### 116TH CONGRESS 2D SESSION

# H. R. 8098

To address hospital consolidation and promote hospital price transparency, and for other purposes.

### IN THE HOUSE OF REPRESENTATIVES

August 25, 2020

Mr. Banks introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, 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 address hospital consolidation and promote hospital price transparency, and for other purposes.

- 1 Be it enacted by the Senate and House of Representa-
- 2 tives of the United States of America in Congress assembled,
- 3 SECTION 1. SHORT TITLE.
- 4 This Act may be cited as the "Hospital Competition
- 5 Act of 2020".
- 6 SEC. 2. HOSPITAL CONSOLIDATION.
- 7 (a) AUTHORIZATION OF APPROPRIATIONS.—There is
- 8 authorized to be appropriated \$160,000,000 to the Fed-
- 9 eral Trade Commission to hire staff to investigate, as con-

1	sistent with the Sherman Antitrust Act and other relevant
2	Federal laws, anti-competitive mergers and practices
3	under such laws to the extent such mergers and practices
4	relate to providers of inpatient and outpatient health care
5	services, as defined by the Secretary of Health and
6	Human Services.
7	(b) Medicare Advantage Rates Applied to Cer-
8	TAIN HHI HOSPITALS.—
9	(1) In General.—Section 1866(a) of the So-
10	cial Security Act (42 U.S.C. 1395cc(a)) is amend-
11	$\operatorname{ed}$ —
12	(A) in paragraph (1)—
13	(i) in subparagraph (X), by striking
14	"and" at the end;
15	(ii) in subparagraph (Y), by striking
16	the period at the end and inserting ";
17	and"; and
18	(iii) by inserting after subparagraph
19	(Y) the following new subparagraph:
20	"(Z) subject to paragraph (4), in the case
21	of a hospital located in a county whose popu-
22	lation density is above the median population
23	density for all counties in the United States
24	with respect to which there is a Herfindahl-
25	Hirschman Index (HHI) of greater than 4.000.

1	to apply the average reimbursement rate with
2	respect to individuals (regardless of whether
3	such an individual is entitled to or eligible for
4	benefits under this title, but excluding individ-
5	uals eligible for medical assistance under a
6	State plan under title XIX) furnished items and
7	services at such hospital that would be billable
8	under this title for such items and services if
9	furnished by such hospital to an individual en-
10	rolled under part C."; and
11	(B) by adding at the end the following new
12	paragraph:
13	"(4)(A) The requirement under paragraph
14	(1)(Z) shall not apply in the case of a hospital in a
15	hospital referral region if—
16	"(i) the HRR market share of such hos-
17	pital (as determined under subparagraph (B))
18	is less than 0.15; or
19	"(ii) the hospital is located in a rural area
20	(as defined in section $1886(d)(2)(D)$ );
21	"(B) For purposes of subparagraph (A), the
22	HRR market share of a hospital in a hospital refer-
23	ral region is equal to—
24	"(i) the total revenue of the hospital, di-
25	vided by

1	"(11) the total revenue of all hospital in the
2	hospital referral region.".
3	(2) Effective date.—The amendments made
4	by this subsection shall apply with respect to items
5	and services furnished on or after January 1, 2021.
6	(c) Grants for Hospital Infrastructure Im-
7	PROVEMENT.—
8	(1) IN GENERAL.—The Secretary of Health and
9	Human Services shall carry out a grant program
10	under which the Secretary shall provide grants to el-
11	igible States, in accordance with this subsection.
12	(2) Uses.—An eligible State receiving a grant
13	under this subsection may use such grant to improve
14	the State hospital infrastructure and to supplement
15	any other funds provided for a purpose authorized
16	under a State or local hospital grant programs
17	under State law.
18	(3) Eligibility.—
19	(A) In general.—An eligible State may
20	receive not more than one grant under this sub-
21	section with respect to each qualifying criterion
22	described in subparagraph (B) that is met by
23	the State.
24	(B) ELIGIBLE STATE.—For purposes of
25	this subsection, the term "eligible State" means

1	a State that meets any one or more of the fol-
2	lowing qualifying criteria:
3	(i) The State does not have in effect
4	any State certificate of need law that re-
5	quires a health care provider to provide to
6	a regulatory body a certification that the
7	community needs the services provided by
8	the health care provider.
9	(ii) The State has in effect State
10	scope of practice laws that—
11	(I) allow advanced practice pro-
12	viders (such as nurse practitioners,
13	advanced practice registered nurses,
14	clinical nurse specialists, and physi-
15	cian assistants) to evaluate patients;
16	diagnose, order, and interpret diag-
17	nostic tests; and initiate and manage
18	treatments; or
19	(II) provide that the only jus-
20	tification for limiting the scope of
21	practice of a health care provider is
22	safety to the public.
23	(iii) The State does not have in effect
24	any State laws that require managed care
25	plans to accept into the network of such

1	plan any qualified provider who is willing
2	to accept the terms and conditions of the
3	managed care plan.
4	(iv) The State does not have in effect
5	any Certificate of Public Advantage laws
6	that clearly articulate the State's intent to
7	displace competition in favor of regulation
8	or that violate State or Federal antitrus
9	laws.
10	(v) The State does not have in effect
11	any network adequacy laws regulating a
12	health plan's ability to deliver benefits by
13	providing reasonable access to a sufficient
14	number of in-network primary care and
15	specialty physicians, as well as all health
16	care services included under the terms of
17	an insuree's contract with a health insurer
18	(4) Funding.—There is authorized to be ap-
19	propriated to carry out this subsection
20	\$1,000,000,000 for each of the fiscal years 2021
21	through 2030. Funds appropriated under this para-
22	graph shall remain available until expended.
)3	(d) Critical Access Hospital Reimbursement

24 RATES.—

1	(1) Part A.—Section 1814(l)(1) of the Social
2	Security Act (42 U.S.C. 1395f(l)(1)) is amended by
3	inserting "(or, for 2021, 102, plus 1 percentage
4	point for each subsequent year through 2029, and
5	110 for each subsequent year thereafter)" after
6	"101".
7	(2) Part B.—Section 1834(g)(1) of such Act
8	(42 U.S.C. 1395m(g)(1)) is amended by inserting
9	"(or, for 2021, 102, plus 1 percentage point for each
10	subsequent year through 2029, and 110 for each
11	subsequent year thereafter)" after "101".
12	SEC. 3. PRICE TRANSPARENCY.
13	Section 1866 of the Social Security Act (42 U.S.C.
14	1395cc), as amended by section 401, is further amended—
15	(1) in subsection $(a)(1)$ —
16	(A) in subparagraph (Y), by striking
17	"and" at the end;
18	(B) in subparagraph (Z), by striking the
19	period at the end and inserting "; and"; and
20	(C) by inserting after subparagraph (Z)
21	the following new subparagraph:
22	"(AA) in the case of a hospital, to comply with
23	the requirement under subsection (l)."; and
24	(2) by adding at the end the following new sub-
25	section:

1	"(l) REQUIREMENT RELATING TO PUBLISHING CER-
2	TAIN HOSPITAL PRICES.—
3	"(1) In general.—For purposes of subsection
4	(a)(1)(AA), the requirement described in this sub-
5	section is, with respect to a hospital and year (begin-
6	ning with 2021), for the hospital to publicly post,
7	through the system established under paragraph (3),
8	for each commonly shoppable service included in the
9	list published under paragraph (2) for such year, the
10	volume-weighted average price charged by the hos-
11	pital to—
12	"(A) individuals enrolled during such year
13	in group health plans or health insurance cov-
14	erage offered in the individual or group market
15	(as such terms are defined in section 2791 of
16	the Public Health Service Act); and
17	"(B) individuals who are not enrolled in
18	any health insurance coverage or health benefits
19	plan and individuals who are enrolled in such
20	coverage or plan but such coverage or plan does
21	not provide benefits for the service.
22	"(2) Commonly shoppable services.—For
23	purposes of subsection (a)(1)(AA) and this sub-
24	section, the Secretary shall, for 2021 and each sub-
25	sequent year, publish a list of the 100 commonly

- 1 shoppable services that are the most highly utilized
- 2 in a hospital-based setting.
- 3 "(3) Standardized digital reporting sys-
- 4 TEM.—Not later than January 1, 2021, the Sec-
- 5 retary shall establish a standardized digital system
- 6 for purposes of paragraph (1).".

#### 7 SEC. 4. REPEALING ELIGIBILITY OF CERTAIN ACOS.

- 8 (a) In General.—Section 1899(b)(1) of the Social
- 9 Security Act (42 U.S.C. 1395jjj(b)(1)) is amended by
- 10 striking subparagraphs (C) through (E).
- 11 (b) Effective Date.—The amendment made by
- 12 subsection (a) shall take effect on January 1, 2021.
- 13 SEC. 5. OFF-CAMPUS PROVIDER-BASED DEPARTMENT
- 14 MEDICARE SITE NEUTRAL PAYMENT.
- 15 (a) In General.—Section 1834 of the Social Secu-
- 16 rity Act (42 U.S.C. 1395m) is amended by adding at the
- 17 end the following new subsection:
- 18 "(x) Off-Campus Provider-Based Department
- 19 SITE NEUTRAL PAYMENT.—
- 20 "(1) IN GENERAL.—With respect to items and
- 21 services furnished in an off-campus provider-based
- department, payment under this section for such
- items and services shall be the amount determined
- under the fee schedule under section 1848 for such

- 1 items and services furnished if furnished in a physi-
- 2 cian office setting.
- 3 "(2) Off-Campus provider-based depart-
- 4 MENT.—For purposes of this subsection, the term
- 5 'off-campus provider-based department' has such
- 6 meaning as specified by the Secretary.".
- 7 (b) Effective Date.—The amendment made by
- 8 subsection (a) shall apply with respect to items and serv-
- 9 ices furnished on or after January 1, 2021.
- 10 SEC. 6. REPEAL OF HEALTH CARE REFORM PROVISIONS
- 11 LIMITING MEDICARE EXCEPTION TO THE
- 12 PROHIBITION ON CERTAIN PHYSICIAN RE-
- 13 FERRALS FOR HOSPITALS.
- 14 Sections 6001 and 10601 of the Patient Protection
- 15 and Affordable Care Act (Public Law 111–148; 124 Stat.
- 16 684, 1005) and section 1106 of the Health Care and Edu-
- 17 cation Reconciliation Act of 2010 (Public Law 111–152;
- 18 124 Stat. 1049) are repealed and the provisions of law
- 19 amended by such sections are restored as if such sections
- 20 had never been enacted.
- 21 SEC. 7. ADVISORY GROUP ON REDUCING BURDEN OF HOS-
- 22 PITAL ADMINISTRATIVE REQUIREMENTS.
- 23 (a) IN GENERAL.—Not later than January 1, 2021,
- 24 the Secretary of Health and Human Services shall convene
- 25 an advisory group to provide, in accordance with this sec-

1	tion, recommendations on ways the Federal Government
2	could reduce the burden of administrative requirements on
3	hospitals.
4	(b) Recommendations.—Not later than January 1,
5	2022, the advisory board convened under this section
6	shall—
7	(1) submit to the Secretary of Health and
8	Human Services recommendations described under
9	subsection (a) for executive action and any rec-
10	ommendations for State actions for potential consid-
11	eration in making grants under section 2(c) to
12	States; and
13	(2) submit to Congress recommendations de-
14	scribed under subsection (a) for legislative proposals.
15	(c) Membership.—The advisory board under this
16	section shall consist of the following members:
17	(1) Three representatives of companies that
18	have—
19	(A) geographically distributed workforces;
20	(B) at least 10,000 employees; and
21	(C) no more than 10 percent of such em-
22	ployees in any single State.
23	(2) Three representatives of health insurance
24	issuers and health plans, consisting of—

1	(A) one representative of for-profit health
2	insurance issuers and health plans with at least
3	20,000,000 enrollees in the employer-sponsored
4	market;
5	(B) one representative of non-profit health
6	insurance issuers and health plans operating in
7	at least 5 States; and
8	(C) one representative of non-profit health
9	insurance issuers and health plans operating in
10	a rural State (as defined by the Census Bu-
11	reau).
12	(3) Seven public policy experts in the field of
13	hospital consolidation.
13 14	hospital consolidation.  SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION
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14	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION
<ul><li>14</li><li>15</li><li>16</li></ul>	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZA-
14 15 16 17	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZATIONS.
14 15 16 17	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZA-  TIONS.  Section 4 of the Federal Trade Commission Act (15)
14 15 16 17 18	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZA-  TIONS.  Section 4 of the Federal Trade Commission Act (15  U.S.C. 44) is amended, in the undesignated paragraph re-
14 15 16 17 18	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION OVER CERTAIN TAX-EXEMPT ORGANIZATIONS.  Section 4 of the Federal Trade Commission Act (15 U.S.C. 44) is amended, in the undesignated paragraph relating to the definition of the term "Corporation"—
14 15 16 17 18 19 20	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZA-  TIONS.  Section 4 of the Federal Trade Commission Act (15  U.S.C. 44) is amended, in the undesignated paragraph relating to the definition of the term "Corporation"—  (1) by striking ", and any" and inserting ",
14 15 16 17 18 19 20 21	SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION  OVER CERTAIN TAX-EXEMPT ORGANIZA-  TIONS.  Section 4 of the Federal Trade Commission Act (15  U.S.C. 44) is amended, in the undesignated paragraph relating to the definition of the term "Corporation"—  (1) by striking ", and any" and inserting ", any"; and

- that is exempt from taxation under section 501(a) of such Code".
- 3 SEC. 9. LEVELING THE PLAYING FIELD BETWEEN PRO-
- 4 VIDERS AND PAYERS.
- 5 (a) Exemption.—It shall not be a violation of the
- 6 antitrust laws for one or more private health insurer
- 7 issuers or their designated agents to jointly negotiate
- 8 prices of particular hospital services with a hospital pro-
- 9 vider with regards to the reimbursement policies of the
- 10 insurers for those services.
- 11 (b) Definitions.—For purposes of this section:
- 12 (1) Antitrust Laws.—The term "antitrust
- laws" has the meaning given it in subsection (a) of
- the 1st section of the Clayton Act (15 U.S.C. 12(a)),
- except that such term includes section 5 of the Fed-
- eral Trade Commission Act (15 U.S.C. 45) to the
- extent such section 5 applies to unfair methods of
- 18 competition.
- 19 (2) HEALTH INSURANCE ISSUER.—The term
- 20 "health insurance issuer" means an insurance com-
- 21 pany, insurance service, or insurance organization
- 22 (including a health maintenance organization, as de-
- fined in subparagraph (C)) which is licensed to en-
- gage in the business of insurance in a State and
- which is subject to State law which regulates insur-

1	ance (within the meaning of section 514(b)(2) of the
2	Employee Retirement Income Security Act of 1974
3	(29 U.S.C. 1144(b)(2)). Such term does not include
4	a group health plan.
5	(3) HEALTH MAINTENANCE ORGANIZATION.—
6	The term "health maintenance organization"
7	means—
8	(A) a federally qualified health mainte-
9	nance organization (as defined in section
10	300e(a) of title 42 of the Code of Federal Reg-
11	ulations),
12	(B) an organization recognized under State
13	law as a health maintenance organization, or
14	(C) a similar organization regulated under
15	State law for solvency in the same manner and
16	to the same extent as such a health mainte-
17	nance organization.
18	(c) Effective Date.—This section shall take effect
19	on the date of the enactment of this Act but shall not
20	apply with respect to conduct that occurs before such date.
21	SEC. 10. INCREASING TRANSPARENCY BY REMOVING GAG
22	CLAUSES ON PRICE AND QUALITY INFORMA-
23	TION.
24	Subpart II of part A of title XXVII of the Public
25	Health Service Act (42 U.S.C. 300gg–11 et seq.), as

1	amended by section 103, is amended by adding at the end
2	the following:
3	"SEC. 2729B. INCREASING TRANSPARENCY BY REMOVING
4	GAG CLAUSES ON PRICE AND QUALITY IN-
5	FORMATION.
6	"(a) Increasing Price and Quality Trans-
7	PARENCY FOR PLAN SPONSORS AND GROUP AND INDI-
8	VIDUAL MARKET AND CONSUMERS.—
9	"(1) Group Health Plans.—A group health
10	plan or health insurance issuer offering group health
11	insurance coverage may not enter into an agreement
12	with a health care provider, network or association
13	of providers, third-party administrator, or other
14	service provider offering access to a network of pro-
15	viders that would directly or indirectly restrict a
16	group health plan or health insurance issuer from—
17	"(A) providing provider-specific cost or
18	quality of care information, through a consumer
19	engagement tool or any other means, to refer-
20	ring providers, the plan sponsor, enrollees, or
21	eligible enrollees of the plan or coverage;
22	"(B) electronically accessing de-identified
23	claims and encounter data for each enrollee in
24	the plan or coverage, upon request and con-
25	sistent with the privacy regulations promul-

1	gated pursuant to section 264(c) of the Health
2	Insurance Portability and Accountability Act,
3	the amendments to this Act made by the Ge-
4	netic Information Nondiscrimination Act of
5	2008, and the Americans with Disabilities Act
6	of 1990, with respect to the applicable health
7	plan or health insurance coverage, including, on
8	a per claim basis—
9	"(i) financial information, such as the
10	allowed amount, or any other claim-related
11	financial obligations included in the pro-
12	vider contract;
13	"(ii) provider information, including
14	name and clinical designation;
15	"(iii) service codes; or
16	"(iv) any other data element normally
17	included in claim or encounter transactions
18	when received by a plan or issuer; or
19	"(C) sharing data described in subpara-
20	graph (A) or (B) with a business associate as
21	defined in section 160.103 of title 45, Code of
22	Federal Regulations (or successor regulations),
23	consistent with the privacy regulations promul-
24	gated pursuant to section 264(c) of the Health
25	Insurance Portability and Accountability Act.

the amendments to this Act made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

"(2) Individual health insurance coverage may not enter into vidual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

"(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or eligible enrollees of the plan or coverage; or

"(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health

- Insurance Portability and Accountability Act,
  the amendments to this Act made by the Genetic Information Nondiscrimination Act of
  2008, and the Americans with Disabilities Act
  of 1990.
  - "(3) CLARIFICATION REGARDING PUBLIC DIS-CLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).
  - "(4) Attestation.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall annually submit to, as applicable, the applicable authority described in section 2723 or the Secretary of Labor, an attestation that such plan or issuer is in compliance with the requirements of this subsection.
  - "(5) Rule of construction.—Nothing in this section shall be construed to otherwise limit group health plan, plan sponsor, or health insurance issuer access to data currently permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Ac-

1	countability Act, the amendments to this Act made
2	by the Genetic Information Nondiscrimination Act of
3	2008, and the Americans with Disabilities Act of
4	1990.''.
5	SEC. 11. BANNING ANTICOMPETITIVE TERMS IN FACILITY
6	AND INSURANCE CONTRACTS THAT LIMIT AC-
7	CESS TO HIGHER QUALITY, LOWER COST
8	CARE.
9	(a) In General.—Section 2729B of the Public
10	Health Service Act, as added by section 301, is amended
11	by adding at the end the following:
12	"(b) Protecting Health Plans Network De-
13	SIGN FLEXIBILITY.—
14	"(1) IN GENERAL.—A group health plan or a
15	health insurance issuer offering group or individual
16	health insurance coverage shall not enter into an
17	agreement with a provider, network or association of
18	providers, or other service provider offering access to
19	a network of service providers if such agreement, di-
20	rectly or indirectly—
21	"(A) restricts the group health plan or
22	health insurance issuer from—
23	"(i) directing or steering enrollees to
24	other health care providers: or

1	"(ii) offering incentives to encourage
2	enrollees to utilize specific health care pro-
3	viders; or
4	"(B) requires the group health plan or
5	health insurance issuer to enter into any addi-
6	tional contract with an affiliate of the provider,
7	such as an affiliate of the provider, as a condi-
8	tion of entering into a contract with such pro-
9	vider;
10	"(C) requires the group health plan or
11	health insurance issuer to agree to payment
12	rates or other terms for any affiliate not party
13	to the contract of the provider involved; or
14	"(D) restricts other group health plans or
15	health insurance issuers not party to the con-
16	tract from paying a lower rate for items or
17	services than the contracting plan or issuer
18	pays for such items or services.
19	"(2) Additional requirement for self-in-
20	SURED PLANS.—A self-insured group health plan
21	shall not enter into an agreement with a provider,
22	network or association of providers, third-party ad-
23	ministrator, or other service provider offering access
24	to a network of providers if such agreement directly

or indirectly requires the group health plan to cer-

tify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

"(3) Exception for Certain Group Model Issuers.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to—

"(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multispecialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

"(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a provider sponsored health insurance issuer that operates primarily through aligned multi-specialty physician group practices or integrated health systems, or such other similar network

- 1 arrangements as determined by the Secretary
- 2 through rulemaking.
- 3 "(4) Attestation.—A group health plan or
- 4 health insurance issuer offering group or individual
- 5 health insurance coverage shall annually submit to,
- 6 as applicable, the applicable authority described in
- 7 section 2723 or the Secretary of Labor, an attesta-
- 8 tion that such plan or issuer is in compliance with
- 9 the requirements of this subsection.
- 10 "(c) Maintenance of Existing HIPAA, GINA,
- 11 AND ADA PROTECTIONS.—Nothing in this section shall
- 12 modify, reduce, or eliminate the existing privacy protec-
- 13 tions and standards provided by reason of State and Fed-
- 14 eral law, including the requirements of parts 160 and 164
- 15 of title 45, Code of Federal Regulations (or any successor
- 16 regulations).
- 17 "(d) Regulations.—The Secretary, not later than
- 18 1 year after the date of enactment of the Hospital Com-
- 19 petition Act of 2020, shall promulgate regulations to carry
- 20 out this section.
- 21 "(e) Rule of Construction.—Nothing in this sec-
- 22 tion shall be construed to limit network design or cost or
- 23 quality initiatives by a group health plan or health insur-
- 24 ance issuer, including accountable care organizations, ex-
- 25 clusive provider organizations, networks that tier providers

- 1 by cost or quality or steer enrollees to centers of excel-
- 2 lence, or other pay-for-performance programs.
- 3 "(f) Clarification With Respect to Antitrust
- 4 Laws.—Compliance with this section does not constitute
- 5 compliance with the antitrust laws, as defined in sub-
- 6 section (a) of the first section of the Clayton Act (15
- 7 U.S.C. 12(a)).".
- 8 (b) Effective Date.—Section 2729B of the Public
- 9 Health Service Act (as added by section 301 and amended
- 10 by subsection (a)) shall apply with respect to any contract
- 11 entered into on or after the date that is 18 months after
- 12 the date of enactment of this Act. With respect to an ap-
- 13 plicable contract that is in effect on the date of enactment
- 14 of this Act, such section 2729B shall apply on the earlier
- 15 of the date of renewal of such contract or 3 years after
- 16 such date of enactment.
- 17 SEC. 12. DESIGNATION OF A NONGOVERNMENTAL, NON-
- 18 PROFIT TRANSPARENCY ORGANIZATION TO
- 19 LOWER AMERICANS' HEALTH CARE COSTS.
- 20 (a) IN GENERAL.—Subpart C of title XXVII of the
- 21 Public Health Service Act (42 U.S.C. 300gg-91 et seq.),
- 22 as amended by section 102, is further amended by adding
- 23 at the end the following:

1	"SEC. 2796. DESIGNATION OF A NONGOVERNMENTAL, NON-
2	PROFIT TRANSPARENCY ORGANIZATION TO
3	LOWER AMERICANS' HEALTH CARE COSTS.
4	"(a) In General.—The Secretary, in consultation
5	with the Secretary of Labor, not later than 1 year after
6	the date of enactment of the Hospital Competition Act of
7	2020, shall enter into contracts with at least 2 nonprofit
8	entities to support the establishment and maintenance of
9	a database that receives and utilizes health care claims
10	information and related information and issues reports
11	that are available to the public and authorized users, and
12	are submitted to the Department of Health and Human
13	Services.
14	"(b) Requirements.—
15	"(1) In general.—The database established
16	under subsection (a) shall—
17	"(A) improve transparency by using de-
18	identified health care data to—
19	"(i) inform patients about the cost,
20	quality, and value of their care;
21	"(ii) assist providers and hospitals, as
22	they work with patients, to make informed
23	choices about care;
24	"(iii) enable providers, hospitals, and
25	communities to improve services and out-
26	comes for patients by benchmarking their

1	performance against that of other pro-
2	viders, hospitals, and communities;
3	"(iv) enable purchasers, including em-
4	ployers, employee organizations, and health
5	plans, to develop value-based purchasing
6	models, improve quality, and reduce the
7	cost of health care and insurance coverage
8	for enrollees;
9	"(v) enable employers and employee
10	organizations to evaluate network design
11	and construction, and the cost of care for
12	enrollees;
13	"(vi) facilitate State-led initiatives to
14	lower health care costs and improve qual-
15	ity; and
16	"(vii) promote competition based on
17	quality and cost;
18	"(B) collect medical claims, prescription
19	drug claims, and remittance data consistent
20	with the protections and requirements of sub-
21	section (d);
22	"(C) be established in such a manner that
23	allows the data collected pursuant to subpara-
24	graph (B) to be shared with any State all-payer
25	claims database or regional database operated

1	with authorization from States, at cost, using a
2	standardized format, if such State or regional
3	database also submits claims data to the data-
4	base established under this section; and
5	"(D) be available to—
6	"(i) the Director of the Congressional
7	Budget Office, the Comptroller General of
8	the United States, the Executive Director
9	of the Medicare Payment Advisory Com-
10	mission, and the Executive Director of the
11	Medicaid and CHIP Payment Advisory
12	Commission, upon request, subject to the
13	privacy and security requirements of au-
14	thorized users under subsection (e)(2); and
15	"(ii) authorized users, including em-
16	ployers, employee organizations, providers,
17	group health plans, health insurance
18	issuers, researchers, and policymakers,
19	subject to subsection (e).
20	"(2) Privacy and Security; Breach notifi-
21	CATIONS.—
22	"(A) REGULATIONS.—
23	"(i) In General.—The Secretary
24	shall issue regulations prescribing the ex-
25	tent to which, and the manner in which,

1	the following rules (and any successors of
2	such rules) shall apply to the activities
3	under this section of an entity receiving a
4	contract under subsection (a):
5	"(I) The Privacy Rule under part
6	160 and subparts A and E of part
7	164 of title 45, Code of Federal Regu-
8	lations (or any successor regulations).
9	"(II) The Security Rule under
10	part 160 and subparts A and C of
11	part 164 of such title 45 (or any suc-
12	cessor regulations).
13	"(III) The Breach Notification
14	Rule under part 160 and subparts A
15	and D of part 164 of such title 45 (or
16	any successor regulations).
17	"(ii) Supplemental regula-
18	Tions.—In order to ensure data privacy
19	and security and the notification of
20	breaches, the Secretary may issue such
21	supplemental regulations on the subjects of
22	the rules listed under clause (i) as the Sec-
23	retary determines appropriate to address
24	differences between the activities described

1	by this section and the activities covered by
2	such rules.
3	"(B) Enforcement.—Section 1176 of
4	Social Security Act shall apply with respect to
5	a violation of this paragraph in the same man-
6	ner such section 1176 applies to a violation of
7	part C of title XI of the Social Security Act,
8	and the Secretary may include in the regula-
9	tions promulgated under this section provisions
10	to apply such section to this paragraph.
11	"(C) Procedure.—
12	"(i) TIMING.—The Secretary shall
13	issue the initial set of regulations under
14	this paragraph not later than 1 year after
15	the date of enactment of the Hospital
16	Competition Act of 2020.
17	"(ii) Authority to use interim
18	FINAL PROCEDURES.—The Secretary may
19	make such initial set of regulations effec-
20	tive and final immediately upon issuance,
21	on an interim basis, and provide for a pe-
22	riod of public comment on such initial set

of regulations after the date of publication.

1	"(D) REQUIREMENTS OF ENTITY.—An en-
2	tity receiving the contract under this section
3	shall—
4	"(i) not disclose to the public any in-
5	dividually identifiable health information;
6	"(ii) strictly limit staff access to the
7	data to staff with appropriate training,
8	clearance, and background checks and re-
9	quire regular privacy and security training;
10	"(iii) maintain effective security
11	standards for transferring data or making
12	data available to authorized users;
13	"(iv) develop a process for providing
14	access to data to authorized users, in a se-
15	cure manner that maintains privacy and
16	confidentiality of data; and
17	"(v) adhere to current best security
18	practices with respect to the management
19	and use of such data for health services re-
20	search, in accordance with applicable Fed-
21	eral privacy law.
22	"(3) Consultation.—
23	"(A) Advisory committee.—Not later
24	than 180 days after the date of enactment of
25	the Hospital Competition Act of 2020, the Sec-

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retary shall convene an Advisory Committee (referred to in this section as the 'Committee'), consisting of 13 members, to advise the Secretary, a contracting entity, and Congress on the establishment, operations, and use of the database established under this section.

### "(B) Membership.—

"(i) Appointment.—In accordance with clause (ii), the Secretary, in consultation with the Secretary of Labor and the Comptroller General of the United States shall, not later than 180 days after the date of enactment of the Hospital Competition Act of 2020, appoint members to the Committee who have distinguished themselves in the fields of health services health economics, research, health informatics, or the governance of State allpayer claims databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, or third-party administrators of group health

1	plans. Such members shall serve 3-year
2	terms on a staggered basis. Vacancies on
3	the Committee shall be filled by appoint-
4	ment consistent with this subsection not
5	later than 3 months after the vacancy
6	arises.
7	"(ii) Composition.—In accordance
8	with clause (i)—
9	"(I) the Secretary, in consulta-
10	tion with the Secretary of Labor, shall
11	appoint to the Committee—
12	"(aa) 1 member selected by
13	the Secretary, in coordination
14	with the Secretary of Labor, to
15	serve as the chair of the Com-
16	mittee;
17	"(bb) the Assistant Sec-
18	retary for Planning and Evalua-
19	tion of the Department of Health
20	and Human Services, or a des-
21	ignee of such Assistant Sec-
22	retary;
23	"(cc) 1 representative of the
24	Centers for Medicare & Medicaid
25	Services;

1	"(dd) 1 representative of the
2	Agency for Health Research and
3	Quality;
4	"(ee) 1 representative of the
5	Office for Civil Rights of the De-
6	partment of Health and Human
7	Services with expertise in data
8	privacy and security;
9	"(ff) 1 representative of the
10	National Center for Health Sta-
11	tistics; and
12	"(gg) 1 representative of the
13	Employee Benefits and Security
14	Administration of the Depart-
15	ment of Labor; and
16	"(II) the Comptroller General of
17	the United States shall appoint to the
18	Committee—
19	"(aa) 1 representative of an
20	employer that sponsors a group
21	health plan;
22	"(bb) 1 representative of an
23	employee organization that spon-
24	sors a group health plan;

1	"(cc) 1 academic researcher
2	with expertise in health econom-
3	ics or health services research;
4	"(dd) 1 consumer advocate;
5	and
6	"(ee) 2 additional members.
7	"(C) Duties.—The Committee shall—
8	"(i) advise the Secretary on the man-
9	agement of the contract under subsection
10	(a);
11	"(ii) assist and advise the entities re-
12	ceiving the contract under subsection (a) in
13	establishing—
14	"(I) the scope and format of the
15	data to be submitted under subsection
16	(d);
17	"(II) best practices with respect
18	to de-identification of data, as appro-
19	priate;
20	"(III) the appropriate uses of
21	data by authorized users, including
22	developing standards for the approval
23	of requests by organizations to access
24	and use the data; and

1	"(IV) the appropriate formats
2	and methods for making reports and
3	analyses based on the database to the
4	public;
5	"(iii) conduct an annual review of
6	whether data was used according to the
7	appropriate uses as described in clause
8	(ii)(II), and advise the designated entities
9	on using the data for authorized purposes;
10	"(iv) report, as appropriate, to the
11	Secretary and Congress on the operation of
12	the database and opportunities to better
13	achieve the objectives of this section;
14	"(v) establish additional restrictions
15	on researchers who receive compensation
16	from entities described in subsection
17	(e)(2)(B)(ii), in order to protect individ-
18	ually identifiable health information; and
19	"(vi) establish objectives for research
20	and public reporting.
21	"(4) State requirements.—A State may re-
22	quire health insurance issuers and other payers to
23	submit claims data to the database established
24	under this section, provided that such data is sub-
25	mitted to the entities awarded contracts under this

1	section in a form and manner established by the
2	Secretary, and pursuant to subsection (d)(4)(B).
3	"(5) Sanctions.—The Secretary shall take ap-
4	propriate action to sanction users who attempt to re-
5	identify data accessed pursuant to paragraph
6	(1)(D).
7	"(c) Contract Requirements.—
8	"(1) Competitive procedures.—The Sec-
9	retary shall enter into the contract under subsection
10	(a) using full and open competition procedures pur-
11	suant to chapter 33 of title 41, United States Code
12	"(2) Eligible entities.—To be eligible to
13	enter into a contract described in subsection (a), an
14	entity shall—
15	"(A) be a private nonprofit entity governed
16	by a board that includes representatives of the
17	academic research community and individuals
18	with expertise in employer-sponsored insurance
19	research using health care claims data and ac-
20	tuarial analysis;
21	"(B) conduct its business in an open and
22	transparent manner that provides the oppor-
23	tunity for public comment on its activities: and

1	"(C) agree to comply with any require-
2	ments imposed under the rulemaking described
3	in subsection $(d)(4)(A)$ .
4	"(3) Considerations.—In awarding a con-
5	tract under subsection (a), the Secretary shall con-
6	sider an entity's experience in—
7	"(A) health care claims data collection, ag-
8	gregation, quality assurance, analysis, and secu-
9	rity;
10	"(B) supporting academic research on
11	health costs, spending, and utilization for and
12	by privately insured patients;
13	"(C) working with large health insurance
14	issuers and third-party administrators to as-
15	semble a national claims database;
16	"(D) effectively collaborating with and en-
17	gaging stakeholders to develop reports;
18	"(E) meeting budgets and timelines, in-
19	cluding in connection with report generation
20	and
21	"(F) facilitating the creation of, or sup-
22	porting, State all-payer claims databases.
23	"(4) Contract term.—A contract awarded
24	under this section shall be for a period of 5 years

and may be renewed after a subsequent competitive
bidding process under this section.

"(5) Transition of contract.—If the Secretary, following a competitive process at the end of the contract period, selects a new entity to maintain the database, all data shall be transferred to the new entity according to a schedule and process to be determined by the Secretary. Upon termination of a contract, no entity may keep data held by the database or disclose such data to any entity other than the entity so designated by the Secretary. The Secretary shall include enforcement terms in any contract with an organization chosen under this section, to ensure the timely transfer of all data, and any associated code or algorithms, to a new entity in the event of contract termination.

# "(d) RECEIVING HEALTH INFORMATION.—

# "(1) REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary of Labor shall ensure that the applicable self-insured group health plan, through its third-party administrator, pharmacy benefit manager, or other entity designated by the group health plan, as applicable, electronically submits all

1	claims data with respect to the plan, pursuant
2	to subparagraph (B).
3	"(B) Scope of information and for-
4	MAT OF SUBMISSION.—An entity awarded the
5	contract under subsection (a), in consultation
6	with the Committee described in subsection
7	(b)(3), and pursuant to the privacy and security
8	requirements of subsection (b)(2), shall—
9	"(i) specify the data elements required
10	to be submitted under subparagraph (A),
11	which shall include all data related to
12	transactions described in subparagraphs
13	(A) and (E) of section $1173(a)(2)$ of the
14	Social Security Act, including all data ele-
15	ments normally present in such trans-
16	actions when adjudicated, and enrollment
17	information;
18	"(ii) specify the form and manner for
19	such submissions, and the historical period
20	to be included in the initial submission;
21	and
22	"(iii) offer an automated submission
23	option to minimize administrative burdens
24	for entities required to submit data.

1	"(C) De-Identification of data.—An
2	entity awarded the contract under subsection
3	(a) shall—
4	"(i) establish a process under which
5	data is de-identified consistent with the de-
6	identification requirements under section
7	164.514 of title 45, Code of Federal Regu-
8	lations (or any successor regulations),
9	while retaining the ability to link data lon-
10	gitudinally for the purposes of research on
11	cost and quality, and the ability to com-
12	plete risk adjustment and geographic anal-
13	ysis;
14	"(ii) ensure that any third-party sub-
15	contractors who perform the de-identifica-
16	tion process described in clause (i) retain
17	only the minimum necessary information
18	to perform such a process, and adhere to
19	effective security and encryption practices
20	in data storage and transmission;
21	"(iii) store claims and other data col-
22	lected under this subsection only in de-
23	identified form, in accordance with section
24	164.514 of title 45, Code of Federal Regu-
25	lations (or any successor regulations): and

1	"(iv) ensure that individually identifi-
2	able data is encrypted, in accordance with
3	guidance issued by the Secretary under
4	section 13402(h)(2) of the HITECH Act.
5	"(2) Applicable self-insured group
6	HEALTH PLAN.—For purposes of paragraph (1), a
7	self-insured group health plan is an applicable self-
8	insured group health plan if such plan is self-admin-
9	istered, or is administered by a third-party plan ad-
10	ministrator that meets 1 or both of the following cri-
11	teria:
12	"(A) Administers health, medical, or phar-
13	macy benefits for more than 50,000 enrollees.
14	"(B) Is one of the 5 largest administrators
15	or issuers of self-insured group health plans in
16	a State in which such administrator operates,
17	as measured by the aggregate number of enroll-
18	ees in plans administered by such administrator
19	in such State, as determined by the Secretary.
20	"(3) Third-party administrators.—In the
21	case of a third-party administrator that is required
22	under this subsection to submit claims data with re-
23	spect to an applicable self-insured group health plan,
24	such administrator shall submit claims data with re-
25	spect to all self-insured group health plans that the

1 administrator administers, including such plans that 2 are not applicable self-insured group health plans, as 3 described in paragraph (2). "(4) Receiving other information.— 4 "(A) MEDICARE DATA.—The Secretary, 5 6 through rulemaking, shall ensure that the data made available to such entity is available to 7 8 qualified entities under section 1874(e) of the 9 Social Security Act is made available to each 10 entity awarded a contract under subsection (a). 11 "(B) State data.—An entity awarded a 12 contract under subsection (a) shall collect data 13 from State all payer claims databases that seek 14 access to the database established under this 15 section. "(5) AVAILABILITY OF DATA.—An entity re-16 17 quired to submit data under this subsection may not 18 place any restrictions on the use of such data by au-19 thorized users. 20 "(e) Uses of Information.— "(1) IN GENERAL.—An entity awarded a con-21 22 tract under subsection (a) shall make the database 23 available to users who are authorized under this sub-

section, without charge, and reports and analyses

1	based on the data available to the public with no
2	charge.
3	"(2) Authorization of users.—
4	"(A) In general.—An entity may request
5	authorization by an entity awarded a contract
6	under subsection (a) for access to the database
7	in accordance with this paragraph.
8	"(B) Application.—An entity desiring
9	authorization under this paragraph shall submit
10	to an entity awarded a contract an application
11	for such access, which shall include—
12	"(i) in the case of an entity requesting
13	access for research purposes—
14	"(I) a description of the uses and
15	methodologies for evaluating health
16	system performance using such data;
17	and
18	$"(\Pi)$ documentation of approval
19	of the research by an institutional re-
20	view board, if applicable for a par-
21	ticular plan of research; or
22	"(ii) in the case of an entity such as
23	an employer, health insurance issuer,
24	third-party administrator, or health care
25	provider, requesting access for the purpose

of quality improvement or cost-containment, a description of the intended uses for such data.

#### "(C) REQUIREMENTS.—

"(i) Research.—Upon approval of an application for research purposes under subparagraph (B)(i), the authorized user shall enter into a data use and confidentiality agreement with an entity awarded a contract under subsection (a), which shall include a prohibition on attempts to reidentify and disclose individually identifiable health information.

"(ii) QUALITY IMPROVEMENT AND COST-CONTAINMENT.—In consultation with the Committee described in subsection (b)(3), the Secretary shall, through rule-making, establish the form and manner in which authorized users described in subparagraph (B)(ii) may access data. Data provided to such authorized users shall be provided in a form and manner such that users may not obtain individually identifiable price information with respect to direct competitors. Upon approval, such au-

1 thorized user shall enter into a data use 2 and confidentiality agreement with the en-3 tity. "(iii) 4 Customized reports.—Employers and employer organizations may 6 request customized reports from an entity 7 awarded a contract under subsection (a). 8 at cost, subject to the requirements of this 9 section with respect to privacy and secu-10 rity. 11 "(iv) Non-customized reports.— 12 An entity awarded a contract under sub-13 section (a), in consultation with the Com-14 mittee, shall make available to all author-15 ized users aggregate data sets, free of 16 charge. 17 "(f) Funding.— 18 "(1) Initial funding.—There are authorized 19 to be appropriated, and there are appropriated, out 20 of monies in the Treasury not otherwise appro-21 priated, \$20,000,000 for fiscal year 2020, for the 22 implementation of the initial contract and establish-23 ment of the database under this section. "(2) Ongoing funding.—There are author-24

ized to be appropriated \$15,000,000 for each of fis-

1	cal years 2021 through 2025, for purposes of car-
2	rying out this section (other than the grant program
3	under subsection (h)).
4	"(g) Annual Report.—
5	"(1) Submission.—On each of the dates de-
6	scribed in paragraph (2), an entity receiving a con-
7	tract under subsection (a) shall submit to Congress,
8	the Secretary of Health and Human Services, and
9	the Secretary of Labor and publish online for access
10	by the general public, a report containing a descrip-
11	tion of—
12	"(A) trends in the price, utilization, and
13	total spending on health care services, including
14	a geographic analysis of differences in such
15	trends;
16	"(B) limitations in the data set;
17	"(C) progress towards the objectives of
18	this section; and
19	"(D) the performance by the entity of the
20	duties required under such contract.
21	"(2) Dates described.—The reports de-
22	scribed in paragraph (1) shall be submitted—
23	"(A) not later than 3 years after the date
24	of enactment of the Hospital Competition Act
25	of 2020:

1 "(B) the later of 1 year after the date that 2 is 3 years after such date of enactment or 3 March 1 of the year after the date that is 3 4 years after such date of enactment; and 5 "(C) March 1 of each year thereafter. 6 "(3) Public reports and research.—An 7 entity receiving a contract under subsection (a) 8 shall, in coordination with authorized users, make 9 analyses and research available to the public on an 10 ongoing basis to promote the objectives of this sec-11 tion. 12 "(h) Grants to States.— 13 "(1) IN GENERAL.—The Secretary, in consulta-14 tion with the Secretary of Labor, may award grants 15 to States for the purpose of establishing and main-16 taining State all-payer claims databases that im-17 prove transparency of data in order to meet the 18 goals of subsection (a)(1). "(2) REQUIREMENT.—To be eligible to receive 19 20 the funding under paragraph (1), a State shall sub-21 mit data to the database as described in subsection 22 (b)(1)(C), using the format described in subsection 23 (d)(1). 24 "(3) Funding.—There is authorized to be ap-25 propriated \$100,000,000 for the period of fiscal

- years 2020 through 2029 for the purpose of awarding grants to States under this subsection.
- 3 "(i) Exemption From Public Disclosure.—
- "(1) IN GENERAL.—Claims data provided to the database, and the database itself shall not be considered public records and shall be exempt from public disclosure requirements.
- 8 "(2) RESTRICTIONS ON USES FOR CERTAIN
  9 PROCEEDINGS.—Data disclosed to authorized users
  10 shall not be subject to discovery or admission as
  11 public information, or evidence in judicial or admin12 istrative proceedings without consent of the affected
  13 parties.
- 14 "(j) Individually Identifiable Health Infor-15 Mation Defined.—The term 'individually identifiable 16 health information' has the meaning given such term in
- 17 section 1171(6) of the Social Security Act.
- 18 "(k) Rule of Construction.—Nothing in this sec-
- 19 tion shall be construed to affect or modify enforcement
- 20 of the privacy, security, or breach notification rules pro-
- 21 mulgated under section 264(c) of the Health Insurance
- 22 Portability and Accountability Act of 1996 (or successor
- 23 regulations).".
- 24 (b) GAO REPORT.—

1	(1) IN GENERAL.—The Comptroller General of
2	the United States shall conduct a study on—
3	(A) the performance of the entity awarded
4	a contract under section 2795(a) of the Public
5	Health Service Act, as added by subsection (a)
6	under such contract;
7	(B) the privacy and security of the infor-
8	mation reported to the entity; and
9	(C) the costs incurred by such entity in
10	performing such duties.
11	(2) Reports.—Not later than 2 years after the
12	effective date of the first contract entered into under
13	section 2795(a) of the Public Health Service Act, as
14	added by subsection (a), and again not later than 4
15	years after such effective date, the Comptroller Gen-
16	eral of the United States shall submit to Congress
17	a report containing the results of the study con-
18	ducted under paragraph (1), together with rec-
19	ommendations for such legislation and administra-
20	tive action as the Comptroller General determines
21	appropriate.

1	SEC. 13. PROTECTING PATIENTS AND IMPROVING THE AC-
2	CURACY OF PROVIDER DIRECTORY INFOR-
3	MATION.
4	(a) In General.—Subpart II of part A of title
5	XXVII of the Public Health Service Act (42 U.S.C.
6	300gg-11 et seq.), as amended by sections 301 and 302,
7	is further amended by adding at the end the following:
8	"SEC. 2729C. PROTECTING PATIENTS AND IMPROVING THE
9	ACCURACY OF PROVIDER DIRECTORY INFOR-
10	MATION.
11	"(a) Network Status of Providers.—
12	"(1) In general.—Beginning on the date that
13	is one year after the date of enactment of this sec-
14	tion, a group health plan or a health insurance
15	issuer offering group or individual health insurance
16	coverage shall—
17	"(A) establish business processes to ensure
18	that all enrollees in such plan or coverage re-
19	ceive proof of a health care provider's network
20	status, based on what a plan or issuer knows or
21	could reasonably know—
22	"(i) through a written electronic com-
23	munication from the plan or issuer to the
24	enrollee, as soon as practicable and not
25	later than 1 business day after a telephone

1	inquiry is made by such enrollee for such
2	information;
3	"(ii) through an oral confirmation,
4	documented by such issuer or coverage,
5	and kept in the enrollee's file for a min-
6	imum of 2 years; and
7	"(iii) in real-time through an online
8	health care provider directory search tool
9	maintained by the plan or issuer; and
10	"(B) include in any print directory a dis-
11	closure that the information included in the di-
12	rectory is accurate as of the date of the last
13	data update and that enrollees or prospective
14	enrollees should consult the group health plan
15	or issuer's electronic provider directory on its
16	website or call a specified customer service tele-
17	phone number to obtain the most current pro-
18	vider directory information.
19	"(2) Group Health Plan and Health in-
20	SURANCE ISSUER BUSINESS PROCESSES.—Beginning
21	on the date that is one year after the date of enact-
22	ment of the Hospital Competition Act of 2020, a
23	group health plan or a health insurance issuer offer-
24	ing group or individual health insurance coverage
25	shall establish business processes to—

"(A) verify and update, at least once every 90 days, the provider directory information for all providers included in the online health care provider directory search tool described in paragraph (1)(A)(iii); and

"(B) remove any provider from such online directory search tool if such provider has not verified the directory information within the previous 6 months or the plan or issuer has been unable to verify the provider's network participation.

## "(b) Cost-Sharing Limitations.—

"(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not apply, and shall ensure that no provider applies cost-sharing to an enrollee for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for in-network care (including any balance bill issued by the health care provider involved), if such enrollee, or health care provider referring such enrollee, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i), the oral confirmation described in subsection (a)(1)(A)(ii), or a copy of the online

- in 1 provider directory described subsection 2 (a)(1)(A)(iii) on the date the enrollee attempted to obtain the provider's network status) that the en-3 rollee relied on the information described in sub-5 section (a)(1), if the provider's network status or di-6 rectory information on such directory was incorrect 7 at the time the treatment or services involved was 8 provided.
- 9 "(2) Refunds to enrollees.—If a health 10 care provider submits a bill to an enrollee in viola-11 tion of paragraph (1), and the enrollee pays such 12 bill, the provider shall reimburse the enrollee for the 13 full amount paid by the enrollee in excess of the in-14 network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate 15 16 determined by the Secretary.
- "(c) Provider Business Processes.—A health 18 care provider shall have in place business processes to en-19 sure the timely provision of provider directory information 20 to a group health plan or a health insurance issuer offer-21 ing group or individual health insurance coverage to sup-22 port compliance by such plans or issuers with subsection 23 (a)(1). Such providers shall submit provider directory in-

formation to a plan or issuers, at a minimum—

- 1 "(1) when the provider begins a network agree-2 ment with a plan or with an issuer with respect to 3 certain coverage;
  - "(2) when the provider terminates a network agreement with a plan or with an issuer with respect to certain coverage;
  - "(3) when there are material changes to the content of provider directory information described in subsection (a)(1); and
  - "(4) every 90 days throughout the duration of the network agreement with a plan or issuer.

## 12 "(d) Enforcement.—

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- "(1) IN GENERAL.—Subject to paragraph (2), a health care provider that violates a requirement under subsection (c) or takes actions that prevent a group health plan or health insurance issuer from complying with subsection (a)(1) or (b) shall be subject to a civil monetary penalty of not more than \$10,000 for each act constituting such violation.
- "(2) SAFE HARBOR.—The Secretary may waive the penalty described under paragraph (1) with respect to a health care provider that unknowingly violates subsection (b)(1) with respect to an enrollee if such provider rescinds the bill involved and, if applicable, reimburses the enrollee within 30 days of the

- date on which the provider billed the enrollee in violation of such subsection.
- 3 "(3) PROCEDURE.—The provisions of section 4 1128A of the Social Security Act, other than sub-
- 5 sections (a) and (b) and the first sentence of sub-
- 6 section (c)(1) of such section, shall apply to civil
- 7 money penalties under this subsection in the same
- 8 manner as such provisions apply to a penalty or pro-
- 9 ceeding under section 1128A of the Social Security
- 10 Act.
- 11 "(e) SAVINGS CLAUSE.—Nothing in this section shall
- 12 prohibit a provider from requiring in the terms of a con-
- 13 tract, or contract termination, with a group health plan
- 14 or health insurance issuer—
- 15 "(1) that the plan or issuer remove, at the time
- of termination of such contract, the provider from a
- directory of the plan or issuer described in sub-
- 18 section (a)(1); or
- 19 "(2) that the plan or issuer bear financial re-
- sponsibility, including under subsection (b), for pro-
- viding inaccurate network status information to an
- enrollee.
- 23 "(f) Definition.—For purposes of this section, the
- 24 term 'provider directory information' includes the names,
- 25 addresses, specialty, and telephone numbers of individual

- 1 health care providers, and the names, addresses, and tele-
- 2 phone numbers of each medical group, clinic, or facility
- 3 contracted to participate in any of the networks of the
- 4 group health plan or health insurance coverage involved.
- 5 "(g) Rule of Construction.—Nothing in this sec-
- 6 tion shall be construed to preempt any provision of State
- 7 law relating to health care provider directories or network
- 8 adequacy.".
- 9 (b) Effective Date.—Section 2729C of the Public
- 10 Health Service Act, as added by subsection (a), shall take
- 11 effect with respect to plan years beginning on or after the
- 12 date that is 18 months after the date of enactment of this
- 13 Act.
- 14 SEC. 14. TIMELY BILLS FOR PATIENTS.
- 15 (a) IN GENERAL.—
- 16 (1) AMENDMENT.—Part P of title III of the
- 17 Public Health Service Act (42 U.S.C. 280g et seq.)
- is amended by adding at the end the following:
- 19 "SEC. 399V-7. TIMELY BILLS FOR PATIENTS.
- 20 "(a) IN GENERAL.—The Secretary shall require—
- 21 "(1) health care facilities, or in the case of
- 22 practitioners providing services outside of such a fa-
- cility, practitioners, to provide to patients a list of
- services rendered during the visit to such facility or
- practitioner, and, in the case of a facility, the name

1	of the provider for each such service, upon discharge
2	or end of the visit or by postal or electronic commu-
3	nication as soon as practicable and not later than 5
4	calendar days after discharge or date of visit; and
5	"(2) health care facilities and practitioners to
6	furnish all adjudicated bills to the patient as soon as
7	practicable, but not later than 45 calendar days
8	after discharge or date of visit.
9	"(b) Payment After Billing.—No patient may be
10	required to pay a bill for health care services any earlier
11	than 35 days after the postmark date of a bill for such
12	services.
13	"(c) Effect of Violation.—
14	"(1) Notification and refund require-
15	MENTS.—
16	"(A) Provider lists.—If a facility or
17	practitioner fails to provide a patient a list as
18	required under subsection (a)(1), such facility
19	or practitioner shall report such failure to the
20	Secretary.
21	"(B) BILLING.—If a facility or practitioner
22	bills a patient after the 45-calendar-day period
23	described in subsection (a)(2), such facility or
24	practitioner shall—

1	"(i) report such bill to the Secretary;
2	and
3	"(ii) refund the patient for the full
4	amount paid in response to such bill with
5	interest, at a rate determined by the Sec-
6	retary.
7	"(2) Civil monetary penalties.—
8	"(A) IN GENERAL.—The Secretary may
9	impose civil monetary penalties of up to
10	\$10,000 a day on any facility or practitioner
11	that—
12	"(i) fails to provide a list required
13	under subsection $(a)(1)$ more than $10$
14	times, beginning on the date of such tenth
15	failure;
16	"(ii) submits more than 10 bills out-
17	side of the period described in subsection
18	(a)(2), beginning on the date on which
19	such facility or practitioner sends the tenth
20	such bill;
21	"(iii) fails to report to the Secretary
22	any failure to provide lists as required
23	under paragraph (1)(A), beginning on the
24	date that is 45 calendar days after dis-
25	charge or visit; or

1	"(iv) fails to send any bill as required
2	under subsection (a)(2), beginning on the
3	date that is 45 calendar days after the
4	date of discharge or visit, as applicable.
5	"(B) Procedure.—The provisions of sec-
6	tion 1128A of the Social Security Act, other
7	than subsections (a) and (b) and the first sen-
8	tence of subsection (c)(1) of such section, shall
9	apply to civil money penalties under this sub-
10	section in the same manner as such provisions
11	apply to a penalty or proceeding under section
12	1128A of the Social Security Act.
13	"(3) Safe Harbor.—The Secretary may ex-
14	empt a practitioner or facility from the penalties
15	under paragraph (2)(A) or extend the period of time
16	specified under subsection (a)(2) for compliance with
17	such subsection if a practitioner or facility—
18	"(A) makes a good-faith attempt to send a
19	bill within 30 days but is unable to do so be-
20	cause of an incorrect address; or
21	"(B) experiences extenuating cir-
22	cumstances (as defined by the Secretary), such
23	as a hurricane or cyberattack, that may reason-
24	ably delay delivery of a timely bill.".

- 1 (2) RULEMAKING.—Not later than 1 year after
- 2 the date of enactment of this Act, the Secretary
- 3 shall promulgate final regulations to define the term
- 4 "extenuating circumstance" for purposes of section
- 399V-7(c)(3)(B) of the Public Health Service Act,
- 6 as added by paragraph (1).
- 7 (b) Group Health Plan and Health Insurance
- 8 Issuer Requirements.—Subpart II of part A of title
- 9 XXVII of the Public Health Service Act (42 U.S.C.
- 10 300gg-11), as amended by section 304, is further amend-
- 11 ed by adding at the end the following:
- 12 "SEC. 2729D. TIMELY BILLS FOR PATIENTS.
- 13 "(a) IN GENERAL.—A group health plan or health
- 14 insurance issuer offering group or individual health insur-
- 15 ance coverage shall have in place business practices with
- 16 respect to in-network facilities and practitioners to ensure
- 17 that claims are adjudicated in order to facilitate facility
- 18 and practitioner compliance with the requirements under
- 19 section 399V-7(a).
- 20 "(b) Clarification.—Nothing in subsection (a) pro-
- 21 hibits a provider and a group health plan or health insur-
- 22 ance issuer from establishing in a contract the timeline
- 23 for submission by either party to the other party of billing
- 24 information, adjudication, sending of remittance informa-
- 25 tion, or any other coordination required between the pro-

1	vider and the plan or issuer necessary for meeting the
2	deadline described in section 399V-7(a)(2).".
3	(c) Effective Date.—The amendments made by
4	subsections (a) and (b) shall take effect 6 months after
5	the date of enactment of this Act.
6	SEC. 15. GOVERNMENT ACCOUNTABILITY OFFICE STUDY
7	ON PROFIT- AND REVENUE-SHARING IN
8	HEALTH CARE.
9	(a) Study.—Not later than 1 year after the date of
10	enactment of this Act, the Comptroller General of the
11	United States shall conduct a study to—
12	(1) describe what is known about profit- and
13	revenue-sharing relationships in the commercial
14	health care markets, including those relationships
15	that—
16	(A) involve one or more—
17	(i) physician groups that practice
18	within a hospital included in the profit- or
19	revenue-sharing relationship, or refer pa-
20	tients to such hospital;
21	(ii) laboratory, radiology, or pharmacy
22	services that are delivered to privately in-
23	sured patients of such hospital;
24	(iii) surgical services;

1	(iv) hospitals or group purchasing or-
2	ganizations; or
3	(v) rehabilitation or physical therapy
4	facilities or services; and
5	(B) include revenue- or profit-sharing
6	whether through a joint venture, management
7	or professional services agreement, or other
8	form of gain-sharing contract;
9	(2) describe Federal oversight of such relation-
10	ships, including authorities of the Department of
11	Health and Human Services and the Federal Trade
12	Commission to review such relationships and their
13	potential to increase costs for patients, and identify
14	limitations in such oversight; and
15	(3) as appropriate, make recommendations to
16	improve Federal oversight of such relationships.
17	(b) REPORT.—Not later than 1 year after the date
18	of enactment of this Act, the Comptroller General of the
19	United States shall prepare and submit a report on the
20	study conducted under subsection (a) to the Committee
21	on Health, Education, Labor, and Pensions of the Senate
22	and the Committee on Education and Labor and Com-
23	mittee on Energy and Commerce of the House of Rep-
24	resentatives.

1	SEC. 16. ENSURING ENROLLEE ACCESS TO COST-SHARING
2	INFORMATION.
3	(a) In General.—Subpart II of part A of title
4	XXVII of the Public Health Service Act (42 U.S.C.
5	300gg-11 et seq.), as amended by section 306, is further
6	amended by adding at the end the following:
7	"SEC. 2729F. PROVISION OF COST-SHARING INFORMATION.
8	"(a) Provider Disclosures.—A provider that is
9	in-network with respect to a group health plan or a health
10	insurance issuer offering group or individual health insur-
11	ance coverage shall provide to an enrollee in the plan or
12	coverage who submits a request for the information de-
13	scribed in paragraph (1) or (2), together with accurate
14	and complete information about the enrollee's coverage
15	under the applicable plan or coverage—
16	"(1) as soon as practicable and not later than
17	2 business days after the enrollee requests such in-
18	formation, a good faith estimate of the expected en-
19	rollee cost-sharing for the provision of a particular
20	health care service (including any service that is rea-
21	sonably expected to be provided in conjunction with
22	such specific service); and
23	"(2) as soon as practicable and not later than
24	2 business days after an enrollee requests such in-
25	formation, the contact information for any ancillary

providers for a scheduled health care service.

- 1 "(b) Insurer Disclosures.—A group health plan
- 2 or a health insurance issuer offering group or individual
- 3 health insurance coverage shall provide an enrollee in the
- 4 plan or coverage with a good faith estimate of the enroll-
- 5 ee's cost-sharing (including deductibles, copayments, and
- 6 coinsurance) for which the enrollee would be responsible
- 7 for paying with respect to a specific health care service
- 8 (including any service that is reasonably expected to be
- 9 provided in conjunction with such specific service), as soon
- 10 as practicable and not later than 2 business days after
- 11 a request for such information by an enrollee.
- 12 "(c) Enforcement.—
- "(1) IN GENERAL.—Subject to paragraph (2), a
- health care provider that violates a requirement
- under subsection (a) shall be subject to a civil mone-
- tary penalty of not more than \$10,000 for each act
- 17 constituting such violation.
- 18 "(2) Procedure.—The provisions of section
- 19 1128A of the Social Security Act, other than sub-
- sections (a) and (b) and the first sentence of sub-
- section (c)(1) of such section, shall apply to civil
- 22 money penalties under this subsection in the same
- 23 manner as such provisions apply to a penalty or pro-
- 24 ceeding under section 1128A of the Social Security
- 25 Act.".

1 (b) Effective Date.—Section 2729G of the Public 2 Health Service Act, as added by subsection (a), shall apply with respect to plan years beginning on or after the date that is 18 months after the date of enactment of this Act. SEC. 17. GROUP HEALTH PLAN REPORTING REQUIRE-6 MENTS. 7 Part C of title XXVII of the Public Health Service 8 Act (42 U.S.C. 300gg-91 et seq.), as amended by section 303, is further amended by adding at the end the fol-10 lowing: "SEC. 2797. GROUP HEALTH PLAN REPORTING. 12 "(a) IN GENERAL.—A group health plan or health 13 insurance issuer offering group or individual health insur-14 ance coverage shall submit to the Secretary, not later than 15 March 1 of each year, the following information with respect to the health plan in the previous plan year: 16 17 "(1) The beginning and end dates of the plan 18 year. 19 "(2) The number of enrollees. "(3) Each State in which the plan is offered. 20 21 "(4) The 50 brand prescription drugs most fre-22 quently dispensed by pharmacies for claims paid by

the issuer, and the total number of paid claims for

each such drug.

23

1	"(5) The 50 most costly prescription drugs with
2	respect to the plan by total annual spending, and the
3	annual amount spent by the plan for each such
4	drug.
5	"(6) The 50 prescription drugs with the great-
6	est increase in plan expenditures over the plan year
7	preceding the plan year that is the subject of the re-
8	port, and, for each such drug, the change in
9	amounts expended by the plan in each such plan
10	year.
11	"(7) Total spending on health care services by
12	such group health plan, broken down by—
13	"(A) the type of costs, including—
14	"(i) hospital costs;
15	"(ii) health care provider and clinical
16	service costs;
17	"(iii) costs for prescription drugs; and
18	"(iv) other medical costs; and
19	"(B) spending on prescription drugs by—
20	"(i) the health plan; and
21	"(ii) the enrollees.
22	"(8) The average monthly premium—
23	"(A) paid by employers on behalf of enroll-
24	ees; and
25	"(B) paid by enrollees.

1	"(9) Any impact on premiums by rebates, fees,
2	and any other remuneration paid by drug manufac-
3	turers to the plan or its administrators or service
4	providers, with respect to prescription drugs pre-
5	scribed to enrollees in the plan, including—
6	"(A) the amounts so paid for each thera-
7	peutic class of drugs; and
8	"(B) the amounts so paid for each of the
9	25 drugs that yielded the highest amount of re-
10	bates and other remuneration under the plan
11	from drug manufacturers during the plan year.
12	"(10) Any reduction in premiums and out-of-
13	pocket costs associated with rebates, fees, or other
14	remuneration described in paragraph (9).
15	"(b) Report.—Not later than 18 months after the
16	date on which the first report is required under subsection
17	(a) and biannually thereafter, the Secretary, acting
18	through the Assistant Secretary of Planning and Evalua-
19	tion and in coordination with the Inspector General of the
20	Department of Health and Human Services, shall make
21	available on the internet website of the Department of
22	Health and Human Services a report on prescription drug
23	reimbursements under group health plans, prescription
24	drug pricing trends, and the role of prescription drug costs
25	in contributing to premium increases or decreases under

- 1 such plans, aggregated in such a way as no drug or plan
- 2 specific information will be made public.
- 3 "(e) Privacy Protections.—No confidential or
- 4 trade secret information submitted to the Secretary under
- 5 subsection (a) shall be included in the report under sub-

6 section (b).".

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