

**AMENDMENT IN THE NATURE OF A SUBSTITUTE  
TO H.R. 3120  
OFFERED BY MRS. STEEL OF CALIFORNIA**

Strike all after the enacting clause and insert the following:

**1 SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Healthy Competition  
3 for Better Care Act”.

**4 SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY  
5 AND INSURANCE CONTRACTS THAT LIMIT AC-  
6 CESS TO HIGHER QUALITY, LOWER COST  
7 CARE.**

8 (a) IN GENERAL.—

9 (1) PHSA.—Section 2799A–9 of the Public  
10 Health Service Act (42 U.S.C. 300gg–119) is  
11 amended 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

1 a network of service providers if such agreement, di-  
2 rectly or indirectly—

3 “(A) restricts the group health plan or  
4 health insurance issuer from—

5 “(i) directing or steering enrollees to  
6 other health care providers; or

7 “(ii) offering incentives to encourage  
8 enrollees to utilize specific health care pro-  
9 viders;

10 “(B) requires the group health plan or  
11 health insurance issuer to enter into any addi-  
12 tional contract with an affiliate of the provider  
13 as a condition of entering into a contract with  
14 such provider;

15 “(C) requires the group health plan or  
16 health insurance issuer to agree to payment  
17 rates or other terms for any affiliate not party  
18 to the contract of the provider involved; or

19 “(D) restricts other group health plans or  
20 health insurance issuers not party to the con-  
21 tract, from paying a lower rate for items or  
22 services than the contracting plan or issuer  
23 pays for such items or services.

24 “(2) ADDITIONAL REQUIREMENT FOR SELF-IN-  
25 SURED PLANS.—A self-insured group health plan

1 shall not enter into an agreement with a provider,  
2 network or association of providers, third-party ad-  
3 ministrator, or other service provider offering access  
4 to a network of providers if such agreement directly  
5 or indirectly requires the group health plan to cer-  
6 tify, attest, or otherwise confirm in writing that the  
7 group health plan is bound by restrictive contracting  
8 terms between the service provider and a third-party  
9 administrator that the group health plan is not  
10 party to, without a disclosure that such terms exist.

11 “(3) EXCEPTION FOR CERTAIN GROUP MODEL  
12 ISSUERS.—Paragraph (1)(A) shall not apply to a  
13 group health plan or health insurance issuer offering  
14 group or individual health insurance coverage with  
15 respect to—

16 “(A) a health maintenance organization  
17 (as defined in section 2791(b)(3)), if such  
18 health maintenance organization operates pri-  
19 marily through exclusive contracts with multi-  
20 specialty physician groups, nor to any arrange-  
21 ment between such a health maintenance orga-  
22 nization and its affiliates; or

23 “(B) a value-based network arrangement,  
24 such as an exclusive provider network, account-  
25 able care organization or other alternative pay-

1           ment model, center of excellence, a provider  
2           sponsored health insurance issuer that operates  
3           primarily through aligned multi-specialty physi-  
4           cian group practices or integrated health sys-  
5           tems, or such other similar network arrange-  
6           ments as determined by the Secretary through  
7           rulemaking.

8           “(4) ATTESTATION.—A group health plan or  
9           health insurance issuer offering group or individual  
10          health insurance coverage shall annually submit to,  
11          as applicable, the applicable authority described in  
12          section 2723 or the Secretary of Labor, an attesta-  
13          tion that such plan or issuer is in compliance with  
14          the requirements of this subsection.

15          “(c) MAINTENANCE OF EXISTING HIPAA, GINA,  
16          AND ADA PROTECTIONS.—Nothing in this section shall  
17          modify, reduce, or eliminate the existing privacy protec-  
18          tions and standards provided by reason of State and Fed-  
19          eral law, including the requirements of parts 160 and 164  
20          of title 45, Code of Federal Regulations (or any successor  
21          regulations).

22          “(d) REGULATIONS.—The Secretary, in consultation  
23          with the Secretary of Labor and the Secretary of the  
24          Treasury, not later than 1 year after the date of enact-

1 ment of this section, shall promulgate regulations to carry  
2 out this section.

3 “(e) **RULE OF CONSTRUCTION.**—Nothing in this sec-  
4 tion shall be construed to limit network design or cost or  
5 quality initiatives by a group health plan or health insur-  
6 ance issuer, including accountable care organizations, ex-  
7 clusive provider organizations, networks that tier providers  
8 by cost or quality or steer enrollees to centers of excel-  
9 lence, or other pay-for-performance programs.

10 “(f) **CLARIFICATION WITH RESPECT TO ANTITRUST**  
11 **LAWS.**—Compliance with this section does not constitute  
12 compliance with the antitrust laws, as defined in sub-  
13 section (a) of the first section of the Clayton Act (15  
14 U.S.C. 12(a)).”.

15 (2) **EMPLOYEE RETIREMENT INCOME SECURITY**  
16 **ACT OF 1974.**—

17 (A) **IN GENERAL.**—Section 724 of the Em-  
18 ployee Retirement Income Security Act of 1974  
19 (29 U.S.C. 1185m) is amended—

20 (i) in the header, by striking “**BY RE-**  
21 **MOVING**” and all that follows through  
22 “**INFORMATION**” and inserting “**; PRO-**  
23 **HIBITION ON ANTICOMPETITIVE**  
24 **AGREEMENTS**”;

1 (ii) in subsection (a)(4), in the first  
2 sentence, by striking “section” and insert-  
3 ing “subsection”; and

4 (iii) by adding at the end the fol-  
5 lowing:

6 “(b) PROTECTING HEALTH PLANS NETWORK DE-  
7 SIGN FLEXIBILITY.—

8 “(1) IN GENERAL.—A group health plan or a  
9 health insurance issuer offering group health insur-  
10 ance coverage may not enter into an agreement with  
11 a covered entity (as defined in paragraph (3)) if  
12 such agreement, directly or indirectly—

13 “(A) restricts (including by operation of  
14 any agreement in effect between such covered  
15 entity and another covered entity) the group  
16 health plan (whether self-insured or fully-in-  
17 sured) or health insurance issuer from—

18 “(i) directing or steering participants  
19 or beneficiaries to other health care pro-  
20 viders who are not subject to such agree-  
21 ment; or

22 “(ii) offering incentives to encourage  
23 participants or beneficiaries to utilize spe-  
24 cific health care providers;

1           “(B) requires the group health plan or  
2 health insurance issuer to enter into any addi-  
3 tional agreement with an affiliate of the covered  
4 entity;

5           “(C) requires the group health plan or  
6 health insurance issuer to agree to payment  
7 rates or other terms for any affiliate of the cov-  
8 ered entity not party to the agreement; or

9           “(D) restricts other group health plans or  
10 health insurance issuers not party to the agree-  
11 ment from paying a lower rate for items or  
12 services than the plan or issuer involved in the  
13 agreement pays for such items or services.

14           “(2) EXCEPTIONS FOR CERTAIN PROVIDER  
15 GROUP AND VALUE-BASED NETWORK DESIGNS.—  
16 Paragraph (1)(A) shall not apply to a group health  
17 plan or health insurance issuer offering group health  
18 insurance coverage with respect to—

19           “(A) a health maintenance organization  
20 (as defined in section 733(b)(3)), if such health  
21 maintenance organization operates primarily  
22 through exclusive contracts with multi-specialty  
23 physician groups, nor to any arrangement be-  
24 tween such a health maintenance organization  
25 and its affiliates; or

1           “(B) a value-based network arrangement,  
2           such as an exclusive provider network, account-  
3           able care organization, center of excellence, a  
4           provider sponsored health insurance issuer that  
5           operates primarily through aligned multi-spe-  
6           cialty physician group practices or integrated  
7           health systems, or such other similar network  
8           arrangements as determined by the Secretary  
9           through guidance or rulemaking.

10           “(3) COVERED ENTITY DEFINED.—For pur-  
11           poses of this subsection, the term ‘covered entity’  
12           means 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.

16           “(4) STATE GRANDFATHERING OPTION.—An  
17           applicable State authority may make a determina-  
18           tion that the prohibitions under paragraph (1)(A)  
19           (relating to conditions that would direct or steer en-  
20           rollees to, or offer incentives to encourage enrollees  
21           to use, other health care providers) will not apply in  
22           the State with respect to any specified agreement ex-  
23           ecuted on June 19, 2019, and any agreements re-  
24           lated to such specified agreement executed on or be-  
25           fore December 31, 2020, for a maximum length of



1 nonapplicability of up to 10 years from the date of  
2 execution of the contract if the applicable State au-  
3 thority determines that the contract is unlikely to  
4 significantly lessen competition. With respect to a  
5 specified agreement for which an applicable State  
6 authority has made a determination under the pre-  
7 ceding sentence, an applicable State authority may  
8 determine whether renewal of the contract, within  
9 the applicable 10-year period, is allowed.

10 “(5) RULE OF CONSTRUCTION.—Except as pro-  
11 vided in paragraph (1), nothing in this subsection  
12 shall be construed to limit network design or cost or  
13 quality initiatives by a group health plan or health  
14 insurance issuer, including accountable care organi-  
15 zations, exclusive provider organizations, networks  
16 that tier providers by cost or quality or steer enroll-  
17 ees to centers of excellence, or other pay-for-per-  
18 formance programs.”.

19 (B) REGULATIONS.—Not later than 1 year  
20 after the date of the enactment of this Act, the  
21 Secretary of Labor, in consultation with the  
22 Secretary of Health and Human Services and  
23 the Secretary of the Treasury, shall promulgate  
24 regulations to carry out the amendments made  
25 by this paragraph.

1 (C) CLERICAL AMENDMENT.—The table of  
2 contents in section 1 of such Act is amended,  
3 in the entry relating to section 724, by amend-  
4 ing such entry to read as follows:

“Sec. 724. Increasing transparency; prohibition on anticompetitive agree-  
ments.”.

5 (3) IRC.—Section 9824 of the Internal Rev-  
6 enue Code of 1986 is amended by adding at the end  
7 the following:

8 “(b) PROTECTING HEALTH PLANS NETWORK DE-  
9 SIGN FLEXIBILITY.—

10 “(1) IN GENERAL.—A group health plan shall  
11 not enter into an agreement with a provider, net-  
12 work or association of providers, or other service  
13 provider offering access to a network of service pro-  
14 viders if such agreement, directly or indirectly—

15 “(A) restricts the group health plan  
16 from—

17 “(i) directing or steering enrollees to  
18 other health care providers; or

19 “(ii) offering incentives to encourage  
20 enrollees to utilize specific health care pro-  
21 viders;

22 “(B) requires the group health plan to  
23 enter into any additional contract with an affil-

1           iate of the provider as a condition of entering  
2           into a contract with such provider;

3           “(C) requires the group health plan to  
4           agree to payment rates or other terms for any  
5           affiliate not party to the contract of the pro-  
6           vider involved; or

7           “(D) restricts other group health plans not  
8           party to the contract, from paying a lower rate  
9           for items or services than the contracting plan  
10          pays for such items or services.

11          “(2) ADDITIONAL REQUIREMENT FOR SELF-IN-  
12          SURED PLANS.—A self-insured group health plan  
13          shall not enter into an agreement with a provider,  
14          network or association of providers, third-party ad-  
15          ministrator, or other service provider offering access  
16          to a network of providers if such agreement directly  
17          or indirectly requires the group health plan to cer-  
18          tify, attest, or otherwise confirm in writing that the  
19          group health plan is bound by restrictive contracting  
20          terms between the service provider and a third-party  
21          administrator that the group health plan is not  
22          party to, without a disclosure that such terms exist.

23          “(3) EXCEPTION FOR CERTAIN GROUP MODEL  
24          ISSUERS.—Paragraph (1)(A) shall not apply to a  
25          group health plan with respect to—

1           “(A) a health maintenance organization  
2           (as defined in section 9832(b)(3)), if such  
3           health maintenance organization operates pri-  
4           marily through exclusive contracts with multi-  
5           specialty physician groups, nor to any arrange-  
6           ment between such a health maintenance orga-  
7           nization and its affiliates; or

8           “(B) a value-based network arrangement,  
9           such as an exclusive provider network, account-  
10          able care organization or other alternative pay-  
11          ment model, center of excellence, a provider  
12          sponsored health insurance issuer that operates  
13          primarily through aligned multi-specialty physi-  
14          cian group practices or integrated health sys-  
15          tems, or such other similar network arrange-  
16          ments as determined by the Secretary through  
17          rulemaking.

18          “(4) ATTESTATION.—A group health plan shall  
19          annually submit to the Secretary of Labor an attes-  
20          tation that such plan is in compliance with the re-  
21          quirements of this subsection.

22          “(c) MAINTENANCE OF EXISTING HIPAA, GINA,  
23          AND ADA PROTECTIONS.—Nothing in this section shall  
24          modify, reduce, or eliminate the existing privacy protec-  
25          tions and standards provided by reason of State and Fed-

1 eral law, including the requirements of parts 160 and 164  
2 of title 45, Code of Federal Regulations (or any successor  
3 regulations).

4 “(d) REGULATIONS.—The Secretary, in consultation  
5 with the Secretary of Health and Human Services and the  
6 Secretary of Labor, not later than 1 year after the date  
7 of enactment of this section, shall promulgate regulations  
8 to carry out this section.

9 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-  
10 tion shall be construed to limit network design or cost or  
11 quality initiatives by a group health plan, including ac-  
12 countable care organizations, exclusive provider organiza-  
13 tions, networks that tier providers by cost or quality or  
14 steer enrollees to centers of excellence, or other pay-for-  
15 performance programs.

16 “(f) CLARIFICATION WITH RESPECT TO ANTITRUST  
17 LAWS.—Compliance with this section does not constitute  
18 compliance with the antitrust laws, as defined in sub-  
19 section (a) of the first section of the Clayton Act (15  
20 U.S.C. 12(a)).”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 subsection (a) shall apply with respect to any contract en-  
23 tered into, amended, or renewed on or after the date that  
24 is 18 months after the date of enactment of this Act.

