health care facility de-
2 scribed in clause (ii) that has a contractual
3 relationship with the plan or issuer, respec-
4 tively, with respect to the furnishing of
5 such an item or service at the facility.

6 “(ii) HEALTH CARE FACILITY DE-
7 SCRIBED.—A health care facility described
8 in this clause, with respect to a group
9 health plan or health insurance coverage
10 offered in the group market, is each of the
11 following:

12 “(I) A hospital (as defined in
13 1861(e) of the Social Security Act).

14 “(II) A hospital outpatient de-
15 partment.

16 “(III) A critical access hospital
17 (as defined in section 1861(mm) of
18 such Act).

19 “(IV) An ambulatory surgical
20 center (as defined in section
21 1833(i)(1)(A) of such Act).

22 “(V) Any other facility that pro-
23 vides items or services for which cov-
24 erage is provided under the plan or
25 coverage, respectively.

1 “(B) VISIT.—The term ‘visit’ shall, with
2 respect to items and services furnished to an in-
3 dividual at a participating health care facility,
4 include equipment and devices, telemedicine
5 services, imaging services, laboratory services,
6 and such other items and services as the Sec-
7 retary may specify, regardless of whether or not
8 the provider furnishing such items or services is
9 at the facility.

10 “(f) AIR AMBULANCE SERVICES.—

11 “(1) IN GENERAL.—In the case of a participant
12 or beneficiary in a group health plan or health insur-
13 ance coverage offered in the group market who re-
14 ceives air ambulance services from a nonpartici-
15 pating provider (as defined in subsection (b)(3)(G))
16 with respect to such plan or coverage, if such serv-
17 ices would be covered if provided by a participating
18 provider (as defined in such subsection) with respect
19 to such plan or coverage—

20 “(A) the cost-sharing requirement (ex-
21 pressed as a copayment amount, coinsurance
22 rate, or deductible) with respect to such services
23 shall be the same requirement that would apply
24 if such services were provided by such a partici-
25 pating provider, and any coinsurance or deduct-

1 ible shall be based on rates that would apply for
2 such services if they were furnished by such a
3 participating provider;

4 “(B) such cost-sharing amounts shall be
5 counted toward the in-network deductible and
6 in-network out-of-pocket maximum amount
7 under the plan or coverage for the plan year
8 (and such in-network deductible shall be ap-
9 plied) with respect to such items and services so
10 furnished in the same manner as if such cost-
11 sharing payments were with respect to items
12 and services furnished by a participating pro-
13 vider; and

14 “(C) the plan or coverage shall pay to such
15 provider furnishing such services to such partic-
16 ipant or beneficiary the amount by which the
17 recognized amount (as defined in and deter-
18 mined pursuant to subsection (b)(3)(H)(ii)) for
19 such services and year involved exceeds the
20 cost-sharing amount imposed under the plan or
21 coverage, respectively, for such services (as de-
22 termined in accordance with subparagraphs (A)
23 and (B)).

24 “(2) AIR AMBULANCE SERVICE DEFINED.—For
25 purposes of this section, the term ‘air ambulance

1 service’ means medical transport by helicopter or
 2 airplane for patients.

3 “(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
 4 BASES.—In the case of a sponsor of a group health plan
 5 or health insurance issuer offering health insurance cov-
 6 erage in the group market that, pursuant to subsection
 7 (b)(3)(E)(iii), uses a database described in such sub-
 8 section to determine a rate to apply under such subsection
 9 for an item or service by reason of having insufficient in-
 10 formation described in such subsection with respect to
 11 such item or service, such sponsor or issuer shall cover
 12 the cost for access to such database.”.

13 (2) CLERICAL AMENDMENT.—The table of con-
 14 tents of the Employee Retirement Income Security
 15 Act of 1974 is amended by inserting after the item
 16 relating to section 714 the following:

“Sec. 715. Additional market reforms.
 “Sec. 716. Consumer protections.”.

17 (c) IRC AMENDMENTS.—

18 (1) IN GENERAL.—Subchapter B of chapter
 19 100 of the Internal Revenue Code of 1986 is amend-
 20 ed by adding at the end the following:

21 **“SEC. 9816. CONSUMER PROTECTIONS.**

22 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
 23 a group health plan requires or provides for designation
 24 by a participant or beneficiary of a participating primary

1 care provider, then the plan shall permit each participant
2 or beneficiary to designate any participating primary care
3 provider who is available to accept such individual.

4 “(b) COVERAGE OF EMERGENCY SERVICES.—

5 “(1) IN GENERAL.—If a group health plan pro-
6 vides or covers any benefits with respect to services
7 in an emergency department of a hospital or with re-
8 spect to emergency services in an independent free-
9 standing emergency department (as defined in para-
10 graph (3)(D)), the plan shall cover emergency serv-
11 ices (as defined in paragraph (3)(C))—

12 “(A) without the need for any prior au-
13 thorization determination;

14 “(B) whether the health care provider fur-
15 nishing such services is a participating provider
16 or a participating emergency facility, as appli-
17 cable, with respect to such services;

18 “(C) in a manner so that, if such services
19 are provided to a participant or beneficiary by
20 a nonparticipating provider or a nonparti-
21 cating emergency facility—

22 “(i) such services will be provided
23 without imposing any requirement under
24 the plan for prior authorization of services
25 or any limitation on coverage that is more

1 restrictive than the requirements or limita-
2 tions that apply to emergency services re-
3 ceived from participating providers and
4 participating emergency facilities with re-
5 spect to such plan;

6 “(ii) the cost-sharing requirement (ex-
7 pressed as a copayment amount or coinsur-
8 ance rate) is not greater than the require-
9 ment that would apply if such services
10 were provided by a participating provider
11 or a participating emergency facility;

12 “(iii) such cost-sharing requirement is
13 calculated as if the total amount that
14 would have been charged for such services
15 by such participating provider or partici-
16 pating emergency facility were equal to the
17 recognized amount (as defined in para-
18 graph (3)(H)) for such services, plan, and
19 year;

20 “(iv) the group health plan pays to
21 such provider or facility, respectively, the
22 amount by which the recognized amount
23 for such services and year involved exceeds
24 the cost-sharing amount for such services

1 (as determined in accordance with clauses
2 (ii) and (iii)) and year; and

3 “(v) any cost-sharing payments made
4 by the participant or beneficiary with re-
5 spect to such emergency services so fur-
6 nished shall be counted toward any in-net-
7 work deductible or out-of-pocket maxi-
8 mums applied under the plan (and such in-
9 network deductible and out-of-pocket maxi-
10 mums shall be applied) in the same man-
11 ner as if such cost-sharing payments were
12 made with respect to emergency services
13 furnished by a participating provider or a
14 participating emergency facility; and

15 “(D) without regard to any other term or
16 condition of such coverage (other than exclusion
17 or coordination of benefits, or an affiliation or
18 waiting period, permitted under section 2704 of
19 this Act, including as incorporated pursuant to
20 section 715 of the Employee Retirement Income
21 Security Act of 1974 and section 9815 of this
22 Act, and other than applicable cost-sharing).

23 “(2) AUDIT PROCESS AND REGULATIONS FOR
24 MEDIAN CONTRACTED RATES.—

25 “(A) AUDIT PROCESS.—

1 “(i) IN GENERAL.—Not later than
2 July 1, 2021, the Secretary, in consulta-
3 tion with appropriate State agencies and
4 the Secretary of Health and Human Serv-
5 ices and the Secretary of Labor, shall es-
6 tablish through rulemaking a process, in
7 accordance with clause (ii), under which
8 group health plans are audited by the Sec-
9 retary or applicable State authority to en-
10 sure that—

11 “(I) such plans are in compliance
12 with the requirement of applying a
13 median contracted rate under this sec-
14 tion; and

15 “(II) such median contracted
16 rate so applied satisfies the definition
17 under paragraph (3)(E) with respect
18 to the year involved, including with re-
19 spect to a group health plan described
20 in clause (ii) of such paragraph
21 (3)(E).

22 “(ii) AUDIT SAMPLES.—Under the
23 process established pursuant to clause (i),
24 the Secretary—

1 “(I) shall conduct audits de-
2 scribed in such clause, with respect to
3 a year (beginning with 2022), of a
4 sample with respect to such year of
5 claims data from not more than 25
6 group health plans; and

7 “(II) may audit any group health
8 plan if the Secretary has received any
9 complaint about such plan or cov-
10 erage, respectively, that involves the
11 compliance of the plan with either of
12 the requirements described in sub-
13 clauses (I) and (II) of such clause.

14 “(iii) REPORTS.—Beginning for 2022,
15 the Secretary shall annually submit to
16 Congress a report on the number of plans
17 and issuers with respect to which audits
18 were conducted during such year pursuant
19 to this subparagraph.

20 “(B) RULEMAKING.—Not later than July
21 1, 2021, the Secretary, in consultation with the
22 Secretary of Labor and the Secretary of Health
23 and Human Services, shall establish through
24 rulemaking—

1 “(i) the methodology the group health
2 plan shall use to determine the median
3 contracted rate, differentiating by line of
4 business;

5 “(ii) the information such plan or
6 issuer, respectively, shall share with the
7 nonparticipating provider or nonpartici-
8 pating facility, as applicable, when making
9 such a determination;

10 “(iii) the geographic regions applied
11 for purposes of this subparagraph, taking
12 into account access to items and services in
13 rural and underserved areas, including
14 health professional shortage areas, as de-
15 fined in section 332 of the Public Health
16 Service Act; and

17 “(iv) a process to receive complaints
18 of violations of the requirements described
19 in subclauses (I) and (II) of paragraph
20 (2)(A)(i) by group health plans.

21 Such rulemaking shall take into account pay-
22 ments that are made by such plan that are not
23 on a fee-for-service basis. Such methodology
24 may account for relevant payment adjustments
25 that take into account quality or facility type

(including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

“(3) DEFINITIONS.—In this section:

“(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term ‘emergency department of a hospital’ includes a hospital outpatient department that provides emergency services.

“(B) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of

1 section 1867(e)(1)(A) of the Social Security
2 Act.

3 “(C) EMERGENCY SERVICES.—

4 “(i) IN GENERAL.—The term ‘emer-
5 gency services’, with respect to an emer-
6 gency medical condition, means—

7 “(I) a medical screening exam-
8 ination (as required under section
9 1867 of the Social Security Act, or as
10 would be required under such section
11 if such section applied to an inde-
12 pendent freestanding emergency de-
13 partment) that is within the capability
14 of the emergency department of a hos-
15 pital or of an independent free-
16 standing emergency department, as
17 applicable, including ancillary services
18 routinely available to the emergency
19 department to evaluate such emer-
20 gency medical condition; and

21 “(II) within the capabilities of
22 the staff and facilities available at the
23 hospital or the independent free-
24 standing emergency department, as
25 applicable, such further medical exam-

1 ination and treatment as are required
2 under section 1867 of such Act, or as
3 would be required under such section
4 if such section applied to an inde-
5 pendent freestanding emergency de-
6 partment, to stabilize the patient.

7 “(ii) INCLUSION OF CERTAIN SERV-
8 ICES OUTSIDE OF EMERGENCY DEPART-
9 MENT.—

10 “(I) IN GENERAL.—For purposes
11 of this subsection and section 2799A–
12 1, in the case of an individual enrolled
13 in a group health plan or health in-
14 surance coverage offered by a health
15 insurance issuer in the group or indi-
16 vidual market who is furnished serv-
17 ices described in clause (i) by a par-
18 ticipating or nonparticipating provider
19 or a participating or nonparticipating
20 emergency facility to stabilize such in-
21 dividual with respect to an emergency
22 medical condition, the term ‘emer-
23 gency services’ shall include, unless
24 each of the conditions described in
25 subclause (II) are met, in addition to

1 the items and services described in
2 clause (i), items and services for
3 which benefits are provided or covered
4 under the plan or coverage, respec-
5 tively, furnished by a nonparticipating
6 provider or nonparticipating facility,
7 regardless of the department of the
8 hospital in which such individual is
9 furnished such items or services, if,
10 after such stabilization but during
11 such visit in which such individual is
12 so stabilized, the provider or facility
13 determines that such items or services
14 are needed.

15 “(II) CONDITIONS.—For pur-
16 poses of subclause (I), the conditions
17 described in this subclause, with re-
18 spect to an individual who is stabilized
19 and furnished additional items and
20 services described in subclause (I)
21 after such stabilization by a provider
22 or facility described in subclause (I),
23 are the following:

24 “(aa) Such a provider or fa-
25 cility determines such individual

1 is able to travel using nonmedical
2 transportation or nonemergency
3 medical transportation.

4 “(bb) Such provider fur-
5 nishing such additional items and
6 services satisfies the notice and
7 consent criteria of section
8 2799A–2(d) of the Public Health
9 Service Act with respect to such
10 items and services.

11 “(cc) Such an individual is
12 in a condition to receive (as de-
13 termined in accordance with
14 guidance issued by the Secretary)
15 the information described in sec-
16 tion 2799A–2 of the Public
17 Health Service Act and to pro-
18 vide informed consent under such
19 section, in accordance with appli-
20 cable State law.

21 “(D) INDEPENDENT FREESTANDING
22 EMERGENCY DEPARTMENT.—The term ‘inde-
23 pendent freestanding emergency department’
24 means a facility that—

1 “(i) is geographically separate and
2 distinct and licensed separately from a hos-
3 pital under applicable State law; and

4 “(ii) provides any emergency services
5 (as defined in subparagraph (C)).

6 “(E) MEDIAN CONTRACTED RATE.—

7 “(i) IN GENERAL.—The term ‘median
8 contracted rate’ means, subject to clauses
9 (ii) and (iii), with respect to a sponsor of
10 a group health plan—

11 “(I) for an item or service fur-
12 nished during 2022, the median of the
13 contracted rates recognized by the
14 plan (determined with respect to all
15 such plans of such sponsor that are
16 offered within the same line of busi-
17 ness as the total maximum payment
18 (including the cost-sharing amount
19 imposed for such item or service and
20 the amount to be paid by the plan))
21 under such plans on January 31,
22 2019, for the same or a similar item
23 or service that is provided by a pro-
24 vider in the same or similar specialty
25 and provided in the geographic region

1 in which the item or service is fur-
2 nished, consistent with the method-
3 ology established by the Secretary
4 under paragraph (2)(B), increased by
5 the percentage increase in the con-
6 sumer price index for all urban con-
7 sumers (United States city average)
8 over 2019, such percentage increase
9 over 2020, and such percentage in-
10 crease over 2021; and

11 “(II) for an item or service fur-
12 nished during 2023 or a subsequent
13 year, the median contracted rate de-
14 termined under this clause for such
15 an item or service furnished in the
16 previous year, increased by the per-
17 centage increase in the consumer price
18 index for all urban consumers (United
19 States city average) over such pre-
20 vious year.

21 “(ii) NEW PLANS AND COVERAGE.—

22 The term ‘median contracted rate’ means,
23 with respect to a sponsor of a group health
24 plan in a geographic region in which such
25 sponsor, respectively, did not offer any

1 group health plan or health insurance cov-
2 erage during 2019—

3 “(I) for the first year in which
4 such group health plan is offered in
5 such region, a rate (determined in ac-
6 cordance with a methodology estab-
7 lished by the Secretary) for items and
8 services that are covered by such plan
9 and furnished during such first year;
10 and

11 “(II) for each subsequent year
12 such group health plan is offered in
13 such region, the median contracted
14 rate determined under this clause for
15 such items and services furnished in
16 the previous year, increased by the
17 percentage increase in the consumer
18 price index for all urban consumers
19 (United States city average) over such
20 previous year.

21 “(iii) INSUFFICIENT INFORMATION;
22 NEWLY COVERED ITEMS AND SERVICES.—
23 In the case of a sponsor of a group health
24 plan that does not have sufficient informa-
25 tion to calculate the median of the con-

1 tracted rates described in clause (i)(I) in
2 2019 (or, in the case of a newly covered
3 item or service (as defined in clause
4 (iv)(III)), in the first coverage year (as de-
5 fined in clause (iv)(I)) for such item or
6 service with respect to such plan) for an
7 item or service (including with respect to
8 provider type, or amount, of claims for
9 items or services (as determined by the
10 Secretary) provided in a particular geo-
11 graphic region (other than in a case with
12 respect to which clause (ii) applies)) the
13 term ‘median contracted rate’—

14 “(I) for an item or service fur-
15 nished during 2022 (or, in the case of
16 a newly covered item or service, dur-
17 ing the first coverage year for such
18 item or service with respect to such
19 plan), means such rate for such item
20 or service determined by the sponsor
21 through use of any database that is
22 determined, in accordance with rule-
23 making described in paragraph
24 (2)(B), to not have any conflicts of in-
25 terest and to have sufficient informa-

1 tion reflecting allowed amounts paid
2 to a health care provider or facility for
3 relevant services furnished in the ap-
4 plicable geographic region (such as a
5 State all-payer claims database);

6 “(II) for an item or service fur-
7 nished in a subsequent year (before
8 the first sufficient information year
9 (as defined in clause (iv)(II)) for such
10 item or service with respect to such
11 plan), means the rate determined
12 under subclause (I) or this subclause,
13 as applicable, for such item or service
14 for the year previous to such subse-
15 quent year, increased by the percent-
16 age increase in the consumer price
17 index for all urban consumers (United
18 States city average) over such pre-
19 vious year;

20 “(III) for an item or service fur-
21 nished in the first sufficient informa-
22 tion year for such item or service with
23 respect to such plan, has the meaning
24 given the term median contracted rate
25 in clause (i)(I), except that in apply-

1 ing such clause to such item or serv-
2 ice, the reference to ‘furnished during
3 2022’ shall be treated as a reference
4 to furnished during such first suffi-
5 cient information year, the reference
6 to ‘on January 31, 2019,’ shall be
7 treated as a reference to in such suffi-
8 cient information year, and the in-
9 crease described in such clause shall
10 not be applied; and

11 “(IV) for an item or service fur-
12 nished in any year subsequent to the
13 first sufficient information year for
14 such item or service with respect to
15 such plan, has the meaning given such
16 term in clause (i)(II), except that in
17 applying such clause to such item or
18 service, the reference to ‘furnished
19 during 2023 or a subsequent year’
20 shall be treated as a reference to fur-
21 nished during the year after such first
22 sufficient information year or a subse-
23 quent year.

24 “(iv) DEFINITIONS.—For purposes of
25 this subparagraph:

1 “(I) FIRST COVERAGE YEAR.—

2 The term ‘first coverage year’ means,
3 with respect to a group health plan
4 and an item or service for which cov-
5 erage is not offered in 2019 under
6 such plan or coverage, the first year
7 after 2019 for which coverage for
8 such item or service is offered under
9 such plan.

10 “(II) FIRST SUFFICIENT INFOR-
11 MATION YEAR.—The term ‘first suffi-
12 cient information year’ means, with
13 respect to a group health plan—

14 “(aa) in the case of an item
15 or service for which the plan does
16 not have sufficient information to
17 calculate the median of the con-
18 tracted rates described in clause
19 (i)(I) in 2019, the first year sub-
20 sequent to 2022 for which such
21 sponsor has such sufficient infor-
22 mation to calculate the median of
23 such contracted rates in the year
24 previous to such first subsequent
25 year; and

1 “(bb) in the case of a newly
 2 covered item or service, the first
 3 year subsequent to the first cov-
 4 erage year for such item or serv-
 5 ice with respect to such plan for
 6 which the sponsor has sufficient
 7 information to calculate the me-
 8 dian of the contracted rates de-
 9 scribed in clause (i)(I) in the
 10 year previous to such first subse-
 11 quent year.

12 “(III) NEWLY COVERED ITEM OR
 13 SERVICE.—The term ‘newly covered
 14 item or service’ means, with respect to
 15 a group health plan, an item or serv-
 16 ice for which coverage was not offered
 17 in 2019 under such plan or coverage,
 18 but is offered under such plan or cov-
 19 erage in a year after 2019.

20 “(F) NONPARTICIPATING EMERGENCY FA-
 21 CILITY; PARTICIPATING EMERGENCY FACIL-
 22 ITY.—

23 “(i) NONPARTICIPATING EMERGENCY
 24 FACILITY.—The term ‘nonparticipating
 25 emergency facility’ means, with respect to

1 an item or service and a group health plan,
2 an emergency department of a hospital, or
3 an independent freestanding emergency de-
4 partment, that does not have a contractual
5 relationship directly or indirectly with the
6 plan for furnishing such item or service
7 under the plan.

8 “(ii) PARTICIPATING EMERGENCY FA-
9 CILITY.—The term ‘participating emer-
10 gency facility’ means, with respect to an
11 item or service and a group health plan, an
12 emergency department of a hospital, or an
13 independent freestanding emergency de-
14 partment, that has a contractual relation-
15 ship directly or indirectly with the plan,
16 with respect to the furnishing of such an
17 item or service at such facility.

18 “(G) NONPARTICIPATING PROVIDERS; PAR-
19 TICIPATING PROVIDERS.—

20 “(i) NONPARTICIPATING PROVIDER.—
21 The term ‘nonparticipating provider’
22 means, with respect to an item or service
23 and a group health plan, a physician or
24 other health care provider who is acting
25 within the scope of practice of that pro-

1 vider’s license or certification under appli-
2 cable State law and who does not have a
3 contractual relationship with the plan or
4 issuer, respectively, for furnishing such
5 item or service under the plan.

6 “(ii) PARTICIPATING PROVIDER.—The
7 term ‘participating provider’ means, with
8 respect to an item or service and a group
9 health plan, a physician or other health
10 care provider who is acting within the
11 scope of practice of that provider’s license
12 or certification under applicable State law
13 and who has a contractual relationship
14 with the plan for furnishing such item or
15 service under the plan.

16 “(H) RECOGNIZED AMOUNT.—The term
17 ‘recognized amount’ means, with respect to an
18 item or service furnished by a nonparticipating
19 provider or emergency facility during a year
20 and a group health plan—

21 “(i) subject to clause (iii), in the case
22 of such item or service furnished in a State
23 that has in effect a specified State law
24 with respect to such plan; such a non-
25 participating provider or emergency facil-

1 ity; and such an item or service, the
2 amount determined in accordance with
3 such law;

4 “(ii) subject to clause (iii), in the case
5 of such item or service furnished in a State
6 that does not have in effect a specified
7 State law, with respect to such plan; such
8 a nonparticipating provider or emergency
9 facility; and such an item or service, an
10 amount that is the median contracted rate
11 (as defined in subparagraph (E)) for such
12 year and determined in accordance with
13 rulemaking described in paragraph (2)(B)
14 for such item or service; or

15 “(iii) in the case of such item or serv-
16 ice furnished in a State with an All-Payer
17 Model Agreement under section 1115A of
18 the Social Security Act, the amount that
19 the State approves under such system for
20 such item or service so furnished.

21 “(I) SPECIFIED STATE LAW.—The term
22 ‘specified State law’ means, with respect to a
23 State, an item or service furnished by a non-
24 participating provider or emergency facility dur-
25 ing a year and a group health plan, a State law

1 that provides for a method for determining the
2 amount of payment that is required to be cov-
3 ered by such a plan (to the extent such State
4 law applies to such plan, subject to section 514
5 of the Employee Retirement Income Security
6 Act of 1974) in the case of a participant or
7 beneficiary covered under such plan and receiv-
8 ing such item or service from such a nonpartici-
9 pating provider or emergency facility.

10 “(J) STABILIZE.—The term ‘to stabilize’,
11 with respect to an emergency medical condition
12 (as defined in subparagraph (B)), has the
13 meaning give in section 1867(e)(3) of the Social
14 Security Act (42 U.S.C. 1395dd(e)(3)).

15 “(c) ACCESS TO PEDIATRIC CARE.—

16 “(1) PEDIATRIC CARE.—In the case of a person
17 who has a child who is a participant or beneficiary
18 under a group health plan, if the plan requires or
19 provides for the designation of a participating pri-
20 mary care provider for the child, the plan shall per-
21 mit such person to designate a physician (allopathic
22 or osteopathic) who specializes in pediatrics as the
23 child’s primary care provider if such provider par-
24 ticipates in the network of the plan or issuer.

1 “(2) CONSTRUCTION.—Nothing in paragraph
2 (1) shall be construed to waive any exclusions of cov-
3 erage under the terms and conditions of the plan
4 with respect to coverage of pediatric care.

5 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
6 COLOGICAL CARE.—

7 “(1) GENERAL RIGHTS.—

8 “(A) DIRECT ACCESS.—A group health
9 plan described in paragraph (2) may not re-
10 quire authorization or referral by the plan or
11 any person (including a primary care provider
12 described in paragraph (2)(B)) in the case of a
13 female participant or beneficiary who seeks cov-
14 erage for obstetrical or gynecological care pro-
15 vided by a participating health care professional
16 who specializes in obstetrics or gynecology.
17 Such professional shall agree to otherwise ad-
18 here to such plan’s policies and procedures, in-
19 cluding procedures regarding referrals and ob-
20 taining prior authorization and providing serv-
21 ices pursuant to a treatment plan (if any) ap-
22 proved by the plan.

23 “(B) OBSTETRICAL AND GYNECOLOGICAL
24 CARE.—A group health plan described in para-
25 graph (2) shall treat the provision of obstetrical

1 and gynecological care, and the ordering of re-
2 lated obstetrical and gynecological items and
3 services, pursuant to the direct access described
4 under subparagraph (A), by a participating
5 health care professional who specializes in ob-
6 stetrics or gynecology as the authorization of
7 the primary care provider.

8 “(2) APPLICATION OF PARAGRAPH.—A group
9 health plan described in this paragraph is a group
10 health plan that—

11 “(A) provides coverage for obstetric or
12 gynecologic care; and

13 “(B) requires the designation by a partici-
14 pant or beneficiary of a participating primary
15 care provider.

16 “(3) CONSTRUCTION.—Nothing in paragraph
17 (1) shall be construed to—

18 “(A) waive any exclusions of coverage
19 under the terms and conditions of the plan with
20 respect to coverage of obstetrical or gynecolo-
21 gical care; or

22 “(B) preclude the group health plan in-
23 volved from requiring that the obstetrical or
24 gynecological provider notify the primary care

1 health care professional or the plan of treat-
2 ment decisions.

3 “(e) COVERAGE OF NON-EMERGENCY SERVICES
4 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
5 TAIN PARTICIPATING FACILITIES.—

6 “(1) IN GENERAL.—In the case of items or
7 services (other than emergency services to which
8 subsection (b) applies) for which any benefits are
9 provided or covered by a group health plan furnished
10 to a participant or beneficiary of such plan by a
11 nonparticipating provider (as defined in subsection
12 (b)(3)(G)(i)) (and who, with respect to such items
13 and services, has not satisfied the notice and consent
14 criteria of section 2799A–2(d) of the Public Health
15 Service Act) with respect to a visit (as defined by
16 the Secretary in accordance with paragraph (2)(B))
17 at a participating health care facility (as defined in
18 paragraph (2)(A)), with respect to such plan, the
19 plan—

20 “(A) shall not impose on such participant
21 or beneficiary a cost-sharing amount (expressed
22 as a copayment amount or coinsurance rate) for
23 such items and services so furnished that is
24 greater than the cost-sharing amount that
25 would apply under such plan had such items or

1 services been furnished by a participating pro-
2 vider (as defined in subsection (b)(3)(G)(ii));

3 “(B) shall calculate such cost-sharing
4 amount as if the total amount that would have
5 been charged for such items and services by
6 such participating provider were equal to the
7 recognized amount (as defined in subsection
8 (b)(3)(H)) for such items and services, plan,
9 and year;

10 “(C) shall pay to such provider furnishing
11 such items and services to such participant or
12 beneficiary the amount by which the recognized
13 amount (as defined in subsection (b)(3)(H)) for
14 such items and services and year involved ex-
15 ceeds the cost-sharing amount imposed under
16 the plan for such items and services (as deter-
17 mined in accordance with subparagraphs (A)
18 and (B)); and

19 “(D) shall count toward any in-network
20 deductible and in-network out-of-pocket maxi-
21 mums (as applicable) applied under the plan,
22 any cost-sharing payments made by the partici-
23 pant or beneficiary (and such in-network de-
24 ductible shall be applied) with respect to such
25 items and services so furnished in the same

1 manner as if such cost-sharing payments were
2 with respect to items and services furnished by
3 a participating provider.

4 “(2) DEFINITIONS.—In this section:

5 “(A) PARTICIPATING HEALTH CARE FACIL-
6 ITY.—

7 “(i) IN GENERAL.—The term ‘partici-
8 pating health care facility’ means, with re-
9 spect to an item or service and a group
10 health plan, a health care facility described
11 in clause (ii) that has a contractual rela-
12 tionship with the plan, with respect to the
13 furnishing of such an item or service at the
14 facility.

15 “(ii) HEALTH CARE FACILITY DE-
16 SCRIBED.—A health care facility described
17 in this clause, with respect to a group
18 health plan, is each of the following:

19 “(I) A hospital (as defined in
20 1861(e) of the Social Security Act).

21 “(II) A hospital outpatient de-
22 partment.

23 “(III) A critical access hospital
24 (as defined in section 1861(mm) of
25 such Act).

1 “(IV) An ambulatory surgical
2 center (as defined in section
3 1833(i)(1)(A) of such Act).

4 “(V) Any other facility that pro-
5 vides items or services for which cov-
6 erage is provided under the plan or
7 coverage, respectively.

8 “(B) VISIT.—The term ‘visit’ shall, with
9 respect to items and services furnished to an in-
10 dividual at a participating health care facility,
11 include equipment and devices, telemedicine
12 services, imaging services, laboratory services,
13 and such other items and services as the Sec-
14 retary may specify, regardless of whether or not
15 the provider furnishing such items or services is
16 at the facility.

17 “(f) AIR AMBULANCE SERVICES.—

18 “(1) IN GENERAL.—In the case of a participant
19 or beneficiary in a group health plan who receives
20 air ambulance services from a nonparticipating pro-
21 vider (as defined in subsection (b)(3)(G)) with re-
22 spect to such plan or coverage, if such services
23 would be covered if provided by a participating pro-
24 vider (as defined in such subsection) with respect to
25 such plan—

1 “(A) the cost-sharing requirement (ex-
2 pressed as a copayment amount, coinsurance
3 rate, or deductible) with respect to such services
4 shall be the same requirement that would apply
5 if such services were provided by such a partici-
6 pating provider, and any coinsurance or deduct-
7 ible shall be based on rates that would apply for
8 such services if they were furnished by such a
9 participating provider;

10 “(B) such cost-sharing amounts shall be
11 counted toward the in-network deductible and
12 in-network out-of-pocket maximum amount
13 under the plan for the plan year (and such in-
14 network deductible shall be applied) with re-
15 spect to such items and services so furnished in
16 the same manner as if such cost-sharing pay-
17 ments were with respect to items and services
18 furnished by a participating provider; and

19 “(C) the plan or coverage shall pay to such
20 provider furnishing such services to such partici-
21 pant or beneficiary the amount by which the
22 recognized amount (as defined in and deter-
23 mined pursuant to subsection (b)(3)(H)(ii)) for
24 such services and year involved exceeds the
25 cost-sharing amount imposed under the plan for

1 such services (as determined in accordance with
2 subparagraphs (A) and (B)).

3 “(2) AIR AMBULANCE SERVICE DEFINED.—For
4 purposes of this section, the term ‘air ambulance
5 service’ means medical transport by helicopter or
6 airplane for patients.

7 “(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
8 BASES.—In the case of a sponsor of a group health plan
9 that, pursuant to subsection (b)(3)(E)(iii), uses a data-
10 base described in such subsection to determine a rate to
11 apply under such subsection for an item or service by rea-
12 son of having insufficient information described in such
13 subsection with respect to such item or service, such spon-
14 sor shall cover the cost for access to such database.”.

15 (2) CLERICAL AMENDMENT.—The table of sec-
16 tions for subchapter B of chapter 100 of the Inter-
17 nal Revenue Code of 1986 is amended by adding at
18 the end the following new item:

“Sec. 9815. Additional market reforms.

“Sec. 9816. Consumer protections.”.

19 (d) ADDITIONAL APPLICATION PROVISIONS.—

20 (1) APPLICATION TO FEHB.—

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

1 “(p) Each contract under this chapter shall require
2 the carrier to comply with requirements described in the
3 provisions of section 2719A of the Public Health Service
4 Act and sections 2730 and 2731 of such Act, sections 716,
5 717, and 718 of the Employee Retirement Income Secu-
6 rity Act of 1974, sections 9816, 9817, and 9818 of the
7 Internal Revenue Code of 1986 (as applicable), and sec-
8 tion 2(d) of the Ban Surprise Billing Act in the same man-
9 ner as such provisions apply to a group health plan or
10 health insurance issuer offering health insurance coverage,
11 as described in such sections. The provisions of sections
12 2799A–1, 2799A–2, 2799A–3, and 2799A–4 of the Public
13 Health Service Act shall apply to a health care provider
14 and facility and an air ambulance provider described in
15 such respective sections with respect to a participant, ben-
16 eficiary, or enrollee in a health benefits plan under this
17 chapter in the same manner as such provisions apply to
18 such a provider and facility with respect to an enrollee
19 in a group health plan or health insurance coverage of-
20 fered by a health insurance issuer in the group or indi-
21 vidual market, as described in such sections.”.

22 (B) EFFECTIVE DATE.—The amendment
23 made by this paragraph shall apply with respect
24 to contracts entered into or renewed for con-

tract years beginning on or after January 1, 2022.

(2) APPLICATION TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(a)) is amended by adding at the end the following:

“(5) APPLICATION OF ADDITIONAL PROVISIONS.—Subsections (b), (e), (f), (g), and (h) of section 2719A of the Public Health Service Act shall apply to grandfathered health plans for plan years beginning on or after January 1, 2022.”.

(3) COORDINATION.—The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(A) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this title (and the amendments made by this title) are administered so as to have the same effect at all times; and

1 (B) coordination of policies relating to en-
2 forcing the same requirements through such
3 Secretaries in order to have a coordinated en-
4 forcement strategy that avoids duplication of
5 enforcement efforts and assigns priorities in en-
6 forcement.

7 (4) RULE OF CONSTRUCTION.—Nothing in this
8 title, including the amendments made by this title
9 may be construed as modifying, reducing, or elimi-
10 nating—

11 (A) the protections under section 222 of
12 the Indian Health Care Improvement Act (25
13 U.S.C. 1621u) and under subpart I of part 136
14 of title 42, Code of Federal Regulations (or any
15 successor regulation), against payment liability
16 for a patient who receives contract health serv-
17 ices that are authorized by the Indian Health
18 Service; or

19 (B) the requirements under section
20 1866(a)(1)(U) of the Social Security Act (42
21 U.S.C. 1395cc(a)(1)(U)).

22 (e) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to plan years begin-
24 ning on or after January 1, 2022.

1 **SEC. 3. PREVENTING CERTAIN CASES OF BALANCE BILL-**
2 **ING.**

3 (a) IN GENERAL.—Title XXVII of the Public Health
4 Service Act (42 U.S.C. 300gg et seq.) is amended by add-
5 ing at the end the following new part:

6 **“PART D—HEALTH CARE PROVIDER**
7 **REQUIREMENTS**

8 **“SEC. 2799A-1. BALANCE BILLING IN CASES OF EMERGENCY**
9 **SERVICES.**

10 “(a) IN GENERAL.—In the case of a participant, ben-
11 eficiary, or enrollee with benefits under a group health
12 plan or health insurance coverage offered by a health in-
13 surance issuer in the group or individual market who is
14 furnished during a plan year beginning on or after Janu-
15 ary 1, 2022, emergency services for which any benefit is
16 provided under such plan or coverage with respect to an
17 emergency medical condition with respect to a visit at an
18 emergency department of a hospital or an independent
19 freestanding emergency department—

20 “(1) in the case that the hospital or inde-
21 pendent freestanding emergency department is a
22 nonparticipating emergency facility, the emergency
23 department of a hospital or independent free-
24 standing emergency department shall not hold the
25 participant, beneficiary, or enrollee liable for a pay-
26 ment amount for such emergency services so fur-

1 nished that is more than the cost-sharing amount
2 for such services (as determined in accordance with
3 clauses (ii) and (iii) of section 2719A(b)(1)(C), sec-
4 tion 716(b)(1)(C) of the Employee Retirement In-
5 come Security Act of 1974, and section
6 9816(b)(1)(C) of the Internal Revenue Code of
7 1986, as applicable); and

8 “(2) in the case that such services are furnished
9 by a nonparticipating provider, the health care pro-
10 vider shall not hold such participant, beneficiary, or
11 enrollee liable for a payment amount for an emer-
12 gency service furnished to such individual by such
13 provider with respect to such emergency medical
14 condition and visit for which the individual receives
15 emergency services at the hospital or emergency de-
16 partment that is more than the cost-sharing amount
17 for such services furnished by the provider (as deter-
18 mined in accordance with clauses (ii) and (iii) of sec-
19 tion 2719A(b)(1)(C), section 716(b)(1)(C) of the
20 Employee Retirement Income Security Act of 1974,
21 and section 9816(b)(1)(C) of the Internal Revenue
22 Code of 1986, as applicable).

23 “(b) DEFINITION.—In this section, the term ‘visit’
24 shall have such meaning as applied to such term for pur-
25 poses of section 2719A(e).

1 **“SEC. 2799A-2. BALANCE BILLING IN CASES OF NON-EMER-**
2 **GENCY SERVICES PERFORMED BY NON-**
3 **PARTICIPATING PROVIDERS AT CERTAIN**
4 **PARTICIPATING FACILITIES.**

5 “(a) IN GENERAL.—Subject to subsection (b), in the
6 case of a participant, beneficiary, or enrollee with benefits
7 under a group health plan or health insurance coverage
8 offered by a health insurance issuer in the group or indi-
9 vidual market who is furnished during a plan year begin-
10 ning on or after January 1, 2022, items or services (other
11 than emergency services to which section 2799A-1 ap-
12 plies) for which any benefit is provided under such plan
13 or coverage at a participating health care facility by a non-
14 participating provider, such provider shall not bill, and
15 shall not hold liable, such participant, beneficiary, or en-
16 rollee for a payment amount for such an item or service
17 furnished by such provider with respect to a visit at such
18 facility that is more than the cost-sharing amount for such
19 item or service (as determined in accordance with subpara-
20 graphs (A) and (B) of section 2719A(e)(1), section
21 716(e)(1) of the Employee Retirement Income Security
22 Act of 1974, and section 9816(e)(1) of the Internal Rev-
23 enue Code of 1986, as applicable).

24 “(b) EXCEPTION.—

25 “(1) IN GENERAL.—Subsection (a) shall not
26 apply with respect to items or services (other than

1 ancillary services described in paragraph (2)) fur-
2 nished by a nonparticipating provider to a partici-
3 pant, beneficiary, or enrollee of a group health plan
4 or health insurance coverage offered by a health in-
5 surance issuer in the group or individual market, if
6 the provider satisfies the notice and consent criteria
7 of subsection (d).

8 “(2) ANCILLARY SERVICES DESCRIBED.—For
9 purposes of paragraph (1), ancillary services de-
10 scribed in this paragraph are, with respect to a par-
11 ticipating health care facility—

12 “(A) subject to paragraph (3), items and
13 services related to emergency medicine, anesthe-
14 siology, pathology, radiology, and neonatology,
15 whether or not provided by a physician or non-
16 physician practitioner, and items and services
17 provided by assistant surgeons, hospitalists, and
18 intensivists;

19 “(B) subject to paragraph (3), diagnostic
20 services (including radiology and laboratory
21 services);

22 “(C) items and services provided by such
23 other specialty practitioners, as the Secretary
24 specifies through rulemaking; and

1 “(D) items and services provided by a non-
2 participating provider if there is no partici-
3 pating provider who can furnish such item or
4 service at such facility.

5 “(3) EXCEPTION.—The Secretary may, through
6 rulemaking, establish a list (and update such list) of
7 advanced diagnostic laboratory tests, which shall not
8 be included as an ancillary service described in para-
9 graph (2) and with respect to which subsection (a)
10 would apply.

11 “(c) CLARIFICATION.—In the case of a nonpartici-
12 pating provider that satisfies the notice and consent cri-
13 teria of subsection (d) with respect to an item or service
14 (referred to in this subsection as a ‘covered item or serv-
15 ice’), such notice and consent criteria may not be con-
16 strued as applying with respect to any item or service that
17 is furnished as a result of unforeseen, urgent medical
18 needs that arise at the time such covered item or service
19 is furnished. For purposes of the previous sentence, a cov-
20 ered item or service shall not include an ancillary service
21 described in subsection (b)(2).

22 “(d) NOTICE AND CONSENT TO BE TREATED BY A
23 NONPARTICIPATING PROVIDER OR NONPARTICIPATING
24 FACILITY.—

1 “(1) IN GENERAL.—A nonparticipating provider
2 or nonparticipating facility satisfies the notice and
3 consent criteria of this subsection, with respect to
4 items or services furnished by the provider or facility
5 to a participant, beneficiary, or enrollee of a group
6 health plan or health insurance coverage offered by
7 a health insurance issuer in the group or individual
8 market, if the provider (or, if applicable, the partici-
9 pating health care facility on behalf of such pro-
10 vider) or nonparticipating facility—

11 “(A) provides to the participant, bene-
12 ficiary, or enrollee (or to an authorized rep-
13 resentative of the participant, beneficiary, or
14 enrollee) on the date on which the individual is
15 furnished such items or services and, in the
16 case that the participant, beneficiary, or en-
17 rollee makes an appointment to be furnished
18 such items or services, on such date the ap-
19 pointment is made—

20 “(i) an oral explanation of the written
21 notice described in clause (ii); and

22 “(ii) a written notice in paper or elec-
23 tronic form (and including electronic notifi-
24 cation, as practicable) specified by the Sec-
25 retary, not later than July 1, 2021,

1 through guidance (which shall be updated
2 as determined necessary by the Secretary)
3 that—

4 “(I) contains the information re-
5 quired under paragraph (2);

6 “(II) clearly states that consent
7 to receive such items and services
8 from such nonparticipating provider
9 or nonparticipating facility is optional
10 and that the participant, beneficiary,
11 or enrollee may instead seek care from
12 a participating provider or at a par-
13 ticipating facility, with respect to such
14 plan or coverage, as applicable, in
15 which case the cost-sharing responsi-
16 bility of the participant, beneficiary,
17 or enrollee would not exceed such re-
18 sponsibility that would apply with re-
19 spect to such an item or service that
20 is furnished by a participating pro-
21 vider or participating facility, as ap-
22 plicable with respect to such plan;

23 “(III) is available in the fifteen
24 most common languages in the geo-
25 graphic region of the applicable facil-

1 ity and, in the case the primary lan-
2 guage of the beneficiary, participant,
3 or enrollee, respectively, is not one of
4 such 15 languages, makes a good
5 faith effort to also provide such notice
6 orally in such primary language of the
7 beneficiary, participant, or enrollee;
8 and

9 “(IV) is signed and dated by the
10 participant, beneficiary, or enrollee (or
11 by an authorized representative of the
12 participant, beneficiary, or enrollee)
13 and, with respect to items or services
14 to be furnished by such a provider
15 that are not poststabilization services
16 described in section
17 2719A(b)(3)(C)(ii), is so signed and
18 dated not less than 72 hours prior to
19 the participant, beneficiary, or en-
20 rollee being furnished such items or
21 services by such provider; and

22 “(B) obtains from the participant, bene-
23 ficiary, or enrollee (or from such an authorized
24 representative) the consent described in para-

1 graph (3) to be treated by a nonparticipating
2 provider or nonparticipating facility.

3 “(2) INFORMATION REQUIRED UNDER WRITTEN
4 NOTICE.—For purposes of paragraph (1)(A)(ii)(I),
5 the information described in this paragraph, with re-
6 spect to a nonparticipating provider or nonparti-
7 cating facility and a participant, beneficiary, or en-
8 rollee of a group health plan or health insurance cov-
9 erage offered by a health insurance issuer in the
10 group or individual market, is each of the following:

11 “(A) Notification, as applicable, that the
12 health care provider is a nonparticipating pro-
13 vider with respect to the health plan or the
14 health care facility is a nonparticipating facility
15 with respect to the health plan.

16 “(B) Notification of the good faith esti-
17 mated amount that such provider or facility
18 may charge the participant, beneficiary, or en-
19 rollee for such items and services involved, in-
20 cluding a notification that the provision of such
21 estimate or consent to be treated under para-
22 graph (3) does not constitute a contract with
23 respect to the charges estimated for such items
24 and services.

1 “(C) In the case of a participating facility
2 and a nonparticipating provider, a list of any
3 participating providers at the facility who are
4 able to furnish such items and services involved
5 and notification that the participant, bene-
6 ficiary, or enrollee may be referred, at their op-
7 tion, to such a participating provider.

8 “(D) Information about whether prior au-
9 thorization or other care management limita-
10 tions may be required in advance of receiving
11 such items or services at the facility.

12 “(3) CONSENT DESCRIBED TO BE TREATED BY
13 A NONPARTICIPATING PROVIDER OR NONPARTICI-
14 PATING FACILITY.—For purposes of paragraph
15 (1)(B), the consent described in this paragraph, with
16 respect to a participant, beneficiary, or enrollee of a
17 group health plan or health insurance coverage of-
18 fered by a health insurance issuer in the group or
19 individual market who is to be furnished items or
20 services by a nonparticipating provider or nonpartici-
21 pating facility, is a document specified by the Sec-
22 retary through rulemaking, in consultation with the
23 Secretary of Labor, that—

24 “(A) acknowledges that the participant,
25 beneficiary, or enrollee has been—

1 “(i) provided with a written good faith
2 estimate and an oral explanation of the
3 charge that may be applied for the items
4 or services anticipated to be furnished by
5 such provider or facility; and

6 “(ii) informed that the payment of
7 such charge by the participant, beneficiary,
8 or enrollee may not accrue toward meeting
9 any limitation that the plan or coverage
10 places on cost-sharing, including an expla-
11 nation that such payment may not apply to
12 an in-network deductible applied under the
13 plan or coverage; and

14 “(B) documents the consent of the partici-
15 pant, beneficiary, or enrollee to be furnished
16 such item or services by such provider or facil-
17 ity.

18 “(4) RULE OF CONSTRUCTION.—The consent
19 described in paragraph (3), with respect to a partici-
20 pant, beneficiary, or enrollee of a group health plan
21 or health insurance coverage offered by a health in-
22 surance issuer in the group or individual market,
23 shall constitute only consent to the receipt of the in-
24 formation provided pursuant to this subsection and
25 shall not constitute a contractual agreement of the

1 participant, beneficiary, or enrollee to any estimated
2 charge or amount included in such information.

3 “(e) RETENTION OF CERTAIN DOCUMENTS.—A non-
4 participating facility (with respect to such facility or any
5 nonparticipating provider at such facility) or a partici-
6 pating facility (with respect to nonparticipating providers
7 at such facility) that obtains from a participant, bene-
8 ficiary, or enrollee of a group health plan or health insur-
9 ance coverage offered by a health insurance issuer in the
10 group or individual market (or an authorized representa-
11 tive of such participant, beneficiary, or enrollee) a written
12 notice in accordance with subsection (d)(1)(A)(ii), with re-
13 spect to furnishing an item or service to such participant,
14 beneficiary, or enrollee, shall retain such notice for at least
15 a 2-year period after the date on which such item or serv-
16 ice is so furnished.

17 “(f) DEFINITIONS.—In this section:

18 “(1) The terms ‘nonparticipating provider’ and
19 ‘participating provider’ have the meanings given
20 such terms, respectively, in subsection (b)(3) of sec-
21 tion 2719A.

22 “(2) The term ‘participating health care facil-
23 ity’ has the meaning given such term in subsection
24 (e)(2) of section 2719A.

1 “(3) The term ‘nonparticipating facility’
2 means—

3 “(A) with respect to emergency services (as
4 defined in section 2719A(b)(3)(C)(i)) and a
5 group health plan or health insurance coverage
6 offered by a health insurance issuer in the
7 group or individual market, an emergency de-
8 partment of a hospital, or an independent free-
9 standing emergency department, that does not
10 have a contractual relationship with the plan or
11 issuer, respectively, with respect to the fur-
12 nishing of such services under the plan or cov-
13 erage, respectively; and

14 “(B) with respect to services described in
15 section 2719A(b)(3)(C)(ii) and a group health
16 plan or health insurance coverage offered by a
17 health insurance issuer in the group or indi-
18 vidual market, a hospital or an independent
19 freestanding emergency department, that does
20 not have a contractual relationship with the
21 plan or issuer, respectively, with respect to the
22 furnishing of such services under the plan or
23 coverage, respectively.

24 “(4) The term ‘participating facility’ means—

1 “(A) with respect to emergency services (as
2 defined in clause (i) of section 2719A(b)(3)(C))
3 that are not described in clause (ii) of such sec-
4 tion and a group health plan or health insur-
5 ance coverage offered by a health insurance
6 issuer in the group or individual market, an
7 emergency department of a hospital, or an inde-
8 pendent freestanding emergency department,
9 that has a contractual relationship with the
10 plan or issuer, respectively, with respect to the
11 furnishing of such services under the plan or
12 coverage, respectively; and

13 “(B) with respect to services that pursuant
14 to clause (ii) of section 2719A(b)(3)(C) are in-
15 cluded as emergency services (as defined in
16 clause (i) of such section) and a group health
17 plan or health insurance coverage offered by a
18 health insurance issuer in the group or indi-
19 vidual market, a hospital or an independent
20 freestanding emergency department, that has a
21 contractual relationship with the plan or cov-
22 erage, respectively, with respect to the fur-
23 nishing of such services under the plan or cov-
24 erage, respectively.

1 **“SEC. 2799A–3. PROVIDER REQUIREMENT WITH RESPECT**
2 **TO PUBLIC PROVISION OF INFORMATION.**

3 “(a) IN GENERAL.—Each health care provider and
4 health care facility shall make publicly available, and (if
5 applicable) post on a public website of such provider or
6 facility and provide to individuals who are participants,
7 beneficiaries, or enrollees of a group health plan or health
8 insurance coverage offered by a health insurance issuer
9 in the group or individual market a one-page notice in
10 plain language containing information on—

11 “(1) the requirements and prohibitions of such
12 provider or facility under sections 2799A–1, 2799A–
13 2, and 2799A–4 (relating to prohibitions on balance
14 billing in certain circumstances);

15 “(2) if provided for under applicable State law,
16 any other requirements on such provider or facility
17 regarding the amounts such provider or facility may,
18 with respect to an item or service, charge a partici-
19 pant, beneficiary, or enrollee of a group health plan
20 or health insurance coverage offered by a health in-
21 surance issuer in the group or individual market
22 with respect to which such provider or facility does
23 not have a contractual relationship for furnishing
24 such item or service under the plan or coverage, re-
25 spectively, after receiving payment from the plan or
26 coverage, respectively, for such item or service and

1 any applicable cost-sharing payment from such par-
2 ticipant, beneficiary, or enrollee; and

3 “(3) information on contacting appropriate
4 State and Federal agencies in the case that an indi-
5 vidual believes that such provider or facility has vio-
6 lated any requirement described in paragraph (1) or
7 (2) with respect to such individual.

8 “(b) GUIDANCE.—Not later than 6 months after the
9 date of the enactment of this section, the Secretary, in
10 consultation with the Secretary of Labor, shall issue guid-
11 ance on the requirements for the notice under this section.

12 **“SEC. 2799A–4. AIR AMBULANCE SERVICES.**

13 “In the case of a participant, beneficiary, or enrollee
14 with benefits under a group health plan or health insur-
15 ance coverage offered by a health insurance issuer in the
16 group or individual market who is furnished on or after
17 January 1, 2022, air ambulance services from a non-
18 participating provider (as defined in section
19 2719A(b)(3)(G)) with respect to such plan or coverage,
20 such provider shall not bill, and shall not hold liable, such
21 participant, beneficiary, or enrollee for a payment amount
22 for such service furnished by such provider that is more
23 than the cost-sharing amount for such service (as deter-
24 mined in accordance with paragraphs (1) and (2) of sec-
25 tion 2719A(f), section 716(f) of the Employee Retirement

1 Income Security Act of 1974, or section 9816(f) of the
2 Internal Revenue Code of 1986, as applicable).

3 **“SEC. 2799A-5. ENFORCEMENT.**

4 “(a) STATE ENFORCEMENT.—

5 “(1) STATE AUTHORITY.—Each State may re-
6 quire a provider or health care facility (including a
7 provider of air ambulance services) subject to the re-
8 quirements of this part (except section 2799A-5) to
9 satisfy such requirements applicable to the provider
10 or facility.

11 “(2) FAILURE TO IMPLEMENT REQUIRE-
12 MENTS.—In the case of a determination by the Sec-
13 retary that a State has failed to substantially en-
14 force the requirements specified in paragraph (1)
15 with respect to applicable providers and facilities in
16 the State, the Secretary shall enforce such require-
17 ments under subsection (b) insofar as they relate to
18 violations of such requirements occurring in such
19 State.

20 “(3) NOTIFICATION OF SECRETARY OF
21 LABOR.—A State may notify the Secretary of Labor
22 of instances of violations of sections 2799A-1,
23 2799A-2, or 2799A-4 with respect to participants
24 or beneficiaries under a group health plan or health
25 insurance coverage offered by a health insurance

1 issuer in the group market and any enforcement ac-
2 tions taken against providers or facilities as a result
3 of such violations, including the disposition of any
4 such enforcement actions.

5 “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

6 “(1) IN GENERAL.—If a provider or facility is
7 found to be in violation of a requirement specified in
8 subsection (a)(1) by the Secretary, the Secretary
9 may apply a civil monetary penalty with respect to
10 such provider or facility (including, as applicable, a
11 provider of air ambulance services) in an amount not
12 to exceed \$10,000 per violation. The provisions of
13 subsections (c) (with the exception of the first sen-
14 tence of paragraph (1) of such subsection), (d), (e),
15 (g), (h), (k), and (l) of section 1128A of the Social
16 Security Act shall apply to a civil monetary penalty
17 or assessment under this subsection in the same
18 manner as such provisions apply to a penalty, as-
19 sessment, or proceeding under subsection (a) of such
20 section.

21 “(2) LIMITATION.—The provisions of para-
22 graph (1) shall apply to enforcement of a provision
23 (or provisions) specified in subsection (a)(1) only as
24 provided under subsection (a)(2).

1 “(3) COMPLAINT PROCESS.—The Secretary
2 shall, through rulemaking conducted in consultation
3 with the Secretary of Labor, establish a process to
4 receive consumer complaints of violations of such
5 provisions and resolve such complaints within 60
6 days of receipt of such complaints. Such process
7 shall provide that the Secretary of Labor be in-
8 formed of complaints by participants or beneficiaries
9 under a group health plan or health insurance cov-
10 erage offered by a health insurance issuer in the
11 group market and any enforcement actions against
12 providers resulting from such complaints, including
13 the disposition of any such enforcement actions.

14 “(4) EXCEPTION.—The Secretary may waive
15 the penalties described under paragraph (1) with re-
16 spect to a facility or provider (including a provider
17 of air ambulance services) who does not knowingly
18 violate, and should not have reasonably known it vio-
19 lated, sections 2799A–1, 2799A–2, or 2799A–4 with
20 respect to a participant, beneficiary, or enrollee, if
21 such facility or provider, within 30 days of the viola-
22 tion, withdraws the bill that was in violation of such
23 provision and reimburses the health plan or partici-
24 pant, beneficiary, or enrollee, as applicable, in an
25 amount equal to the difference between the amount

1 billed and the amount allowed to be billed under the
 2 provision, plus interest, at an interest rate deter-
 3 mined by the Secretary.

4 “(5) HARDSHIP EXEMPTION.—The Secretary
 5 may establish a hardship exemption to the penalties
 6 under this subsection.

7 “(c) CONTINUED APPLICABILITY OF STATE LAW.—
 8 The sections specified in subsection (a)(1) shall not be
 9 construed to supersede any provision of State law which
 10 establishes, implements, or continues in effect any require-
 11 ment or prohibition except to the extent that such require-
 12 ment or prohibition prevents the application of a require-
 13 ment or prohibition of such a section.”.

14 (b) SECRETARY OF LABOR INVESTIGATIVE AUTHOR-
 15 ITY.—

16 (1) IN GENERAL.—Part 5 of subtitle B of title
 17 I of the Employee Retirement Income Security Act
 18 of 1974 (29 U.S.C. 1131 et seq.) is amended by
 19 adding at the end the following new section:

20 **“SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLA-**
 21 **TIONS OF CERTAIN HEALTH CARE PROVIDER**
 22 **REQUIREMENTS; COMPLAINT PROCESS.**

23 “(a) INVESTIGATIVE AUTHORITY.—Upon receiving a
 24 notice from a State or the Secretary of Health and Human
 25 Services of violations of sections 2799A–1, 2799A–2, or

1 2799A–4 of the Public Health Service Act, the Secretary
2 of Labor shall have the power to conduct an investigation
3 to identify patterns of such violations with respect to par-
4 ticipants or beneficiaries under a group health plan or
5 health insurance coverage offered in connection with a
6 group health plan by a health insurance issuer in the
7 group market. The Secretary may assist States, the Sec-
8 retary of Health and Human Services, plans, or issuers
9 to ensure that appropriate measures have been taken to
10 correct such violations retrospectively and prospectively
11 with respect to participants or beneficiaries under a group
12 health plan or health insurance coverage offered in connec-
13 tion with a group health plan by a health insurance issuer
14 in the group market.

15 “(b) COMPLAINT PROCESS.—Not later than January
16 1, 2022, the Secretary shall establish a process under
17 which the Secretary—

18 “(1) may receive complaints from participants
19 and beneficiaries of group health plans or health in-
20 surance coverage offered in connection with such
21 plans relating to alleged violations of the sections
22 specified in subsection (a); and

23 “(2) transmits such complaints to States or the
24 Secretary of Health and Human Services (as deter-

1 mined appropriate by the Secretary) for potential
2 enforcement actions.”.

3 (2) TECHNICAL AMENDMENT.—The table of
4 contents in section 1 of the Employee Retirement
5 Income Security Act of 1974 (29 U.S.C. 1001 et
6 seq.) is amended by inserting after the item relating
7 to section 521 the following new item:

 “Sec. 522. Investigative authority regarding violations of certain health care
 provider requirements; complaint process.”.

8 (c) DISCLOSURE OF CERTAIN PROTECTIONS
9 AGAINST BALANCE BILLING.—Section 716 of the Em-
10 ployee Retirement Income Security Act of 1974, as added
11 by section 2, is further amended by adding at the end the
12 following new subsection:

13 “(h) DISCLOSURE OF CERTAIN PROTECTIONS
14 AGAINST BALANCE BILLING.—Each group health plan
15 and health insurance issuer offering group health insur-
16 ance coverage shall make publicly available, and (if appli-
17 cable) post on a public website of such plan or issuer—

18 “(1) information in plain language on—

19 “(A) the requirements and prohibitions ap-
20 plied under sections 2799A–1, 2799A–2 and
21 2799A–4 of the Public Health Service Act (re-
22 lating to prohibitions on balance billing in cer-
23 tain circumstances);

1 “(B) if provided for under applicable State
 2 law, any other requirements on providers and
 3 facilities regarding the amounts such providers
 4 and facilities may, with respect to an item or
 5 service, charge a participant, beneficiary, or en-
 6 rollee of such plan or coverage with respect to
 7 which such a provider or facility does not have
 8 a contractual relationship for furnishing such
 9 item or service under the plan or coverage after
 10 receiving payment from the plan or coverage for
 11 such item or service and any applicable cost-
 12 sharing payment from such participant, bene-
 13 ficiary, or enrollee; and

14 “(C) the requirements applied under sub-
 15 sections (b), (e), and (f); and

16 “(2) information on contacting appropriate
 17 State and Federal agencies in the case that an indi-
 18 vidual believes that such a provider or facility has
 19 violated any requirement described in paragraph (1)
 20 with respect to such individual.”.

21 **SEC. 4. INDEPENDENT DISPUTE RESOLUTION PROCESS.**

22 (a) ESTABLISHMENT.—

23 (1) IN GENERAL.—Not later than 1 year after
 24 the date of the enactment of this section, the Sec-
 25 retary of Health and Human Services, the Secretary

1 of Labor, and the Secretary of the Treasury (in this
2 section referred to as the “Secretaries”) shall jointly
3 establish by regulation an independent dispute reso-
4 lution process (in this section referred to as the
5 “IDR process”) under which, with respect to a pay-
6 ment made by a group health plan or health insur-
7 ance issuer offering health insurance coverage in the
8 group or individual market pursuant to subsection
9 (b)(1), (e)(1), or (f)(1) of section 2719A of the Pub-
10 lic Health Service Act, section 716 of the Employee
11 Retirement Income Security Act of 1974, or section
12 9816 of the Internal Revenue Code of 1986 (as ap-
13 plicable) using the recognized amount (as defined in
14 and determined pursuant to section
15 2719A(b)(3)(H)(ii) of the Public Health Service Act
16 or subsection (b)(3)(H)(ii) of section 716 of the Em-
17 ployee Retirement Income Security Act of 1974 or
18 section 9816 of the Internal Revenue Code of 1986,
19 as applicable) to a nonparticipating provider (as de-
20 fined in subparagraph (G) of section 2719A(b)(3) of
21 the Public Health Service Act or subparagraph (G)
22 of subsection (b)(3) of section 716 of the Employee
23 Retirement Income Security Act of 1974 or section
24 9816 of the Internal Revenue Code of 1986, as ap-
25 plicable) or a nonparticipating emergency facility (as

1 defined in subparagraph (F) of such section
2 2719A(b)(3) or such subsection (b)(3) of such sec-
3 tion 716 or such section 9816, as applicable) with
4 respect to an item or service (or, in the case of pay-
5 ment made under section 2719A(f)(1) of the Public
6 Health Service Act or subsection (f)(1) of section
7 716 of the Employee Retirement Income Security
8 Act of 1974 or section 9816 of the Internal Revenue
9 Code of 1986, as applicable, with respect to air am-
10 bulance services) furnished by such provider or facil-
11 ity—

12 (A) subject to subparagraph (B), the non-
13 participating provider, nonparticipating emer-
14 gency facility, or group health plan or health in-
15 surance issuer, respectively, may, not later than
16 the date specified in paragraph (2), submit a
17 request that such payment should be increased
18 or decreased; and

19 (B) in the case a settlement described in
20 subsection (d)(2) is not reached with respect to
21 such request, an entity certified and selected
22 under subsection (c) shall determine in accord-
23 ance with such paragraph an alternative pay-
24 ment to be applied, with respect to such re-
25 quest.

1 (2) DATE SPECIFIED.—For purposes of para-
2 graph (1)(A), the date specified in this paragraph
3 is—

4 (A) in the case of a request described in
5 such paragraph (1)(A) being submitted by a
6 nonparticipating provider or nonparticipating
7 emergency facility, with respect to items and
8 services (or air ambulance services) described in
9 paragraph (1), the date that is 30 days after
10 the applicable date described in subsection
11 (b)(2)(A)(ii); or

12 (B) in the case of such a request filed by
13 a group health plan or health insurance issuer,
14 the date that is 30 days after the date of the
15 submission of the notice described in subsection
16 (b)(1)(B)(ii).

17 (3) CLARIFICATION.—A nonparticipating pro-
18 vider may not, with respect to an item or service (or
19 air ambulance service) furnished by such provider,
20 submit a request under the IDR process if such pro-
21 vider is exempt from the requirement under sub-
22 section (a) of section 2799A–2 of the Public Health
23 Service Act with respect to such item or service pur-
24 suant to subsection (e) of such section.

1 (b) REQUIREMENTS FOR REQUESTS TO BE ELIGI-
2 BLE FOR SUBMISSION UNDER IDR PROCESS.—

3 (1) TIMING REQUIREMENTS.—A request may
4 not be submitted under the IDR process, with re-
5 spect to items and services (or air ambulance serv-
6 ices) furnished by a nonparticipating provider or
7 nonparticipating emergency facility for which a
8 group health plan or health insurance issuer offering
9 health insurance coverage in the group or individual
10 market made a payment pursuant to subsection
11 (b)(1), (e)(1), or (f)(1) of section 2719A of the Pub-
12 lic Health Service Act or subsection (b)(1), (e)(1), or
13 (f)(1) of section 716 of the Employee Retirement In-
14 come Security Act of 1974 or section 9816 of the
15 Internal Revenue Code of 1986 (as applicable) un-
16 less—

17 (A) in the case such request is being sub-
18 mitted by the nonparticipating provider or non-
19 participating emergency facility—

20 (i) the provider or facility, respec-
21 tively, filed, not later than 30 days after
22 the date such payment is received by the
23 provider or facility, respectively, an appeal
24 under the appeals process of the group
25 health plan or health insurance issuer, the

1 subject of which includes the payment for
2 such items and services (or air ambulance
3 services); and

4 (ii) such request is not submitted be-
5 fore the sooner of the date on which such
6 appeal has been resolved or the date that
7 is 30 days after the date on which such ap-
8 peal is so filed; or

9 (B) in the case such request is being sub-
10 mitted by the group health plan or health insur-
11 ance issuer—

12 (i) the group health plan or health in-
13 surance issuer, respectively, not later than
14 30 days after such provider or facility, re-
15 spectively, receives such payment, submits
16 to such provider or facility, respectively, a
17 notice that such plan or issuer, respec-
18 tively, disputes the amount of such pay-
19 ment with respect to such items and serv-
20 ices (or air ambulance services); and

21 (ii) such request is not submitted be-
22 fore the date that is 30 days after the date
23 of the submission of such notice.

24 (2) MINIMUM MEDIAN CONTRACTED RATE.—A
25 request may not be submitted under the IDR proc-

1 ess, with respect to items and services (or air ambu-
2 lance services) furnished in a geographic area by a
3 nonparticipating provider or nonparticipating emer-
4 gency facility for which a group health plan or
5 health insurance issuer offering health insurance
6 coverage in the group or individual market made a
7 payment pursuant to subsection (b)(1), (e)(1), or
8 (f)(1) of section 2719A of the Public Health Service
9 Act or subsection (b)(1), (e)(1), or (f)(1) of section
10 716 of the Employee Retirement Income Security
11 Act of 1974 or section 9816 of the Internal Revenue
12 Code of 1986 (as applicable) unless—

13 (A) in the case such item or service is fur-
14 nished during 2022, the median contracted rate
15 (as defined in subsection (b)(3)(E) of section
16 2719A of the Public Health Service Act or sub-
17 section (b)(3)(E) of section 716 of the Em-
18 ployee Retirement Income Security Act of 1974
19 or section 9816 of the Internal Revenue Code
20 of 1986 (as applicable)) for such year under
21 such plan or such coverage with respect to each
22 such item or service furnished by such a pro-
23 vider or such a facility in such area is at least
24 \$750 (or, in the case of air ambulance services,
25 is at least \$25,000); or

1 (B) in the case such item or service (or air
2 ambulance services) is furnished during a sub-
3 sequent year, the median contracted rate (as so
4 defined) for such year under such plan or such
5 coverage with respect to each such item or serv-
6 ice furnished by such a provider or such a facil-
7 ity in such area is at least the amount applied
8 under this paragraph for the previous year, in-
9 creased by the percentage increase in the con-
10 sumer price index for all urban consumers
11 (United States city average) over such previous
12 year.

13 (3) LIMITATION ON BATCHING OF ITEMS AND
14 SERVICES IN A REQUEST.—A request may not be
15 submitted under the IDR process by a nonpartici-
16 pating provider, nonparticipating emergency facility,
17 or a group health plan or health insurance issuer of-
18 fering health insurance coverage in the group or in-
19 dividual market, with respect to multiple items and
20 services (or multiple air ambulance services), un-
21 less—

22 (A) all such items and services (or air am-
23 bulance services) included in such request are
24 furnished by the same provider or facility;

1 (B) payment for all such items and serv-
2 ices (or air ambulance services) made pursuant
3 to subsection (b)(1), (e)(1), or (f)(1) of section
4 2719A of the Public Health Service Act or sub-
5 section (b)(1), (e)(1), or (f)(1) of section 716 of
6 the Employee Retirement Income Security Act
7 of 1974 or section 9816 of the Internal Rev-
8 enue Code of 1986 (as applicable) was made by
9 a single group health plan or health insurance
10 coverage;

11 (C) all such items and services (or air am-
12 bulance services) are related to the treatment of
13 the same condition; and

14 (D) all such items and services were fur-
15 nished during the 30-day period following the
16 date on which the first item or service (or air
17 ambulance service) included in such request was
18 furnished.

19 (c) IDR ENTITIES.—

20 (1) PROCESS OF CERTIFICATION.—The process
21 described in subsection (a) shall include a certifi-
22 cation process under which eligible entities may be
23 certified to carry out the IDR process.

24 (2) CERTIFICATION.—

1 (A) IN GENERAL.—An entity wishing to
2 participate in the IDR process under this sec-
3 tion shall request certification from the Secre-
4 taries. The Secretaries shall determine whether
5 or not to certify applicant entities, taking into
6 consideration whether the entity is unbiased
7 and unaffiliated with health insurance issuers,
8 group health plans, health care facilities, and
9 health care providers and free of conflicts of in-
10 terest, in accordance with the Secretaries’ rule-
11 making on determining criteria for conflicts of
12 interest.

13 (B) ELIGIBLE ENTITIES.—For purposes of
14 this section, an eligible entity is an entity that
15 is a nongovernmental entity and that agrees to
16 comply with the fee limitations described in
17 subparagraph (C).

18 (C) FEE LIMITATIONS.—For purposes of
19 subparagraph (B), the fee limitations described
20 in this subparagraph are limitations established
21 by the Secretaries for the amount a certified
22 IDR entity may charge a nonparticipating pro-
23 vider, nonparticipating emergency facility,
24 group health plan, or health insurance issuer
25 offering health insurance coverage in the group

1 or individual market for services furnished by
2 such entity with respect to the resolution of a
3 specified request of such provider, facility, plan,
4 or issuer under the process described in sub-
5 section (a).

6 (3) SELECTION OF CERTIFIED IDR ENTITY.—

7 The group health plan or health insurance issuer of-
8 fering health insurance coverage in the group or in-
9 dividual market and the nonparticipating provider or
10 the nonparticipating emergency facility (as applica-
11 ble) involved in a request submitted under the IDR
12 process shall agree on a certified IDR entity to re-
13 solve such request. In the case that such plan or
14 issuer (as applicable) and such provider or facility
15 (as applicable) cannot so agree, such an entity shall
16 be selected by the Secretaries at random, in accord-
17 ance with a manner and timeline specified by the
18 Secretaries.

19 (d) PAYMENT DETERMINATION.—

20 (1) TIMING.—A certified IDR entity selected
21 under subsection (c)(3) with respect to a request
22 under the IDR process shall, subject to paragraph
23 (2), not later than 30 days after being so selected,
24 determine the alternative payment that should be
25 made for items and services (or air ambulance serv-

ices) included in such request in accordance with paragraph (3).

(2) SETTLEMENT.—

(A) IN GENERAL.—If such entity determines that a settlement between the group health plan or issuer, as applicable, and the provider or facility, as applicable, is likely with respect to a request under the IDR process, the entity may direct the parties to attempt, for a period not to exceed 10 days, a good faith negotiation for a settlement of such request.

(B) TIMING.—The period for a settlement described in subparagraph (A) shall accrue toward the 30-day period described in paragraph (1).

(3) DETERMINATION OF ALTERNATIVE PAYMENT.—

(A) IN GENERAL.—The group health plan or health insurance issuer offering health insurance coverage in the group or individual market (as applicable) and the nonparticipating provider or nonparticipating emergency facility (as applicable) involved shall, with respect to a request under the IDR process, each submit to the certified IDR entity selected under sub-

1 section (c)(3) for such request a final offer to
2 be considered for the alternative payment to be
3 applied with respect to items and services (or
4 air ambulance services) which are the subject of
5 the request. Such entity shall determine, in ac-
6 cordance with subparagraph (B), which such
7 offer is the most reasonable and will be applied
8 as the alternative payment.

9 (B) CONSIDERATIONS IN DETERMINA-
10 TION.—

11 (i) IN GENERAL.—In determining
12 which final offer is the alternative payment
13 to be applied, the certified IDR entity se-
14 lected under subsection (c)(3) for such re-
15 quest shall consider—

16 (I) the median contracted rates
17 (as defined in subsection (b)(3)(E) of
18 section 2719A of the Public Health
19 Service Act or subsection (b)(3)(E) of
20 section 716 of the Employee Retire-
21 ment Income Security Act of 1974 or
22 section 9816 of the Internal Revenue
23 Code of 1986 (as applicable)) for the
24 applicable year for items or services
25 (or air ambulance services) that are

1 comparable to the items and services
2 (or air ambulance services) included
3 in the request and that are furnished
4 in the same geographic area (as de-
5 fined by the Secretaries for purposes
6 of such subsection) as such items and
7 services (or air ambulance services)
8 (not including any facility fees with
9 respect to such rates); and

10 (II) in the case of items and
11 services (other than air ambulances
12 services), each circumstance described
13 in clause (ii) with respect to which in-
14 formation is submitted by either party
15 or, in the case of air ambulance serv-
16 ices, each circumstance described in
17 clause (iii) with respect to which in-
18 formation is submitted by either
19 party.

20 (ii) ADDITIONAL CIRCUMSTANCES FOR
21 CERTAIN ITEMS AND SERVICES.—For pur-
22 poses of clause (i)(II), the circumstances
23 described in this clause are, with respect to
24 items and services (other than air ambu-
25 lance services) included in the request

1 under the IDR process of a nonpartici-
2 pating provider, nonparticipating emer-
3 gency facility, group health plan, or health
4 insurance issuer the following:

5 (I) The level of training, edu-
6 cation, experience, and quality and
7 outcomes measurements of the pro-
8 vider or facility that furnished such
9 items and services (such as those en-
10 dored by the consensus-based entity
11 authorized under section 1890 of the
12 Social Security Act).

13 (II) The market share held by
14 the provider or facility, or the plan or
15 issuer, in the geographic area in
16 which the item or service was pro-
17 vided.

18 (III) Any other extenuating cir-
19 cumstances with respect to the fur-
20 nishing of such items and services
21 that relate to the acuity of the indi-
22 vidual receiving such items and serv-
23 ices or the complexity of furnishing
24 such items and services to such indi-
25 vidual.

1 (iii) ADDITIONAL CIRCUMSTANCES
2 FOR AIR AMBULANCE SERVICES.—For pur-
3 poses of clause (i)(II), the circumstances
4 described in this clause are, with respect to
5 air ambulance services included in the re-
6 quest under the IDR process of a non-
7 participating provider, group health plan,
8 or health insurance issuer the following:

9 (I) The quality and outcomes
10 measurements of the provider that
11 furnished such services.

12 (II) Any other extenuating cir-
13 cumstances with respect to the fur-
14 nishing of such services that relate to
15 the acuity of the individual receiving
16 such services or the complexity of fur-
17 nishing such services to such indi-
18 vidual.

19 (III) The training, education, ex-
20 perience, and quality of the medical
21 personnel that furnished such serv-
22 ices.

23 (IV) Ambulance vehicle type, in-
24 cluding the clinical capability level of
25 such vehicle.

1 (V) Population density of the
2 pick up location (such as urban, sub-
3 urban, rural, or frontier).

4 (iv) PROHIBITION ON CONSIDERATION
5 OF BILLED CHARGES.—In determining
6 which final offer is the alternative payment
7 amount to be applied with respect to items
8 and services (or air ambulance services)
9 furnished by a provider or facility and in-
10 cluded in the request under the IDR proc-
11 ess, the certified IDR entity selected under
12 subsection (c)(3) with respect to such re-
13 quest shall not consider the amount that
14 would have been billed by such provider or
15 facility with respect to such items and
16 services had the provisions of section
17 2799A–1, 2799A–2, or 2799A–4 of the
18 Public Health Service Act (as applicable)
19 not applied.

20 (C) EFFECTS OF DETERMINATION.—

21 (i) IN GENERAL.—A determination of
22 a certified IDR entity under subparagraph
23 (A) shall be binding.

24 (ii) LIMITATION ON CERTAIN SUBSE-
25 QUENT IDR CLAIMS.—In the case of a de-

1 termination of a certified IDR entity under
2 subparagraph (A), with respect to a re-
3 quest submitted under subsection (a)(1)(A)
4 and the two parties involved with such re-
5 quest, the party that submitted such initial
6 request may not submit during the 90-day
7 period following such determination a sub-
8 sequent request under such subsection in-
9 volving the same other party to such re-
10 quest with respect to such an item or serv-
11 ice (or air ambulance service) that was the
12 subject of such initial request.

13 (D) COSTS OF INDEPENDENT DISPUTE
14 RESOLUTION PROCESS.—In the case of a re-
15 quest made by a nonparticipating provider, non-
16 participating emergency facility, group health
17 plan, or health insurance issuer offering health
18 insurance coverage in the group or individual
19 market and submitted to a certified IDR enti-
20 ty—

21 (i) if such entity makes a determina-
22 tion with respect to such request under
23 subparagraph (A), the party whose offer is
24 not chosen under such clause shall be re-

1 sponsible for paying all fees charged by
2 such entity; and

3 (ii) if the parties reach a settlement
4 with respect to such request prior to such
5 a determination, each party shall pay half
6 of all fees charged by such entity, unless
7 the parties otherwise agree.

8 (E) PAYMENT.—Not later than 30 days
9 after the date on which a determination de-
10 scribed in subparagraph (B) is made with re-
11 spect to a request under the IDR process of a
12 nonparticipating provider, nonparticipating
13 emergency facility, group health plan, or health
14 insurance issuer offering health insurance cov-
15 erage in the group or individual market—

16 (i) in the case that the alternative
17 payment determined to be applied is great-
18 er than the amount paid with respect to
19 such request, such plan or issuer (as appli-
20 cable) shall pay directly to the provider or
21 facility (as applicable) the difference be-
22 tween such alternative payment and the
23 amount so paid; and

24 (ii) in the case that the alternative
25 payment determined to be applied is less

1 than the amount paid with respect to such
2 request, such provider or facility (as appli-
3 cable) shall pay directly to the plan or
4 issuer (as applicable) the difference be-
5 tween the amount so paid and such alter-
6 native payment.

7 (e) PUBLICATION OF INFORMATION RELATING TO
8 DISPUTES.—

9 (1) PUBLICATION OF INFORMATION.—For 2022
10 and each subsequent year, the Secretaries shall
11 make available on the public website of the Depart-
12 ment of Health and Human Services, the Depart-
13 ment of Labor, and the Department of the Treas-
14 ury—

15 (A) the number of requests submitted
16 under the IDR process during such year;

17 (B) the practice size of the providers and
18 facilities submitting requests under the IDR
19 process during such year;

20 (C) the number of such requests with re-
21 spect to which a final determination was made
22 under subsection (d)(3)(A); and

23 (D) the information described in para-
24 graph (2) with respect to each request with re-

1 spect to which such a determination was so
2 made.

3 (2) INFORMATION WITH RESPECT TO RE-
4 QUESTS.—For purposes of paragraph (1), the infor-
5 mation described in this paragraph is, with respect
6 to a request under the IDR process of a nonpartici-
7 pating provider, nonparticipating emergency facility,
8 group health plan, or health insurance issuer offer-
9 ing health insurance coverage in the group or indi-
10 vidual market—

11 (A) a description of each item and service
12 (or air ambulance service) included in such re-
13 quest;

14 (B) the geography in which the items and
15 services (or air ambulance services) included in
16 such request were provided;

17 (C) the amount of the offer submitted
18 under subsection (d)(3)(A) by the group health
19 plan or health insurance issuer (as applicable)
20 and by the nonparticipating provider or non-
21 participating emergency facility (as applicable)
22 expressed as a percentage of the median con-
23 tracted rate;

24 (D) whether the offer selected by the cer-
25 tified IDR entity under such subsection to be

1 the alternative payment applied was the offer
2 submitted by such plan or issuer (as applicable)
3 or by such provider or facility (as applicable)
4 and the amount of such offer so selected ex-
5 pressed as a percentage of the median con-
6 tracted rate;

7 (E) the category and practice specialty of
8 each such provider or facility involved in fur-
9 nishing such items and services (or, in the case
10 of air ambulance services, the ambulance vehicle
11 type, including the clinical capability level of
12 such vehicle); and

13 (F) the identity of the group health plan or
14 health insurance issuer, provider, or facility,
15 with respect to the request.

16 (3) IDR ENTITY REQUIREMENTS.—For 2022
17 and each subsequent year, an IDR entity, as a con-
18 dition of certification as an IDR entity, shall submit
19 to the Secretaries such information as the Secre-
20 taries determines necessary for the Secretaries to
21 carry out the provisions of this subsection.

22 (f) ENFORCEMENT.—

23 (1) IN GENERAL.—Any health care provider,
24 health care facility, group health plan, or health in-
25 surance issuer offering group or individual health in-

1 surance coverage that violates a provision of this
2 section shall be subject to a civil monetary penalty
3 in an amount not to exceed \$10,000 for each such
4 violation.

5 (2) APPLICATION.—The provisions of section
6 1128A of the Social Security Act (other than sub-
7 sections (a) and (b) and the first sentence of sub-
8 section (c)(1)) shall apply with respect to a civil
9 monetary penalty imposed under this subsection in
10 the same manner as such provisions apply with re-
11 spect to a penalty or proceeding under subsection
12 (a) of such section, except that any reference to “the
13 Secretary” in such provisions shall be treated as a
14 reference to “the Secretaries”.

15 (g) DEFINITIONS.—In this subsection, terms “group
16 health plan”, “group market”, “health insurance issuer”,
17 “health insurance coverage”, “individual health insurance
18 coverage”, “group health insurance coverage”, and “indi-
19 vidual market” have the meanings given such terms, re-
20 spectively, in section 2791 of the Public Health Service
21 Act.

22 **SEC. 5. ADVISORY COMMITTEE ON GROUND AMBULANCE**
23 **AND PATIENT BILLING.**

24 (a) IN GENERAL.—Not later than 60 days after the
25 date of enactment of this Act, the Secretary of Labor, Sec-

1 retary of Health and Human Services, and the Secretary
2 of the Treasury (the Secretaries) shall jointly establish an
3 advisory committee for the purpose of reviewing options
4 to improve the disclosure of charges and fees for ground
5 ambulance services, better inform consumers of insurance
6 options for such services, and protect consumers from bal-
7 ance billing.

8 (b) COMPOSITION OF THE ADVISORY COMMITTEE.—

9 The advisory committee shall be composed of the following
10 members:

11 (1) The Secretary of Labor, or the Secretary's
12 designee.

13 (2) The Secretary of Health and Human Serv-
14 ices, or the Secretary's designee.

15 (3) The Secretary of the Treasury, or the Sec-
16 retary's designee.

17 (4) One representative, to be appointed jointly
18 by the Secretaries, for each of the following:

19 (A) Each relevant Federal agency, as de-
20 termined by the Secretaries.

21 (B) State insurance regulators.

22 (C) Health insurance providers or trade or-
23 ganization.

24 (D) Patient advocacy groups.

25 (E) Consumer advocacy groups.

1 (F) State and local governments.

2 (G) Physician specializing in emergency,
3 trauma, cardiac, or stroke.

4 (5) Three representatives, to be appointed joint-
5 ly by the Secretaries, to represent the various seg-
6 ments of the ground ambulance industry.

7 (6) Up to an additional three representatives
8 otherwise not described in paragraphs (1) through
9 (5), as determined necessary and appropriate by the
10 Secretaries.

11 (c) CONSULTATION.—The advisory committee shall,
12 as appropriate, consult with relevant experts and stake-
13 holders, including those not otherwise included under sub-
14 section (b), while conducting the review described in sub-
15 section (a).

16 (d) RECOMMENDATIONS.—The advisory committee
17 shall make recommendations with respect to disclosure of
18 charges and fees for ground ambulance services and insur-
19 ance coverage, consumer protection and enforcement au-
20 thorities of the Departments of Labor, Health and Human
21 Services, and the Treasury and State authorities, and the
22 prevention of balance billing to consumers. The rec-
23 ommendations shall address, at a minimum—

24 (1) options, best practices, and identified stand-
25 ards to prevent instances of balance billing;

1 (2) steps that can be taken by State legisla-
2 tures, State insurance regulators, State attorneys
3 general, and other State officials as appropriate,
4 consistent with current legal authorities regarding
5 consumer protection; and

6 (3) legislative options for Congress to prevent
7 balance billing.

8 (e) REPORT.—Not later than 180 days after the date
9 of the first meeting of the advisory committee, the advi-
10 sory committee shall submit to the Secretaries, and the
11 Committees on Education and Labor, Energy and Com-
12 merce, and Ways and Means of the House of Representa-
13 tives and the Committees on Finance and Health, Edu-
14 cation, Labor, and Pensions a report containing the rec-
15 ommendations made under subsection (d).

16 (f) RULEMAKING.—Upon receipt of the report under
17 subsection (e), the Secretaries shall consider the rec-
18 ommendations of the advisory committee and issue regula-
19 tions or other guidance as deemed necessary to provide
20 consumer protections for patients of ground ambulance
21 providers.

22 **SEC. 6. IMPROVING PROVIDER DIRECTORIES.**

23 (a) PHSA.—Part A of title XXVII of the Public
24 Health Service Act (42 U.S.C. 300gg et seq.) is amended
25 by adding at the end the following new section:

1 **“SEC. 2730. PROTECTING PATIENTS AND IMPROVING THE**
2 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
3 **MATION.**

4 “(a) NETWORK STATUS OF PROVIDERS.—

5 “(1) IN GENERAL.—Beginning on the date that
6 is one year after the date of enactment of this sec-
7 tion, a group health plan or a health insurance
8 issuer offering group or individual health insurance
9 coverage shall—

10 “(A) establish business processes to ensure
11 that all enrollees in such plan or coverage re-
12 ceive proof of a health care provider’s network
13 status, based on what a plan or issuer knows or
14 should know—

15 “(i) upon a telephone inquiry by an
16 enrollee—

17 “(I) through a written electronic
18 communication from the plan or
19 issuer to the enrollee, as soon as prac-
20 ticable and not later than 1 business
21 day after such inquiry is made by
22 such participant, beneficiary, or en-
23 rollee for such information;

24 “(II) through an oral commu-
25 nication from the plan or issuer to the
26 enrollee, as soon as practicable and

1 not later than 1 business day after
2 such inquiry is made by such enrollee
3 for such information, which commu-
4 nication shall be documented by such
5 plan or issuer, and such documenta-
6 tion shall be kept in the enrollee's file
7 for a minimum of 2 years; and

8 “(ii) in real-time through an online
9 health care provider directory search tool
10 maintained by the plan or issuer; and

11 “(B) include in any print directory—

12 “(i) a disclosure that the information
13 included in the directory is accurate as of
14 the date of the last data update and that
15 enrollees or prospective enrollees should
16 consult the group health plan's or issuer's
17 electronic provider directory on its website
18 or call a specified customer service tele-
19 phone number to obtain the most current
20 provider directory information; and

21 “(ii) a list of the categories of pro-
22 viders of ancillary services for which the
23 plan or coverage has no in-network pro-
24 viders.

1 “(2) GROUP HEALTH PLAN AND HEALTH IN-
2 SURANCE ISSUER BUSINESS PROCESSES.—Beginning
3 on the date that is one year after the date of the en-
4 actment of this section, a group health plan or a
5 health insurance issuer offering group or individual
6 health insurance coverage shall establish business
7 processes to—

8 “(A) verify and update, at least once every
9 90 days, the provider directory information for
10 all providers included in the online health care
11 provider directory search tool described in para-
12 graph (1)(A)(ii); and

13 “(B) remove any provider from such online
14 directory search tool if such provider has not
15 verified the directory information within the
16 previous 6 months or the plan or issuer has
17 been unable to verify the provider’s network
18 participation.

19 “(b) COST-SHARING LIMITATIONS.—A group health
20 plan or a health insurance issuer offering group or indi-
21 vidual health insurance coverage shall not apply, and shall
22 ensure that no provider applies, cost-sharing to an enrollee
23 for treatment or services provided by a health care pro-
24 vider in excess of the normal cost-sharing applied for such
25 treatment or services provided in-network (including any

1 balance bill issued by the health care provider involved),
2 if such enrollee, or health care provider referring such en-
3 rollee, demonstrates (based on the electronic, written in-
4 formation described in subsection (a)(1)(A)(i)(I), the oral
5 confirmation described in subsection (a)(1)(A)(i)(II) re-
6 ceived by the enrollee not more than 30 days before the
7 date the treatment or services were received, or a copy
8 of the online provider directory described in subsection
9 (a)(1)(A)(ii) on a date not more than 30 days before the
10 date the treatment or services were received), that the en-
11 rollee relied on the information described in subsection
12 (a)(1) for which such enrollee provides such documenta-
13 tion, that indicated that the provider is an in-network pro-
14 vider, if the provider was out-of-network at the time the
15 treatment or service involved was received.

16 “(c) DEFINITION.—For purposes of this section, the
17 term ‘provider directory information’ includes the names,
18 addresses, specialty, and telephone numbers of individual
19 health care providers, and the names, addresses, and tele-
20 phone numbers of each medical group, clinic, or facility
21 contracted to participate in any of the networks of the
22 group health plan or health insurance coverage involved.

23 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
24 tion shall be construed to preempt any provision of State
25 law relating to health care provider directories.”.

1 (b) ERISA.—Subpart B of part 7 of subtitle B of
2 title I of the Employee Retirement Income Security Act
3 of 1974 (29 U.S.C. 1185 et seq.), as amended by section
4 2, is further amended by adding at the end the following:

5 **“SEC. 717. PROTECTING PATIENTS AND IMPROVING THE**
6 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
7 **MATION.**

8 “(a) NETWORK STATUS OF PROVIDERS.—

9 “(1) IN GENERAL.—Beginning on the date that
10 is one year after the date of enactment of this sec-
11 tion, a group health plan (or health insurance cov-
12 erage offered in connection with such a plan) shall—

13 “(A) establish business processes to ensure
14 that all participants and beneficiaries in such
15 plan or coverage receive proof of a health care
16 provider’s network status, based on what a plan
17 or issuer of such coverage knows or should
18 know—

19 “(i) upon a telephone inquiry by a
20 participant or beneficiary—

21 “(I) through a written electronic
22 communication from the plan or
23 issuer to the participant or bene-
24 ficiary, as soon as practicable and not
25 later than 1 business day after such

1 inquiry is made by such participant or
2 beneficiary for such information;

3 “(II) through an oral commu-
4 nication from the plan or issuer to the
5 participant or beneficiary, as soon as
6 practicable and not later than 1 busi-
7 ness day after such inquiry is made by
8 such participant or beneficiary for
9 such information, which communica-
10 tion shall be documented by such plan
11 or issuer, and such documentation
12 shall be kept in the participant’s or
13 beneficiary’s file for a minimum of 2
14 years; and

15 “(ii) in real-time through an online
16 health care provider directory search tool
17 maintained by the plan or issuer; and

18 “(B) include in any print directory—

19 “(i) a disclosure that the information
20 included in the directory is accurate as of
21 the date of the last data update and that
22 participants or beneficiaries or prospective
23 participants or beneficiaries should consult
24 the group health plan’s or issuer’s elec-
25 tronic provider directory on its website or

1 call a specified customer service telephone
2 number to obtain the most current pro-
3 vider directory information; and

4 “(ii) a list of the categories of pro-
5 viders of ancillary services for which the
6 plan or coverage has no in-network pro-
7 viders.

8 “(2) GROUP HEALTH PLAN AND HEALTH IN-
9 SURANCE ISSUER BUSINESS PROCESSES.—Beginning
10 on the date that is one year after the date of enact-
11 ment of this section, a group health plan (or health
12 insurance coverage offered in connection with such a
13 plan) shall establish business processes to—

14 “(A) verify and update, at least once every
15 90 days, the provider directory information for
16 all providers included in the online health care
17 provider directory search tool described in para-
18 graph (1)(A)(ii); and

19 “(B) remove any provider from such online
20 directory search tool if such provider has not
21 verified the directory information within the
22 previous 6 months or the plan or issuer has
23 been unable to verify the provider’s network
24 participation.

1 “(b) COST-SHARING LIMITATIONS.—A group health
2 plan (or health insurance coverage offered in connection
3 with such a plan) shall not apply, and shall ensure that
4 no provider applies, cost-sharing to a participant or bene-
5 ficiary for treatment or services provided by a health care
6 provider in excess of the normal cost-sharing applied for
7 such treatment or services provided in-network (including
8 any balance bill issued by the health care provider in-
9 volved), if such participant or beneficiary, or health care
10 provider referring such participant or beneficiary, dem-
11 onstrates (based on the electronic, written information de-
12 scribed in subsection (a)(1)(A)(i)(I), the oral confirmation
13 described in subsection (a)(1)(A)(i)(II) received by the
14 participant or beneficiary not more than 30 days before
15 the date the treatment or services were received, or a copy
16 of the online provider directory described in subsection
17 (a)(1)(A)(ii) on a date not more than 30 days before the
18 date the treatment or services were received), that the par-
19 ticipant or beneficiary relied on the information described
20 in subsection (a)(1) for which such participant or bene-
21 ficiary provides such documentation, that indicated that
22 the provider is an in-network provider, if the provider was
23 out-of-network at the time the treatment or service in-
24 volved was received.

1 “(c) DEFINITION.—For purposes of this section, the
 2 term ‘provider directory information’ includes the names,
 3 addresses, specialty, and telephone numbers of individual
 4 health care providers, and the names, addresses, and tele-
 5 phone numbers of each medical group, clinic, or facility
 6 contracted to participate in any of the networks of the
 7 group health plan or health insurance coverage involved.”.

8 (c) IRC.—Subchapter B of chapter 100 of the Inter-
 9 nal Revenue Code of 1986, as amended by section 2, is
 10 further amended by adding at the end the following:

11 **“SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE**
 12 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
 13 **MATION.**

14 “(a) NETWORK STATUS OF PROVIDERS.—

15 “(1) IN GENERAL.—Beginning on the date that
 16 is one year after the date of enactment of this sec-
 17 tion, a group health plan shall—

18 “(A) establish business processes to ensure
 19 that all participants or beneficiaries in such
 20 plan receive proof of a health care provider’s
 21 network status, based on what a plan or issuer
 22 knows or should know—

23 “(i) upon a telephone inquiry by a
 24 participant or beneficiary—

1 “(I) through a written electronic
2 communication from the plan to the
3 participant or beneficiary, as soon as
4 practicable and not later than 1 busi-
5 ness day after such inquiry is made by
6 such participant or beneficiary for
7 such information;

8 “(II) through an oral commu-
9 nication from the plan to the partici-
10 pant or beneficiary, as soon as prac-
11 ticable and not later than 1 business
12 day after such inquiry is made by
13 such participant or beneficiary for
14 such information, which communica-
15 tion shall be documented by such
16 plan, and such documentation shall be
17 kept in the participant’s or bene-
18 ficiary’s file for a minimum of 2
19 years; and

20 “(ii) in real-time through an online
21 health care provider directory search tool
22 maintained by the plan; and

23 “(B) include in any print directory—

24 “(i) a disclosure that the information
25 included in the directory is accurate as of

1 the date of the last data update and that
2 participants or beneficiaries or prospective
3 participants or beneficiaries should consult
4 the group health plan’s electronic provider
5 directory on its website or call a specified
6 customer service telephone number to ob-
7 tain the most current provider directory in-
8 formation; and

9 “(ii) a list of the categories of pro-
10 viders of ancillary services for which the
11 plan or coverage has no in-network pro-
12 viders.

13 “(2) GROUP HEALTH PLAN BUSINESS PROC-
14 ESSES.—Beginning on the date that is one year
15 after the date of enactment of this section, a group
16 health plan shall establish business processes to—

17 “(A) verify and update, at least once every
18 90 days, the provider directory information for
19 all providers included in the online health care
20 provider directory search tool described in para-
21 graph (1)(A)(ii); and

22 “(B) remove any provider from such online
23 directory search tool if such provider has not
24 verified the directory information within the
25 previous 6 months or the plan or issuer has

1 been unable to verify the provider’s network
2 participation.

3 “(b) COST-SHARING LIMITATIONS.—A group health
4 plan shall not apply, and shall ensure that no provider
5 applies, cost-sharing to a participant or beneficiary for
6 treatment or services provided by a health care provider
7 in excess of the normal cost-sharing applied for such treat-
8 ment or services provided in-network (including any bal-
9 ance bill issued by the health care provider involved), if
10 such participant or beneficiary, or health care provider re-
11 ferring such participant or beneficiary, demonstrates
12 (based on the electronic, written information described in
13 subsection (a)(1)(A)(i)(I), the oral confirmation described
14 in subsection (a)(1)(A)(i)(II) received by the participant
15 or beneficiary not more than 30 days before the date the
16 treatment or services were received, or a copy of the online
17 provider directory described in subsection (a)(1)(A)(ii) on
18 a date not more than 30 days before the date the treat-
19 ment or services were received), that the participant or
20 beneficiary relied on the information described in sub-
21 section (a)(1) for which such participant or beneficiary
22 provides such documentation, that indicated that the pro-
23 vider is an in-network provider, if the provider was out-
24 of-network at the time the treatment or service involved
25 was received.

1 “(c) DEFINITION.—For purposes of this section, the
 2 term ‘provider directory information’ includes the names,
 3 addresses, specialty, and telephone numbers of individual
 4 health care providers, and the names, addresses, and tele-
 5 phone numbers of each medical group, clinic, or facility
 6 contracted to participate in any of the networks of the
 7 group health plan involved.

8 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
 9 tion shall be construed to preempt any provision of State
 10 law relating to health care provider directories.”.

11 (d) CLERICAL AMENDMENTS.—

12 (1) ERISA.—The table of contents in section 1
 13 of the Employee Retirement Income Security Act of
 14 1974 (29 U.S.C. 1001 et seq.), as amended by sec-
 15 tion 2, is further amended by inserting after the
 16 item relating to section 716 the following new item:

“Sec. 717. Protecting patients and improving the accuracy of provider directory
 information.”.

17 (2) IRC.—The table of sections for subchapter
 18 B of chapter 100 of the Internal Revenue Code of
 19 1986, as amended by section 2, is further amended
 20 by adding at the end the following new item:

“Sec. 9817. Protecting patients and improving the accuracy of provider direc-
 tory information.”.

21 (e) PROVIDER REQUIREMENTS.—Part D of title
 22 XXVII of the Public Health Service Act (42 U.S.C. 300gg
 23 et seq.), as added by section 3, is amended—

1 (1) by redesignating section 2799A–5 as section
2 2799A–7; and

3 (2) by inserting after section 2799A–4 the fol-
4 lowing new section:

5 **“SEC. 2799A-5. PROVIDER REQUIREMENTS TO PROTECT PA-**
6 **TIENTS AND IMPROVE THE ACCURACY OF**
7 **PROVIDER DIRECTORY INFORMATION.**

8 “(a) PROVIDER BUSINESS PROCESSES.—A health
9 care provider shall have in place business processes to en-
10 sure the timely provision of provider directory information
11 to a group health plan or a health insurance issuer offer-
12 ing group or individual health insurance coverage to sup-
13 port compliance by such plans or issuers with section
14 2730(a)(1), section 717(a)(1) of the Employee Retirement
15 Income Security Act of 1974, or section 9817(a)(1) of the
16 Internal Revenue Code of 1986 (as applicable). Such pro-
17 viders shall submit provider directory information to a
18 plan or issuers, at a minimum—

19 “(1) when the provider begins a network agree-
20 ment with a plan or with an issuer with respect to
21 certain coverage;

22 “(2) when the provider terminates a network
23 agreement with a plan or with an issuer with respect
24 to certain coverage;

1 “(3) when there are material changes to the
2 content of provider directory information described
3 in section 2730(a)(1), section 717(a)(1) of the Em-
4 ployee Retirement Income Security Act of 1974, or
5 section 9817(a)(1) of the Internal Revenue Code of
6 1986 (as applicable); and

7 “(4) every 90 days throughout the duration of
8 the network agreement with a plan or issuer.

9 “(b) ENFORCEMENT.—

10 “(1) CIVIL PENALTIES.—

11 “(A) IN GENERAL.—Subject to paragraph
12 (2), a health care provider that violates a re-
13 quirement under subsection (a) or takes actions
14 that prevent a group health plan or health in-
15 surance issuer from complying with subsection
16 (a)(1) or (b) of sections 2730, 717 of the Em-
17 ployee Retirement Income Security Act of 1974,
18 or 9817 of the Internal Revenue Code of 1986
19 (as applicable) shall be subject to a civil mone-
20 tary penalty of not more than \$10,000 for each
21 act constituting such violation.

22 “(B) SAFE HARBOR.—The Secretary may
23 waive the penalty described under paragraph
24 (1) with respect to a health care provider that
25 unknowingly violates section 2730(b)(1), section

1 717(b)(1) of the Employee Retirement Income
2 Security Act of 1974, or section 9817(b)(1) of
3 the Internal Revenue Code of 1986 (as applica-
4 ble) with respect to an enrollee if such provider
5 rescinds the bill involved and, if applicable, re-
6 imburses the enrollee within 30 days of the date
7 on which the provider billed the enrollee in vio-
8 lation of such subsection.

9 “(C) PROCEDURE.—The provisions of sec-
10 tion 1128A of the Social Security Act, other
11 than subsections (a) and (b) and the first sen-
12 tence of subsection (c)(1) of such section, shall
13 apply to civil money penalties under this sub-
14 section in the same manner as such provisions
15 apply to a penalty or proceeding under section
16 1128A of the Social Security Act.

17 “(2) REFUNDS TO ENROLLEES.—If a health
18 care provider submits a bill to an enrollee based on
19 cost-sharing for treatment or services provided by
20 the health care provider that is in excess of the nor-
21 mal cost-sharing applied for such treatment or serv-
22 ices provided in-network, as prohibited under section
23 2730(b), section 717(b) of the Employee Retirement
24 Income Security Act of 1974, or section 9817(b) of
25 the Internal Revenue Code of 1986 (as applicable)

1 and the enrollee pays such bill, the provider shall re-
2 imburse the enrollee for the full amount paid by the
3 enrollee in excess of the in-network cost-sharing
4 amount for the treatment or services involved, plus
5 interest, at an interest rate determined by the Sec-
6 retary.

7 “(c) LIMITATION.—Nothing in this section shall pro-
8 hibit a provider from requiring in the terms of a contract,
9 or contract termination, with a group health plan or health
10 insurance issuer—

11 “(1) that the plan or issuer remove, at the time
12 of termination of such contract, the provider from a
13 directory of the plan or issuer described in section
14 2730(a)(1), section 717(a)(1) of the Employee Re-
15 tirement Income Security Act of 1974, or section
16 9817(a)(1) of the Internal Revenue Code of 1986
17 (as applicable); or

18 “(2) that the plan or issuer bear financial re-
19 sponsibility, including under section 2730(b), section
20 717(b) of the Employee Retirement Income Security
21 Act of 1974, or section 9817(b) of the Internal Rev-
22 enue Code of 1986 (as applicable) for providing in-
23 accurate network status information to an enrollee.

24 “(d) DEFINITION.—For purposes of this section, the
25 term ‘provider directory information’ includes the names,

1 addresses, specialty, and telephone numbers of individual
 2 health care providers, and the names, addresses, and tele-
 3 phone numbers of each medical group, clinic, or facility
 4 contracted to participate in any of the networks of the
 5 group health plan or health insurance coverage involved.

6 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
 7 tion shall be construed to preempt any provision of State
 8 law relating to health care provider directories.”.

9 **SEC. 7. INCREASING TRANSPARENCY IN HEALTH COV-**
 10 **ERAGE.**

11 (a) DISCLOSURE OF DIRECT AND INDIRECT COM-
 12 PENSATION FOR BROKERS AND CONSULTANTS TO EM-
 13 PLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN
 14 PLANS ON THE INDIVIDUAL MARKET.—

15 (1) GROUP HEALTH PLANS.—Section 408(b)(2)
 16 of the Employee Retirement Income Security Act of
 17 1974 (29 U.S.C. 1108(b)(2)) is amended—

18 (A) by striking “(2) Contracting or mak-
 19 ing” and inserting “(2)(A) Contracting or mak-
 20 ing”; and

21 (B) by adding at the end the following:

22 “(B)(i) No contract or arrangement for services
 23 between a covered plan and a covered service pro-
 24 vider, and no extension or renewal of such a contract
 25 or arrangement, is reasonable within the meaning of

1 this paragraph unless the requirements of this sub-
2 paragraph are met.

3 “(ii)(I) For purposes of this subparagraph:

4 “(aa) The term ‘covered plan’ means a
5 group health plan as defined section 733(a).

6 “(bb) The term ‘covered service provider’
7 means a service provider that enters into a con-
8 tract or arrangement with the covered plan and
9 reasonably expects \$1,000 (or such amount as
10 the Secretary may establish in regulations to
11 account for inflation since the date of the enact-
12 ment of the Ban Surprise Billing Act, as appro-
13 priate) or more in compensation, direct or indi-
14 rect, to be received in connection with providing
15 one or more of the following services, pursuant
16 to the contract or arrangement, regardless of
17 whether such services will be performed, or such
18 compensation received, by the covered service
19 provider, an affiliate, or a subcontractor:

20 “(AA) Brokerage services, for which
21 the covered service provider, an affiliate, or
22 a subcontractor reasonably expects to re-
23 ceive indirect compensation or direct com-
24 pensation described in item (dd), provided
25 to a covered plan with respect to selection

1 of insurance products (including vision and
2 dental), recordkeeping services, medical
3 management vendor, benefits administra-
4 tion (including vision and dental), stop-loss
5 insurance, pharmacy benefit management
6 services, wellness services, transparency
7 tools and vendors, group purchasing orga-
8 nization preferred vendor panels, disease
9 management vendors and products, compli-
10 ance services, employee assistance pro-
11 grams, or third party administration serv-
12 ices.

13 “(BB) Consulting, for which the cov-
14 ered service provider, an affiliate, or a sub-
15 contractor reasonably expects to receive in-
16 direct compensation or direct compensation
17 described in item (dd), related to the devel-
18 opment or implementation of plan design,
19 insurance or insurance product selection
20 (including vision and dental), record-
21 keeping, medical management, benefits ad-
22 ministration selection (including vision and
23 dental), stop-loss insurance, pharmacy ben-
24 efit management services, wellness design
25 and management services, transparency

1 tools, group purchasing organization agree-
2 ments and services, participation in and
3 services from preferred vendor panels, dis-
4 ease management, compliance services, em-
5 ployee assistance programs, or third party
6 administration services.

7 “(cc) The term ‘affiliate’, with respect to a
8 covered service provider, means an entity that
9 directly or indirectly (through one or more
10 intermediaries) controls, is controlled by, or is
11 under common control with, such provider, or is
12 an officer, director, or employee of, or partner
13 in, such provider.

14 “(dd)(AA) The term ‘compensation’ means
15 anything of monetary value, but does not in-
16 clude non-monetary compensation valued at
17 \$250 (or such amount as the Secretary may es-
18 tablish in regulations to account for inflation
19 since the date of enactment of the Ban Surprise
20 Billing Act, as appropriate) or less, in the ag-
21 gregate, during the term of the contract or ar-
22 rangement.

23 “(BB) The term ‘direct compensation’
24 means compensation received directly from a
25 covered plan.

1 “(CC) The term ‘indirect compensation’
2 means compensation received from any source
3 other than the covered plan, the plan sponsor,
4 the covered service provider, or an affiliate.
5 Compensation received from a subcontractor is
6 indirect compensation, unless it is received in
7 connection with services performed under a con-
8 tract or arrangement with a subcontractor.

9 “(ee) The term ‘responsible plan fiduciary’
10 means a fiduciary with authority to cause the
11 covered plan to enter into, or extend or renew,
12 the contract or arrangement.

13 “(ff) The term ‘subcontractor’ means any
14 person or entity (or an affiliate of such person
15 or entity) that is not an affiliate of the covered
16 service provider and that, pursuant to a con-
17 tract or arrangement with the covered service
18 provider or an affiliate, reasonably expects to
19 receive \$1,000 (or such amount as the Sec-
20 retary may establish in regulations to account
21 for inflation since the date of enactment of the
22 Ban Surprise Billing Act, as appropriate) or
23 more in compensation for performing one or
24 more services described in item (bb) under a
25 contract or arrangement with the covered plan.

1 “(II) For purposes of this subparagraph, a de-
2 scription of compensation or cost may be expressed
3 as a monetary amount, formula, or a per capita
4 charge for each enrollee or, if the compensation or
5 cost cannot reasonably be expressed in such terms,
6 by any other reasonable method, including a disclo-
7 sure that additional compensation may be earned
8 but may not be calculated at the time of contract if
9 such a disclosure includes a description of the cir-
10 cumstances under which the additional compensation
11 may be earned and a reasonable and good faith esti-
12 mate if the covered service provider cannot otherwise
13 readily describe compensation or cost and explains
14 the methodology and assumptions used to prepare
15 such estimate. Any such description shall contain
16 sufficient information to permit evaluation of the
17 reasonableness of the compensation or cost.

18 “(III) No person or entity is a ‘covered service
19 provider’ within the meaning of subclause (I)(bb)
20 solely on the basis of providing services as an affil-
21 iate or a subcontractor that is performing one or
22 more of the services described in subitem (AA) or
23 (BB) of such subclause under the contract or ar-
24 rangement with the covered plan.

1 “(iii) A covered service provider shall disclose to
2 a responsible plan fiduciary, in writing, the fol-
3 lowing:

4 “(I) A description of the services to be pro-
5 vided to the covered plan pursuant to the con-
6 tract or arrangement.

7 “(II) If applicable, a statement that the
8 covered service provider, an affiliate, or a sub-
9 contractor will provide, or reasonably expects to
10 provide, services pursuant to the contract or ar-
11 rangement directly to the covered plan as a fi-
12 diciary (within the meaning of section 3(21)).

13 “(III) A description of all direct compensa-
14 tion, either in the aggregate or by service, that
15 the covered service provider, an affiliate, or a
16 subcontractor reasonably expects to receive in
17 connection with the services described in sub-
18 clause (I).

19 “(IV)(aa) A description of all indirect com-
20 pensation that the covered service provider, an
21 affiliate, or a subcontractor reasonably expects
22 to receive in connection with the services de-
23 scribed in subclause (I)—

24 “(AA) including compensation from a
25 vendor to a brokerage firm based on a

1 structure of incentives not solely related to
2 the contract with the covered plan; and

3 “(BB) not including compensation re-
4 ceived by an employee from an employer
5 on account of work performed by the em-
6 ployee.

7 “(bb) A description of the arrangement be-
8 tween the payer and the covered service pro-
9 vider, an affiliate, or a subcontractor, as appli-
10 cable, pursuant to which such indirect com-
11 pensation is paid.

12 “(cc) Identification of the services for
13 which the indirect compensation will be re-
14 ceived, if applicable.

15 “(dd) Identification of the payer of the in-
16 direct compensation.

17 “(V) A description of any compensation
18 that will be paid among the covered service pro-
19 vider, an affiliate, or a subcontractor, in con-
20 nection with the services described in subclause
21 (I) if such compensation is set on a transaction
22 basis (such as commissions, finder’s fees, or
23 other similar incentive compensation based on
24 business placed or retained), including identi-
25 fication of the services for which such com-

1 pensation will be paid and identification of the
2 payers and recipients of such compensation (in-
3 cluding the status of a payer or recipient as an
4 affiliate or a subcontractor), regardless of
5 whether such compensation also is disclosed
6 pursuant to subclause (III) or (IV).

7 “(VI) A description of any compensation
8 that the covered service provider, an affiliate, or
9 a subcontractor reasonably expects to receive in
10 connection with termination of the contract or
11 arrangement, and how any prepaid amounts
12 will be calculated and refunded upon such ter-
13 mination.

14 “(iv) A covered service provider shall disclose to
15 a responsible plan fiduciary, in writing a description
16 of the manner in which the compensation described
17 in clause (iii), as applicable, will be received.

18 “(v)(I) A covered service provider shall disclose
19 the information required under clauses (iii) and (iv)
20 to the responsible plan fiduciary not later than the
21 date that is reasonably in advance of the date on
22 which the contract or arrangement is entered into,
23 and extended or renewed.

24 “(II) A covered service provider shall disclose
25 any change to the information required under clause

1 (iii) and (iv) as soon as practicable, but not later
2 than 60 days from the date on which the covered
3 service provider is informed of such change, unless
4 such disclosure is precluded due to extraordinary cir-
5 cumstances beyond the covered service provider's
6 control, in which case the information shall be dis-
7 closed as soon as practicable.

8 “(vi)(I) Upon the written request of the respon-
9 sible plan fiduciary or covered plan administrator, a
10 covered service provider shall furnish any other in-
11 formation relating to the compensation received in
12 connection with the contract or arrangement that is
13 required for the covered plan to comply with the re-
14 porting and disclosure requirements under this Act.

15 “(II) The covered service provider shall disclose
16 the information required under clause (iii)(I) reason-
17 ably in advance of the date upon which such respon-
18 sible plan fiduciary or covered plan administrator
19 states that it is required to comply with the applica-
20 ble reporting or disclosure requirement, unless such
21 disclosure is precluded due to extraordinary cir-
22 cumstances beyond the covered service provider's
23 control, in which case the information shall be dis-
24 closed as soon as practicable.

1 “(vii) No contract or arrangement will fail to be
2 reasonable under this subparagraph solely because
3 the covered service provider, acting in good faith and
4 with reasonable diligence, makes an error or omis-
5 sion in disclosing the information required pursuant
6 to clause (iii) (or a change to such information dis-
7 closed pursuant to clause (v)(II)) or clause (vi), pro-
8 vided that the covered service provider discloses the
9 correct information to the responsible plan fiduciary
10 as soon as practicable, but not later than 30 days
11 from the date on which the covered service provider
12 knows of such error or omission.

13 “(viii)(I) Pursuant to subsection (a), subpara-
14 graphs (C) and (D) of section 406(a)(1) shall not
15 apply to a responsible plan fiduciary, notwith-
16 standing any failure by a covered service provider to
17 disclose information required under clause (iii), if
18 the following conditions are met:

19 “(aa) The responsible plan fiduciary did
20 not know that the covered service provider
21 failed or would fail to make required disclosures
22 and reasonably believed that the covered service
23 provider disclosed the information required to
24 be disclosed.

1 “(bb) The responsible plan fiduciary, upon
2 discovering that the covered service provider
3 failed to disclose the required information, re-
4 quests in writing that the covered service pro-
5 vider furnish such information.

6 “(cc) If the covered service provider fails
7 to comply with a written request described in
8 subclause (II) within 90 days of the request,
9 the responsible plan fiduciary notifies the Sec-
10 retary of the covered service provider’s failure,
11 in accordance with subclauses (II) and (III).

12 “(II) A notice described in subclause (I)(cc)
13 shall contain—

14 “(aa) the name of the covered plan;

15 “(bb) the plan number used for the annual
16 report on the covered plan;

17 “(cc) the plan sponsor’s name, address,
18 and employer identification number;

19 “(dd) the name, address, and telephone
20 number of the responsible plan fiduciary;

21 “(ee) the name, address, phone number,
22 and, if known, employer identification number
23 of the covered service provider;

24 “(ff) a description of the services provided
25 to the covered plan;

1 “(gg) a description of the information that
2 the covered service provider failed to disclose;

3 “(hh) the date on which such information
4 was requested in writing from the covered serv-
5 ice provider; and

6 “(ii) a statement as to whether the covered
7 service provider continues to provide services to
8 the plan.

9 “(III) A notice described in subclause (I)(cc)
10 shall be filed with the Department not later than 30
11 days following the earlier of—

12 “(aa) The covered service provider’s re-
13 fusals to furnish the information requested by
14 the written request described in subclause
15 (I)(bb); or

16 “(bb) 90 days after the written request re-
17 ferred to in subclause (I)(cc) is made.

18 “(IV) If the covered service provider fails to
19 comply with the written request under subclause
20 (I)(bb) within 90 days of such request, the respon-
21 sible plan fiduciary shall determine whether to ter-
22 minate or continue the contract or arrangement
23 under section 404. If the requested information re-
24 lates to future services and is not disclosed promptly
25 after the end of the 90-day period, the responsible

1 plan fiduciary shall terminate the contract or ar-
2 rangement as expeditiously as possible, consistent
3 with such duty of prudence.

4 “(ix) Nothing in this subparagraph shall be
5 construed to supersede any provision of State law
6 that governs disclosures by parties that provide the
7 services described in this section, except to the ex-
8 tent that such law prevents the application of a re-
9 quirement of this section.”.

10 (2) APPLICABILITY OF EXISTING REGULA-
11 TIONS.—Nothing in the amendments made by para-
12 graph (1) shall be construed to affect the applica-
13 bility of section 2550.408b–2 of title 29, Code of
14 Federal Regulations (or any successor regulations),
15 with respect to any applicable entity other than a
16 covered plan or a covered service provider (as de-
17 fined in section 408(b)(2)(B)(ii) of the Employee
18 Retirement Income Security Act of 1974, as amend-
19 ed by paragraph (1)).

20 (3) INDIVIDUAL MARKET COVERAGE.—Subpart
21 1 of part B of title XXVII of the Public Health
22 Service Act (42 U.S.C. 300gg–41 et seq.) is amend-
23 ed by adding at the end the following:

1 **“SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL**
2 **MARKET COVERAGE.**

3 “(a) IN GENERAL.—A health insurance issuer offer-
4 ing individual health insurance coverage shall make disclo-
5 sures to enrollees in such coverage, as described in sub-
6 section (b), and reports to the Secretary, as described in
7 subsection (c), regarding direct or indirect compensation
8 provided to an agent or broker associated with enrolling
9 individuals in such coverage.

10 “(b) DISCLOSURE.—A health insurance issuer de-
11 scribed in subsection (a) shall disclose to an enrollee the
12 amount of direct or indirect compensation provided to an
13 agent or broker for services provided by such agent or
14 broker associated with plan selection and enrollment. Such
15 disclosure shall be—

16 “(1) made prior to the individual finalizing plan
17 selection; and

18 “(2) included on any documentation confirming
19 the individual’s enrollment.

20 “(c) REPORTING.—A health insurance issuer de-
21 scribed in subsection (a) shall annually report to the Sec-
22 retary, prior to the beginning of open enrollment, any di-
23 rect or indirect compensation provided to an agent or
24 broker associated with enrolling individuals in such cov-
25 erage.

1 “(d) RULEMAKING.—Not later than 1 year after the
 2 date of enactment of the Ban Surprise Billing Act, the
 3 Secretary shall finalize, through notice-and-comment rule-
 4 making, the form and manner in which issuers described
 5 in subsection (a) are required to make the disclosures de-
 6 scribed in subsection (b) and the reports described in sub-
 7 section (c). Such rulemaking may also include adjustments
 8 to notice requirements to reflect the different processes
 9 for plan renewals, in order to provide enrollees with full,
 10 timely information.”.

11 (4) TRANSITION RULE.—No contract executed
 12 prior to the effective date described in paragraph (5)
 13 by a group health plan subject to the requirements
 14 of section 408(b)(2)(B) of the Employee Retirement
 15 Income Security Act of 1974 (as amended by para-
 16 graph (1)) or by a health insurance issuer subject to
 17 the requirements of section 2746 of the Public
 18 Health Service Act (as added by paragraph (3))
 19 shall be subject to the requirements of such section
 20 408(b)(2)(B) or such section 2746, as applicable.

21 (5) EFFECTIVE DATE.—The amendments made
 22 by paragraphs (1) and (3) shall apply beginning one
 23 year after the date of enactment of this Act.

24 (b) STANDARDIZED REPORTING FORMAT.—Section
 25 716 of the Employee Retirement Income Security Act of

1 1974, as added by section 2 and amended by section 3(c),
2 is further amended by adding at the end the following new
3 subsection:

4 “(i) STANDARDIZED REPORTING FORMAT.—

5 “(1) IN GENERAL.—Not later than 1 year after
6 the date of enactment of this subsection, the Sec-
7 retary shall establish a standardized reporting for-
8 mat for the reporting, by group health plans (or
9 health insurance coverage offered in connection with
10 such a plan) to State All Payer Claims Databases,
11 of medical claims, pharmacy claims, dental claims,
12 and eligibility and provider files that are collected
13 from private and public payers, and shall provide
14 guidance to States on the process by which States
15 may collect such data from such plans or coverage
16 in the standardized reporting format.

17 “(2) DEFINITION.—In this subsection, the term
18 ‘State All Payer Claims Database’ means, with re-
19 spect to a State, a database that may include med-
20 ical claims, pharmacy claims, dental claims, and eli-
21 gibility and provider files, which are collected from
22 private and public payers.”.

23 **SEC. 8. ACCESS TO COST-SHARING INFORMATION.**

24 (a) INSURER AND PLAN REQUIREMENTS.—

1 (1) PHSA.—Part A of title XXVII of the Pub-
 2 lic Health Service Act (42 U.S.C. 300gg–11 et seq.),
 3 as amended by section 6(a), is further amended by
 4 inserting after section 2730 the following:

5 **“SEC. 2731. PROVISION OF COST-SHARING INFORMATION.**

6 “A group health plan or a health insurance issuer of-
 7 fering group or individual health insurance coverage shall
 8 provide a participant, beneficiary, or enrollee in the plan
 9 or coverage with a good faith estimate of the enrollee’s
 10 cost-sharing (including deductibles, copayments, and coin-
 11 surance) for which the participant, beneficiary, or enrollee
 12 may be responsible for paying with respect to a specific
 13 health care service (including any service that is reason-
 14 ably expected to be provided in conjunction with such spe-
 15 cific service), as soon as practicable and not later than
 16 2 business days after a request for such information by
 17 a participant, beneficiary, or enrollee.”.

18 (2) ERISA.—Subpart B of part 7 of subtitle B
 19 of title I of the Employee Retirement Income Secu-
 20 rity Act of 1974 (29 U.S.C. 1185 et seq.), as
 21 amended by section 6(b), is further amended by add-
 22 ing at the end the following:

23 **“SEC. 718. PROVISION OF COST-SHARING INFORMATION.**

24 “A group health plan (or health insurance coverage
 25 offered in connection with such a plan) shall provide a par-

1 participant or beneficiary in the plan or coverage with a good
2 faith estimate of the participant's or beneficiary's cost-
3 sharing (including deductibles, copayments, and coinsur-
4 ance) for which the participant or beneficiary may be re-
5 sponsible for paying with respect to a specific health care
6 service (including any service that is reasonably expected
7 to be provided in conjunction with such specific service),
8 as soon as practicable and not later than 2 business days
9 after a request for such information by a participant or
10 beneficiary.”.

11 (3) IRC.—Subchapter B of chapter 100 of the
12 Internal Revenue Code of 1986, as amended by sec-
13 tion 6(c), is further amended by adding at the end
14 the following:

15 **“SEC. 9818. PROVISION OF COST-SHARING INFORMATION.**

16 “A group health plan shall provide a participant or
17 beneficiary in the plan with a good faith estimate of the
18 participant's or beneficiary's cost-sharing (including
19 deductibles, copayments, and coinsurance) for which the
20 participant or beneficiary may be responsible for paying
21 with respect to a specific health care service (including any
22 service that is reasonably expected to be provided in con-
23 junction with such specific service), as soon as practicable
24 and not later than 2 business days after a request for such
25 information by a participant or beneficiary.”.

1 (4) CLERICAL AMENDMENTS.—

2 (A) ERISA.—The table of contents in sec-
 3 tion 1 of the Employee Retirement Income Se-
 4 curity Act of 1974 (29 U.S.C. 1001 et seq.), as
 5 amended by section 8(b)(4), is further amended
 6 by inserting after the item relating to section
 7 717 the following new item:

“Sec. 718. Provision of cost-sharing information.”.

8 (B) IRC.—The table of sections for sub-
 9 chapter B of chapter 100 of the Internal Rev-
 10 enue Code of 1986, as amended by section
 11 8(b)(4), is further amended by adding at the
 12 end the following new item:

“Sec. 9818. Provision of cost-sharing information.”.

13 (b) PROVIDER REQUIREMENTS.—Part D of title
 14 XXVII of the Public Health Service Act, as added by sec-
 15 tion 3 and amended by section 6, is further amended by
 16 inserting before section 2799A–7 the following new sec-
 17 tion:

18 **“SEC. 2799A–6. PROVISION OF COST-SHARING INFORMA-**
 19 **TION.**

20 “A provider that is in-network with respect to a
 21 group health plan or a health insurance issuer offering
 22 group or individual health insurance coverage shall, upon
 23 request by a participant, beneficiary, or enrollee, provide
 24 to a participant, beneficiary, or enrollee in the plan or cov-

1 erage the following information, together with accurate
2 and complete information about the participant's, bene-
3 ficiary's, or enrollee's coverage under the applicable plan
4 or coverage:

5 “(1) As soon as practicable and not later than
6 2 business days after the participant, beneficiary, or
7 enrollee requests such information, a good faith esti-
8 mate of the expected participant, beneficiary, or en-
9 rollee cost-sharing for the provision of a particular
10 health care service (including any service that is rea-
11 sonably expected to be provided in conjunction with
12 such specific service).

13 “(2) As soon as practicable and not later than
14 2 business days after a participant, beneficiary, or
15 enrollee requests such information, the contact infor-
16 mation for any ancillary providers for a scheduled
17 health care service.”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 subsections (a) and (b) shall apply with respect to plan
20 years beginning on or after the date that is 18 months
21 after the date of enactment of this Act.

1 **SEC. 9. TRANSPARENCY REGARDING IN-NETWORK AND**
2 **OUT-OF-NETWORK DEDUCTIBLES AND OUT-**
3 **OF-POCKET LIMITATIONS.**

4 (a) PHSA.—Section 2719A of the Public Health
5 Service Act, as amended by section 2, is further amended
6 by adding at the end the following new subsection:

7 “(g) TRANSPARENCY REGARDING IN-NETWORK AND
8 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
9 LIMITATIONS.—

10 “(1) IN GENERAL.—A group health plan or a
11 health insurance issuer offering group or individual
12 health insurance coverage and providing or covering
13 any benefit with respect to items or services shall in-
14 clude, in clear writing, on any plan or insurance
15 identification card issued to enrollees in the plan or
16 coverage the amount of the in-network and out-of-
17 network deductibles and the in-network and out-of-
18 network out-of-pocket maximum limitation that
19 apply to such plan or coverage.

20 “(2) GUIDANCE.—The Secretary, in consulta-
21 tion with the Secretary of Labor and Secretary of
22 the Treasury, shall issue guidance to implement
23 paragraph (1).”.

24 (b) ERISA.—Section 716 of the Employee Retire-
25 ment Income Security Act of 1974, as added by section
26 2 and as amended by sections 3(c) and 7(b), is further

1 amended by adding at the end the following new sub-
2 section:

3 “(j) TRANSPARENCY REGARDING IN-NETWORK AND
4 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
5 LIMITATIONS.—

6 “(1) IN GENERAL.—A group health plan or a
7 health insurance issuer offering group health insur-
8 ance coverage and providing or covering any benefit
9 with respect to items or services shall include, in
10 clear writing, on any plan or insurance identification
11 card issued to participants or beneficiaries in the
12 plan or coverage the amount of the in-network and
13 out-of-network deductibles and the in-network and
14 out-of-network out-of-pocket maximum limitation
15 that apply to such plan or coverage.

16 “(2) GUIDANCE.—The Secretary, in consulta-
17 tion with the Secretary of Health and Human Serv-
18 ices and Secretary of the Treasury, shall issue guid-
19 ance to implement paragraph (1).”.

20 (c) IRC.—Section 9816 of the Internal Revenue Code
21 of 1986, as added by section 2, is further amended by
22 adding at the end the following new subsection:

23 “(h) TRANSPARENCY REGARDING IN-NETWORK AND
24 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
25 LIMITATIONS.—

1 “(1) IN GENERAL.—A group health plan pro-
2 viding or covering any benefit with respect to items
3 or services shall include, in clear writing, on any
4 plan or insurance identification card issued to par-
5 ticipants or beneficiaries in the plan the amount of
6 the in-network and out-of-network deductibles and
7 the in-network and out-of-network out-of-pocket
8 maximum limitation that apply to such plan.

9 “(2) GUIDANCE.—The Secretary, in consulta-
10 tion with the Secretary of Health and Human Serv-
11 ices and Secretary of Labor, shall issue guidance to
12 implement paragraph (1).”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this subsection shall apply with respect to plan years be-
15 ginning on or after January 1, 2022.

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