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:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Healthy Competition for Better Care Act''.

SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY AND INSURANCE CONTRACTS THAT LIMIT ACCESS TO HIGHER QUALITY, LOWER COST CARE.

(a) IN GENERAL.—

(1) PHSA.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) is amended by adding at the end the following:

''(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to

a network of service providers if such agreement, directly or indirectly—

''(A) restricts the group health plan or health insurance issuer from—

''(i) directing or steering enrollees to other health care providers; or

''(ii) offering incentives to encourage enrollees to utilize specific health care providers;

''(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

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

''(D) restricts other group health plans or health insurance issuers not party to the contract, from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

''(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan

shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, 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 or other alternative pay-

ment model, 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 arrangements as determined by the Secretary through rulemaking.

''(4) ATTESTATION.—A group health plan or 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.

''(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the requirements of parts 160 and 164 of title 45, Code of Federal Regulations (or any successor regulations).

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

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

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

''(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).''.

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

(A) IN GENERAL.—Section 724 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m) is amended—

(i) in the header, by striking ''**BY REMOVING**'' and all that follows through ''**INFORMATION**'' and inserting ''**; PROHIBITION ON ANTICOMPETITIVE AGREEMENTS**'';

(ii) in subsection (a)(4), in the first sentence, by striking ''section'' and inserting ''subsection''; and

(iii) by adding at the end the following:

''(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not enter into an agreement with a covered entity (as defined in paragraph (3)) if such agreement, directly or indirectly—

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

''(i) directing or steering participants or beneficiaries to other health care providers who are not subject to such agreement; or

''(ii) offering incentives to encourage participants or beneficiaries to utilize specific health care providers;

''(B) requires the group health plan or health insurance issuer to enter into any additional agreement with an affiliate of the covered entity;

''(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate of the covered entity not party to the agreement; or

''(D) restricts other group health plans or health insurance issuers not party to the agreement from paying a lower rate for items or services than the plan or issuer involved in the agreement pays for such items or services.

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

''(A) a health maintenance organization (as defined in section 733(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty 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 arrangements as determined by the Secretary through guidance or rulemaking.

''(3) COVERED ENTITY DEFINED.—For purposes of this subsection, the term 'covered entity' means a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers.

''(4) STATE GRANDFATHERING OPTION.—An applicable State authority may make a determination that the prohibitions under paragraph (1)(A) (relating to conditions that would direct or steer enrollees to, or offer incentives to encourage enrollees to use, other health care providers) will not apply in the State with respect to any specified agreement executed on June 19, 2019, and any agreements related to such specified agreement executed on or before December 31, 2020, for a maximum length of

nonapplicability of up to 10 years from the date of execution of the contract if the applicable State authority determines that the contract is unlikely to significantly lessen competition. With respect to a specified agreement for which an applicable State authority has made a determination under the preceding sentence, an applicable State authority may determine whether renewal of the contract, within the applicable 10-year period, is allowed.

''(5) RULE OF CONSTRUCTION.—Except as provided in paragraph (1), nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.''.

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

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

"Sec. 724. Increasing transparency; prohibition on anticompetitive agreements.".

(3) IRC.—Section 9824 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

"(1) IN GENERAL.—A group health plan shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

"(A) restricts the group health plan from—

"(i) directing or steering enrollees to other health care providers; or

"(ii) offering incentives to encourage enrollees to utilize specific health care providers;

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

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

''(C) requires the group health plan to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

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

''(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, 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 with respect to—

''(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty 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 or other alternative payment model, 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 arrangements as determined by the Secretary through rulemaking.

''(4) ATTESTATION.—A group health plan shall annually submit to the Secretary of Labor an attestation that such plan is in compliance with the requirements of this subsection.

''(c) MAINTENANCE OF EXISTING HIPAA, GINA, AND ADA PROTECTIONS.—Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Fed-

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

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

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

''(f) CLARIFICATION WITH RESPECT TO ANTITRUST LAWS.—Compliance with this section does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).''.

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