

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 5800
OFFERED BY M . _____**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Ban Surprise Billing
3 Act”.

4 SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

5 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

8 (1) by amending subsection (b) to read as fol-
9 lows:

10 “(b) COVERAGE OF EMERGENCY SERVICES.—

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

1 the plan or issuer shall cover emergency services (as
2 defined in paragraph (3)(C))—

3 “(A) without the need for any prior au-
4 thorization determination;

5 “(B) whether the health care provider fur-
6 nishing such services is a participating provider
7 or a participating emergency facility, as appli-
8 cable, with respect to such services;

9 “(C) in a manner so that, if such services
10 are provided to a participant, beneficiary, or en-
11 rollee by a nonparticipating provider or a non-
12 participating emergency facility—

13 “(i) such services will be provided
14 without imposing any requirement under
15 the plan or coverage for prior authoriza-
16 tion of services or any limitation on cov-
17 erage that is more restrictive than the re-
18 quirements or limitations that apply to
19 emergency services received from partici-
20 pating providers and participating emer-
21 gency facilities with respect to such plan or
22 coverage, respectively;

23 “(ii) the cost-sharing requirement (ex-
24 pressed as a copayment amount or coinsur-
25 ance rate) is not greater than the require-

1 ment that would apply if such services
2 were provided by a participating provider
3 or a participating emergency facility;

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

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

20 “(v) any cost-sharing payments made
21 by the participant, beneficiary, or enrollee
22 with respect to such emergency services so
23 furnished shall be counted toward any in-
24 network deductible or out-of-pocket maxi-
25 mums applied under the plan or coverage,

1 respectively (and such in-network deduct-
2 ible and out-of-pocket maximums shall be
3 applied) in the same manner as if such
4 cost-sharing payments were made with re-
5 spect to emergency services furnished by a
6 participating provider or a participating
7 emergency facility; and

8 “(D) without regard to any other term or
9 condition of such coverage (other than exclusion
10 or coordination of benefits, or an affiliation or
11 waiting period, permitted under section 2704 of
12 this Act, including as incorporated pursuant to
13 section 715 of the Employee Retirement Income
14 Security Act of 1974 and section 9815 of the
15 Internal Revenue Code of 1986, and other than
16 applicable cost-sharing).

17 “(2) AUDIT PROCESS AND REGULATIONS FOR
18 MEDIAN CONTRACTED RATES.—

19 “(A) AUDIT PROCESS.—

20 “(i) IN GENERAL.—Not later than
21 July 1, 2021, the Secretary, in consulta-
22 tion with appropriate State agencies and
23 the Secretary of Labor and the Secretary
24 of the Treasury, shall establish through
25 rulemaking a process, in accordance with

1 clause (ii), under which group health plans
2 and health insurance issuers offering
3 health insurance coverage in the group or
4 individual market are audited by the Sec-
5 retary or applicable State authority to en-
6 sure that—

7 “(I) such plans and coverage are
8 in compliance with the requirement of
9 applying a median contracted rate
10 under this section; and

11 “(II) such median contracted
12 rate so applied satisfies the definition
13 under paragraph (3)(E) with respect
14 to the year involved, including with re-
15 spect to a group health plan or health
16 insurance issuer described in clause
17 (ii) of such paragraph (3)(E).

18 “(ii) AUDIT SAMPLES.—Under the
19 process established pursuant to clause (i),
20 the Secretary—

21 “(I) shall conduct audits de-
22 scribed in such clause, with respect to
23 a year (beginning with 2022), of a
24 sample with respect to such year of
25 claims data from not more than 25

1 group health plans and health insur-
2 ance issuers offering health insurance
3 coverage in the group or individual
4 market; and

5 “(II) may audit any group health
6 plan or health insurance issuer offer-
7 ing health insurance coverage in the
8 group or individual market if the Sec-
9 retary has received any complaint
10 about such plan or coverage, respec-
11 tively, that involves the compliance of
12 the plan or coverage, respectively,
13 with either of the requirements de-
14 scribed in subclauses (I) and (II) of
15 such clause.

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

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

1 “(i) the methodology the group health
2 plan or health insurance issuer offering
3 health insurance coverage in the group or
4 individual market shall use to determine
5 the median contracted rate, differentiating
6 by line of business;

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

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

18 “(iv) a process to receive complaints
19 of violations of the requirements described
20 in subclauses (I) and (II) of subparagraph
21 (A)(i) by group health plans and health in-
22 surance issuers offering health insurance
23 coverage in the group or individual market.

24 Such rulemaking shall take into account pay-
25 ments that are made by such plan or issuer, re-

1 spectively, that are not on a fee-for-service
2 basis. Such methodology may account for rel-
3 evant payment adjustments that take into ac-
4 count quality or facility type (including higher
5 acuity settings and the case-mix of various fa-
6 cility types) that are otherwise taken into ac-
7 count for purposes of determining payment
8 amounts with respect to participating facilities.
9 In carrying out clause (iii), the Secretary shall
10 consult with the National Association of Insur-
11 ance Commissioners to establish the geographic
12 regions under such clause and shall periodically
13 update such regions, as appropriate.

14 “(3) DEFINITIONS.—In this part:

15 “(A) EMERGENCY DEPARTMENT OF A HOS-
16 PITAL.—The term ‘emergency department of a
17 hospital’ includes a hospital outpatient depart-
18 ment that provides emergency services.

19 “(B) EMERGENCY MEDICAL CONDITION.—
20 The term ‘emergency medical condition’ means
21 a medical condition manifesting itself by acute
22 symptoms of sufficient severity (including se-
23 vere pain) such that a prudent layperson, who
24 possesses an average knowledge of health and
25 medicine, could reasonably expect the absence

1 of immediate medical attention to result in a
2 condition described in clause (i), (ii), or (iii) of
3 section 1867(e)(1)(A) of the Social Security
4 Act.

5 “(C) EMERGENCY SERVICES.—

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

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

23 “(II) within the capabilities of
24 the staff and facilities available at the
25 hospital or the independent free-

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

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

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

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

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

1 “(aa) Such a provider or fa-
2 cility determines such individual
3 is able to travel using nonmedical
4 transportation or nonemergency
5 medical transportation.

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

12 “(cc) Such an individual is
13 in a condition to receive (as de-
14 termined in accordance with
15 guidance issued by the Secretary)
16 the information described in sec-
17 tion 2799A–2 and to provide in-
18 formed consent under such sec-
19 tion, in accordance with applica-
20 ble State law.

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

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

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

6 “(E) MEDIAN CONTRACTED RATE.—

7 “(i) IN GENERAL.—The term ‘median
8 contracted rate’ means, subject to clauses
9 (ii) and (iii), with respect to a sponsor of
10 a group health plan and health insurance
11 issuer offering health insurance coverage in
12 the group or individual market—

13 “(I) for an item or service fur-
14 nished during 2022, the median of the
15 contracted rates recognized by the
16 plan or issuer, respectively (deter-
17 mined with respect to all such plans
18 of such sponsor or all such coverage
19 offered by such issuer that are offered
20 within the same line of business as
21 the plan or coverage) as the total
22 maximum payment (including the
23 cost-sharing amount imposed for such
24 item or service and the amount to be
25 paid by the plan or issuer, respec-

1 tively) under such plans or coverage,
2 respectively, on January 31, 2019, for
3 the same or a similar item or service
4 that is provided by a provider in the
5 same or similar specialty and provided
6 in the geographic region in which the
7 item or service is furnished, consistent
8 with the methodology established by
9 the Secretary under paragraph
10 (2)(B), increased by the percentage
11 increase in the consumer price index
12 for all urban consumers (United
13 States city average) over 2019, such
14 percentage increase over 2020, and
15 such percentage increase over 2021;
16 and

17 “(II) for an item or service fur-
18 nished during 2023 or a subsequent
19 year, the median contracted rate de-
20 termined under this clause for such
21 an item or service furnished in the
22 previous year, increased by the per-
23 centage increase in the consumer price
24 index for all urban consumers (United

1 States city average) over such pre-
2 vious year.

3 “(ii) NEW PLANS AND COVERAGE.—

4 The term ‘median contracted rate’ means,
5 with respect to a sponsor of a group health
6 plan or health insurance issuer offering
7 health insurance coverage in the group or
8 individual market in a geographic region in
9 which such sponsor or issuer, respectively,
10 did not offer any group health plan or
11 health insurance coverage during 2019—

12 “(I) for the first year in which
13 such group health plan or health in-
14 surance coverage, respectively, is of-
15 fered in such region, a rate (deter-
16 mined in accordance with a method-
17 ology established by the Secretary) for
18 items and services that are covered by
19 such plan and furnished during such
20 first year; and

21 “(II) for each subsequent year
22 such group health plan or health in-
23 surance coverage, respectively, is of-
24 fered in such region, the median con-
25 tracted rate determined under this

1 clause for such items and services fur-
2 nished in the previous year, increased
3 by the percentage increase in the con-
4 sumer price index for all urban con-
5 sumers (United States city average)
6 over such previous year.

7 “(iii) INSUFFICIENT INFORMATION;
8 NEWLY COVERED ITEMS AND SERVICES.—
9 In the case of a sponsor of a group health
10 plan or health insurance issuer offering
11 health insurance coverage in the group or
12 individual market that does not have suffi-
13 cient information to calculate the median
14 of the contracted rates described in clause
15 (i)(I) in 2019 (or, in the case of a newly
16 covered item or service (as defined in
17 clause (iv)(III)), in the first coverage year
18 (as defined in clause (iv)(I)) for such item
19 or service with respect to such plan or cov-
20 erage) for an item or service (including
21 with respect to provider type, or amount,
22 of claims for items or services (as deter-
23 mined by the Secretary) provided in a par-
24 ticular geographic region (other than in a

1 case with respect to which clause (ii) ap-
2 plies)) the term ‘median contracted rate’—

3 “(I) for an item or service fur-
4 nished during 2022 (or, in the case of
5 a newly covered item or service, dur-
6 ing the first coverage year for such
7 item or service with respect to such
8 plan or coverage), means such rate for
9 such item or service determined by
10 the sponsor or issuer, respectively,
11 through use of any database that is
12 determined, in accordance with rule-
13 making described in paragraph
14 (2)(B), to not have any conflicts of in-
15 terest and to have sufficient informa-
16 tion reflecting allowed amounts paid
17 to a health care provider or facility for
18 relevant services furnished in the ap-
19 plicable geographic region (such as a
20 State all-payer claims database);

21 “(II) for an item or service fur-
22 nished in a subsequent year (before
23 the first sufficient information year
24 (as defined in clause (iv)(II)) for such
25 item or service with respect to such

1 plan or coverage), means the rate de-
2 termined under subclause (I) or this
3 subclause, as applicable, for such item
4 or service for the year previous to
5 such subsequent year, increased by
6 the percentage increase in the con-
7 sumer price index for all urban con-
8 sumers (United States city average)
9 over such previous year;

10 “(III) for an item or service fur-
11 nished in the first sufficient informa-
12 tion year for such item or service with
13 respect to such plan or coverage, has
14 the meaning given the term median
15 contracted rate in clause (i)(I), except
16 that in applying such clause to such
17 item or service, the reference to ‘fur-
18 nished during 2022’ shall be treated
19 as a reference to furnished during
20 such first sufficient information year,
21 the reference to ‘in 2019’ shall be
22 treated as a reference to such suffi-
23 cient information year, and the in-
24 crease described in such clause shall
25 not be applied; and

1 “(IV) for an item or service fur-
2 nished in any year subsequent to the
3 first sufficient information year for
4 such item or service with respect to
5 such plan or coverage, has the mean-
6 ing given such term in clause (i)(II),
7 except that in applying such clause to
8 such item or service, the reference to
9 ‘furnished during 2023 or a subse-
10 quent year’ shall be treated as a ref-
11 erence to furnished during the year
12 after such first sufficient information
13 year or a subsequent year.

14 “(iv) DEFINITIONS.—For purposes of
15 this subparagraph:

16 “(I) FIRST COVERAGE YEAR.—
17 The term ‘first coverage year’ means,
18 with respect to a group health plan or
19 health insurance coverage offered by a
20 health insurance issuer in the group
21 or individual market and an item or
22 service for which coverage is not of-
23 fered in 2019 under such plan or cov-
24 erage, the first year after 2019 for
25 which coverage for such item or serv-

1 ice is offered under such plan or
2 health insurance coverage.

3 “(II) FIRST SUFFICIENT INFOR-
4 MATION YEAR.—The term ‘first suffi-
5 cient information year’ means, with
6 respect to a group health plan or
7 health insurance coverage offered by a
8 health insurance issuer in the group
9 or individual market—

10 “(aa) in the case of an item
11 or service for which the plan or
12 coverage does not have sufficient
13 information to calculate the me-
14 dian of the contracted rates de-
15 scribed in clause (i)(I) in 2019,
16 the first year subsequent to 2022
17 for which the sponsor or issuer
18 has such sufficient information to
19 calculate the median of such con-
20 tracted rates in the year previous
21 to such first subsequent year;
22 and

23 “(bb) in the case of a newly
24 covered item or service, the first
25 year subsequent to the first cov-

1 erage year for such item or serv-
2 ice with respect to such plan or
3 coverage for which the sponsor or
4 issuer has sufficient information
5 to calculate the median of the
6 contracted rates described in
7 clause (i)(I) in the year previous
8 to such first subsequent year.

9 “(III) NEWLY COVERED ITEM OR
10 SERVICE.—The term ‘newly covered
11 item or service’ means, with respect to
12 a group health plan or health insur-
13 ance issuer offering health insurance
14 coverage in the group or individual
15 market, an item or service for which
16 coverage was not offered in 2019
17 under such plan or coverage, but is
18 offered under such plan or coverage in
19 a year after 2019.

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

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

1 an item or service and a group health plan
2 or health insurance coverage offered by a
3 health insurance issuer in the group or in-
4 dividual market, an emergency department
5 of a hospital, or an independent free-
6 standing emergency department, that does
7 not have a contractual relationship directly
8 or indirectly with the plan or issuer, re-
9 spectively, for furnishing such item or serv-
10 ice under the plan or coverage, respec-
11 tively.

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

1 “(G) NONPARTICIPATING PROVIDERS; PAR-
2 TICIPATING PROVIDERS.—

3 “(i) NONPARTICIPATING PROVIDER.—

4 The term ‘nonparticipating provider’
5 means, with respect to an item or service
6 and a group health plan or health insur-
7 ance coverage offered by a health insur-
8 ance issuer in the group or individual mar-
9 ket, a physician or other health care pro-
10 vider who is acting within the scope of
11 practice of that provider’s license or certifi-
12 cation under applicable State law and who
13 does not have a contractual relationship
14 with the plan or issuer, respectively, for
15 furnishing such item or service under the
16 plan or coverage, respectively.

17 “(ii) PARTICIPATING PROVIDER.—The
18 term ‘participating provider’ means, with
19 respect to an item or service and a group
20 health plan or health insurance coverage
21 offered by a health insurance issuer in the
22 group or individual market, a physician or
23 other health care provider who is acting
24 within the scope of practice of that pro-
25 vider’s license or certification under appli-

1 cable State law and who has a contractual
2 relationship with the plan or issuer, respec-
3 tively, for furnishing such item or service
4 under the plan or coverage, respectively.

5 “(H) RECOGNIZED AMOUNT.—The term
6 ‘recognized amount’ means, with respect to an
7 item or service furnished by a nonparticipating
8 provider or emergency facility during a year
9 and a group health plan or health insurance
10 coverage offered by a health insurance issuer in
11 the group or individual market—

12 “(i) subject to clause (iii), in the case
13 of such item or service furnished in a State
14 that has in effect a specified State law
15 with respect to such plan, coverage, or
16 issuer, respectively, such a nonparti-
17 cating provider or emergency facility, and
18 such an item or service, the amount deter-
19 mined in accordance with such law;

20 “(ii) subject to clause (iii), in the case
21 of such item or service furnished in a State
22 that does not have in effect a specified
23 State law, with respect to such plan, cov-
24 erage, or issuer, respectively, such a non-
25 participating provider or emergency facil-

1 ity, and such an item or service, an
2 amount that is the median contracted rate
3 (as defined in subparagraph (E)) for such
4 year and determined in accordance with
5 rulemaking described in paragraph (2)(B))
6 for such item or service; or

7 “(iii) in the case of such item or serv-
8 ice furnished in a State with an All-Payer
9 Model Agreement under section 1115A of
10 the Social Security Act, the amount that
11 the State approves under such system for
12 such item or service so furnished.

13 “(I) SPECIFIED STATE LAW.—The term
14 ‘specified State law’ means, with respect to a
15 State, an item or service furnished by a non-
16 participating provider or emergency facility dur-
17 ing a year and a group health plan or health in-
18 surance coverage offered by a health insurance
19 issuer in the group or individual market, a
20 State law that provides for a method for deter-
21 mining the amount of payment that is required
22 to be covered by such a plan, coverage, or
23 issuer, respectively (to the extent such State
24 law applies to such plan, coverage, or issuer,
25 subject to section 514 of the Employee Retire-

1 ment Income Security Act of 1974) in the case
2 of a participant, beneficiary, or enrollee covered
3 under such plan or coverage and receiving such
4 item or service from such a nonparticipating
5 provider or emergency facility.

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

11 (2) by adding at the end the following new sub-
12 sections:

13 “(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
14 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
15 PARTICIPATING FACILITIES.—

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

1 and consent criteria of section 2799A–2(d)) with re-
2 spect to a visit (as defined by the Secretary in ac-
3 cordance with paragraph (2)(B)) at a participating
4 health care facility (as defined in paragraph (2)(A)),
5 with respect to such plan or coverage, respectively,
6 the plan or coverage, respectively—

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

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

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

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

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

19 “(2) DEFINITIONS.—In this section:

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

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

1 fering health insurance coverage in the
2 group or individual market, a health care
3 facility described in clause (ii) that has a
4 contractual relationship with the plan or
5 issuer, respectively, with respect to the fur-
6 nishing of such an item or service at the
7 facility.

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

14 “(I) A hospital (as defined in
15 1861(e) of the Social Security Act).

16 “(II) A hospital outpatient de-
17 partment.

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

21 “(IV) An ambulatory surgical
22 center (as defined in section
23 1833(i)(1)(A) of such Act).

24 “(V) Any other facility that pro-
25 vides items or services for which cov-

1 erage is provided under the plan or
2 coverage, respectively.

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

12 “(f) AIR AMBULANCE SERVICES.—

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

22 “(A) the cost-sharing requirement (ex-
23 pressed as a copayment amount, coinsurance
24 rate, or deductible) with respect to such services
25 shall be the same requirement that would apply

1 if such services were provided by such a partici-
2 pating provider, and any coinsurance or deduct-
3 ible shall be based on rates that would apply for
4 such services if they were furnished by such a
5 participating provider;

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

16 “(C) the plan or coverage shall pay to such
17 provider furnishing such services to such partici-
18 ipant, beneficiary, or enrollee the amount by
19 which the recognized amount (as defined in and
20 determined pursuant to subsection
21 (b)(3)(H)(ii)) for such services and year in-
22 volved exceeds the cost-sharing amount imposed
23 under the plan or coverage, respectively, for
24 such services (as determined in accordance with
25 subparagraphs (A) and (B)).

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

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

15 (b) ERISA AMENDMENTS.—

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

20 **“SEC. 716. CONSUMER PROTECTIONS.**

21 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
22 a group health plan or health insurance issuer offering
23 group health insurance coverage requires or provides for
24 designation by a participant or beneficiary of a partici-
25 pating primary care provider, then the plan or issuer shall

1 permit each participant or beneficiary to designate any
2 participating primary care provider who is available to ac-
3 cept such individual.

4 “(b) COVERAGE OF EMERGENCY SERVICES.—

5 “(1) IN GENERAL.—If a group health plan, or
6 a health insurance issuer offering group health in-
7 surance coverage, provides or covers any benefits
8 with respect to services in an emergency department
9 of a hospital or with respect to emergency services
10 in an independent freestanding emergency depart-
11 ment (as defined in paragraph (3)(D)), the plan or
12 issuer shall cover emergency services (as defined in
13 paragraph (3)(C))—

14 “(A) without the need for any prior au-
15 thorization determination;

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

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

24 “(i) such services will be provided
25 without imposing any requirement under

1 the plan for prior authorization of services
2 or any limitation on coverage that is more
3 restrictive than the requirements or limita-
4 tions that apply to emergency services re-
5 ceived from participating providers and
6 participating emergency facilities with re-
7 spect to such plan or coverage, respec-
8 tively;

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

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

23 “(iv) the group health plan or health
24 insurance issuer, respectively, pays to such
25 provider or facility, respectively, the

1 amount by which the recognized amount
2 for such services and year involved exceeds
3 the cost-sharing amount for such services
4 (as determined in accordance with clauses
5 (ii) and (iii)) and year; and

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

19 “(D) without regard to any other term or
20 condition of such coverage (other than exclusion
21 or coordination of benefits, or an affiliation or
22 waiting period, permitted under section 2704 of
23 the Public Health Service Act, including as in-
24 corporated pursuant to section 715 of this Act
25 and section 9815 of the Internal Revenue Code

1 of 1986, and other than applicable cost-shar-
2 ing).

3 “(2) AUDIT PROCESS AND REGULATIONS FOR
4 MEDIAN CONTRACTED RATES.—

5 “(A) AUDIT PROCESS.—

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

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

22 “(II) such median contracted
23 rate so applied satisfies the definition
24 under paragraph (3)(E) with respect
25 to the year involved, including with re-

1 spect to a group health plan or health
2 insurance issuer described in clause
3 (ii) of such paragraph (3)(E).

4 “(ii) **AUDIT SAMPLES.**—Under the
5 process established pursuant to clause (i),
6 the Secretary—

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

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

1 “(iii) REPORTS.—Beginning for 2022,
2 the Secretary shall annually submit to
3 Congress information on the number of
4 plans and issuers with respect to which au-
5 dits were conducted during such year pur-
6 suant to this subparagraph.

7 “(B) RULEMAKING.—Not later than July
8 1, 2021, the Secretary, in consultation with the
9 Secretary of the Treasury and the Secretary of
10 Health and Human Services, shall establish
11 through rulemaking—

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

18 “(ii) the information such plan or
19 issuer, respectively, shall share with the
20 nonparticipating provider or nonpartici-
21 pating facility, as applicable, when making
22 such a determination;

23 “(iii) the geographic regions applied
24 for purposes of this subparagraph, taking
25 into account access to items and services in

1 rural and underserved areas, including
2 health professional shortage areas, as de-
3 fined in section 332 of the Public Health
4 Service Act; and

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

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

1 “(3) DEFINITIONS.—In this section:

2 “(A) EMERGENCY DEPARTMENT OF A HOS-
3 PITAL.—The term ‘emergency department of a
4 hospital’ includes a hospital outpatient depart-
5 ment that provides emergency services.

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

17 “(C) EMERGENCY SERVICES.—

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

21 “(I) a medical screening exam-
22 ination (as required under section
23 1867 of the Social Security Act, or as
24 would be required under such section
25 if such section applied to an inde-

1 pendent freestanding emergency de-
2 partment) that is within the capability
3 of the emergency department of a hos-
4 pital or of an independent free-
5 standing emergency department, as
6 applicable, including ancillary services
7 routinely available to the emergency
8 department to evaluate such emer-
9 gency medical condition; and

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

21 “(ii) INCLUSION OF CERTAIN SERV-
22 ICES OUTSIDE OF EMERGENCY DEPART-
23 MENT.—

24 “(I) IN GENERAL.—For purposes
25 of this subsection and section 2799A—

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

1 so stabilized, the provider or facility
2 determines that such items or services
3 are needed.

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

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

18 “(bb) Such provider fur-
19 nishing such additional items and
20 services satisfies the notice and
21 consent criteria of section
22 2799A–2(d) of the Public Health
23 Service Act with respect to such
24 items and services.

1 “(cc) Such an individual is
2 in a condition to receive (as de-
3 termined in accordance with
4 guidance issued by the Secretary)
5 the information described in sec-
6 tion 2799A-2 of the Public
7 Health Service Act and to pro-
8 vide informed consent under such
9 section, in accordance with appli-
10 cable State law.

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

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

18 “(ii) provides any emergency services
19 (as defined in subparagraph (C)).

20 “(E) MEDIAN CONTRACTED RATE.—

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

1 issuer offering health insurance coverage in
2 the group market—

3 “(I) for an item or service fur-
4 nished during 2022, the median of the
5 contracted rates recognized by the
6 plan or issuer, respectively (deter-
7 mined with respect to all such plans
8 of such sponsor or all such coverage
9 offered by such issuer that are offered
10 within the same line of business as
11 the plan or coverage) as the total
12 maximum payment (including the
13 cost-sharing amount imposed for such
14 item or service and the amount to be
15 paid by such plan or such issuer, re-
16 spectively) under such plans or cov-
17 erage, respectively, on January 31,
18 2019, for the same or a similar item
19 or service that is provided by a pro-
20 vider in the same or similar specialty
21 and provided in the geographic region
22 in which the item or service is fur-
23 nished, consistent with the method-
24 ology established by the Secretary
25 under paragraph (2)(B), increased by

1 the percentage increase in the con-
2 sumer price index for all urban con-
3 sumers (United States city average)
4 over 2019, such percentage increase
5 over 2020, and such percentage in-
6 crease over 2021; and

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

17 “(ii) NEW PLANS AND COVERAGE.—
18 The term ‘median contracted rate’ means,
19 with respect to a sponsor of a group health
20 plan or health insurance issuer offering
21 health insurance coverage in the group
22 market in a geographic region in which
23 such sponsor or issuer, respectively, did
24 not offer any group health plan or health
25 insurance coverage during 2019—

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

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

21 “(iii) INSUFFICIENT INFORMATION;
22 NEWLY COVERED ITEMS AND SERVICES.—
23 In the case of a sponsor of a group health
24 plan or health insurance issuer offering
25 health insurance coverage in the group

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

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

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

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

23 “(III) for an item or service fur-
24 nished in the first sufficient informa-
25 tion year for such item or service with

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

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

1 after such first sufficient information
2 year or a subsequent year.

3 “(iv) DEFINITIONS.—For purposes of
4 this subparagraph:

5 “(I) FIRST COVERAGE YEAR.—
6 The term ‘first coverage year’ means,
7 with respect to a group health plan or
8 health insurance coverage offered by a
9 health insurance issuer in the group
10 market and an item or service for
11 which coverage is not offered in 2019
12 under such plan or coverage, the first
13 year after 2019 for which coverage for
14 such item or service is offered under
15 such plan or health insurance cov-
16 erage.

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

24 “(aa) in the case of an item
25 or service for which the plan or

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

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

23 “(III) NEWLY COVERED ITEM OR
24 SERVICE.—The term ‘newly covered
25 item or service’ means, with respect to

1 a group health plan or health insur-
2 ance issuer offering health insurance
3 coverage in the group market, an item
4 or service for which coverage was not
5 offered in 2019 under such plan or
6 coverage, but is offered under such
7 plan or coverage in a year after 2019.

8 “(F) NONPARTICIPATING EMERGENCY FA-
9 CILITY; PARTICIPATING EMERGENCY FACIL-
10 ITY.—

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

24 “(ii) PARTICIPATING EMERGENCY FA-
25 CILITY.—The term ‘participating emer-

1 gency facility’ means, with respect to an
2 item or service and a group health plan or
3 health insurance coverage offered by a
4 health insurance issuer in the group mar-
5 ket, an emergency department of a hos-
6 pital, or an independent freestanding emer-
7 gency department, that has a contractual
8 relationship directly or indirectly with the
9 plan or issuer, respectively, with respect to
10 the furnishing of such an item or service at
11 such facility.

12 “(G) NONPARTICIPATING PROVIDERS; PAR-
13 TICIPATING PROVIDERS.—

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

1 item or service under the plan or coverage,
2 respectively.

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

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

23 “(i) subject to clause (iii), in the case
24 of such item or service furnished in a State
25 that has in effect a specified State law

1 with respect to such plan, coverage, or
2 issuer, respectively, such a nonpartici-
3 pating provider or emergency facility, and
4 such an item or service, the amount deter-
5 mined in accordance with such law;

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

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

24 “(I) SPECIFIED STATE LAW.—The term
25 ‘specified State law’ means, with respect to a

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

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

20 “(c) ACCESS TO PEDIATRIC CARE.—

21 “(1) PEDIATRIC CARE.—In the case of a person
22 who has a child who is a participant or beneficiary
23 under a group health plan, or health insurance cov-
24 erage offered by a health insurance issuer in the
25 group market, if the plan or issuer requires or pro-

1 vides for the designation of a participating primary
2 care provider for the child, the plan or issuer shall
3 permit such person to designate a physician
4 (allopathic or osteopathic) who specializes in pediatri-
5 cies as the child’s primary care provider if such pro-
6 vider participates in the network of the plan or
7 issuer.

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

13 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
14 COLOGICAL CARE.—

15 “(1) GENERAL RIGHTS.—

16 “(A) DIRECT ACCESS.—A group health
17 plan, or health insurance issuer offering group
18 health insurance coverage, described in para-
19 graph (2) may not require authorization or re-
20 ferral by the plan, issuer, or any person (includ-
21 ing a primary care provider described in para-
22 graph (2)(B)) in the case of a female partici-
23 pant or beneficiary who seeks coverage for ob-
24 stetrical or gynecological care provided by a
25 participating health care professional who spe-

1 cializes in obstetrics or gynecology. Such profes-
2 sional shall agree to otherwise adhere to such
3 plan’s or issuer’s policies and procedures, in-
4 cluding procedures regarding referrals and ob-
5 taining prior authorization and providing serv-
6 ices pursuant to a treatment plan (if any) ap-
7 proved by the plan or issuer.

8 “(B) OBSTETRICAL AND GYNECOLOGICAL
9 CARE.—A group health plan or health insur-
10 ance issuer described in paragraph (2) shall
11 treat the provision of obstetrical and gynecolo-
12 gical care, and the ordering of related obstet-
13 rical and gynecological items and services, pur-
14 suant to the direct access described under sub-
15 paragraph (A), by a participating health care
16 professional who specializes in obstetrics or
17 gynecology as the authorization of the primary
18 care provider.

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

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

1 “(B) requires the designation by a partici-
2 pant or beneficiary of a participating primary
3 care provider.

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

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

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

15 “(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
16 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
17 PARTICIPATING FACILITIES.—

18 “(1) IN GENERAL.—In the case of items or
19 services (other than emergency services to which
20 subsection (b) applies) for which any benefits are
21 provided or covered by a group health plan or health
22 insurance issuer offering health insurance coverage
23 in the group market furnished to a participant or
24 beneficiary of such plan or coverage by a nonpartici-
25 pating provider (as defined in subsection

1 (b)(3)(G)(i)) (and who, with respect to such items
2 and services, has not satisfied the notice and consent
3 criteria of section 2799A–2(d) of the Public Health
4 Service Act) with respect to a visit (as defined by
5 the Secretary in accordance with paragraph (2)(B))
6 at a participating health care facility (as defined in
7 paragraph (2)(A)), with respect to such plan or cov-
8 erage, respectively, the plan or coverage, respec-
9 tively—

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

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

1 “(C) shall pay to such provider furnishing
2 such items and services to such participant or
3 beneficiary the amount by which the recognized
4 amount (as defined in subsection (b)(3)(H)) for
5 such items and services and year involved ex-
6 ceeds the cost-sharing amount imposed under
7 the plan or coverage, respectively, for such
8 items and services (as determined in accordance
9 with subparagraphs (A) and (B)); and

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

21 “(2) DEFINITIONS.—In this section:

22 “(A) PARTICIPATING HEALTH CARE FACIL-
23 ITY.—

24 “(i) IN GENERAL.—The term ‘partici-
25 pating health care facility’ means, with re-

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

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

15 “(I) A hospital (as defined in
16 1861(e) of the Social Security Act).

17 “(II) A hospital outpatient de-
18 partment.

19 “(III) A critical access hospital
20 (as defined in section 1861(mm) of
21 such Act).

22 “(IV) An ambulatory surgical
23 center (as defined in section
24 1833(i)(1)(A) of such Act).

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

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

14 “(f) AIR AMBULANCE SERVICES.—

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

24 “(A) the cost-sharing requirement (ex-
25 pressed as a copayment amount, coinsurance

1 rate, or deductible) with respect to such services
2 shall be the same requirement that would apply
3 if such services were provided by such a partici-
4 pating provider, and any coinsurance or deduct-
5 ible shall be based on rates that would apply for
6 such services if they were furnished by such a
7 participating provider;

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

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

1 terminated in accordance with subparagraphs (A)
2 and (B)).

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

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

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

“Sec. 715. Additional market reforms.

“Sec. 716. Consumer protections.”.

21 (c) IRC AMENDMENTS.—

22 (1) IN GENERAL.—Subchapter B of chapter
23 100 of the Internal Revenue Code of 1986 is amend-
24 ed by adding at the end the following:

1 **“SEC. 9816. CONSUMER PROTECTIONS.**

2 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
3 a group health plan requires or provides for designation
4 by a participant or beneficiary of a participating primary
5 care provider, then the plan shall permit each participant
6 or beneficiary to designate any participating primary care
7 provider who is available to accept such individual.

8 “(b) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

22 “(C) in a manner so that, if such services
23 are provided to a participant or beneficiary by
24 a nonparticipating provider or a nonpartici-
25 pating emergency facility—

1 “(i) such services will be provided
2 without imposing any requirement under
3 the plan for prior authorization of services
4 or any limitation on coverage that is more
5 restrictive than the requirements or limita-
6 tions that apply to emergency services re-
7 ceived from participating providers and
8 participating emergency facilities with re-
9 spect to such plan;

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

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

24 “(iv) the group health plan pays to
25 such provider or facility, respectively, the

1 amount by which the recognized amount
2 for such services and year involved exceeds
3 the cost-sharing amount for such services
4 (as determined in accordance with clauses
5 (ii) and (iii)) and year; and

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

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

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

3 “(A) AUDIT PROCESS.—

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

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

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

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

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

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

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

23 “(B) RULEMAKING.—Not later than July
24 1, 2021, the Secretary, in consultation with the
25 Secretary of Labor and the Secretary of Health

1 and Human Services, shall establish through
2 rulemaking—

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

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

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

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

23 Such rulemaking shall take into account pay-
24 ments that are made by such plan that are not
25 on a fee-for-service basis. Such methodology

1 may account for relevant payment adjustments
2 that take into account quality or facility type
3 (including higher acuity settings and the case-
4 mix of various facility types) that are otherwise
5 taken into account for purposes of determining
6 payment amounts with respect to participating
7 facilities. In carrying out clause (iii), the Sec-
8 retary shall consult with the National Associa-
9 tion of Insurance Commissioners to establish
10 the geographic regions under such clause and
11 shall periodically update such regions, as appro-
12 priate.

13 “(3) DEFINITIONS.—In this section:

14 “(A) EMERGENCY DEPARTMENT OF A HOS-
15 PITAL.—The term ‘emergency department of a
16 hospital’ includes a hospital outpatient depart-
17 ment that provides emergency services.

18 “(B) EMERGENCY MEDICAL CONDITION.—
19 The term ‘emergency medical condition’ means
20 a medical condition manifesting itself by acute
21 symptoms of sufficient severity (including se-
22 vere pain) such that a prudent layperson, who
23 possesses an average knowledge of health and
24 medicine, could reasonably expect the absence
25 of immediate medical attention to result in a

1 condition described in clause (i), (ii), or (iii) of
2 section 1867(e)(1)(A) of the Social Security
3 Act.

4 “(C) EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

1 “(aa) Such a provider or fa-
2 cility determines such individual
3 is able to travel using nonmedical
4 transportation or nonemergency
5 medical transportation.

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

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

23 “(D) INDEPENDENT FREESTANDING
24 EMERGENCY DEPARTMENT.—The term ‘inde-

1 pendent freestanding emergency department’
2 means a facility that—

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

6 “(ii) provides any emergency services
7 (as defined in subparagraph (C)).

8 “(E) MEDIAN CONTRACTED RATE.—

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

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

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

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

23 “(ii) NEW PLANS AND COVERAGE.—
24 The term ‘median contracted rate’ means,
25 with respect to a sponsor of a group health

1 plan in a geographic region in which such
2 sponsor, respectively, did not offer any
3 group health plan or health insurance cov-
4 erage during 2019—

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

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

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

1 plan that does not have sufficient informa-
2 tion to calculate the median of the con-
3 tracted rates described in clause (i)(I) in
4 2019 (or, in the case of a newly covered
5 item or service (as defined in clause
6 (iv)(III)), in the first coverage year (as de-
7 fined in clause (iv)(I)) for such item or
8 service with respect to such plan) for an
9 item or service (including with respect to
10 provider type, or amount, of claims for
11 items or services (as determined by the
12 Secretary) provided in a particular geo-
13 graphic region (other than in a case with
14 respect to which clause (ii) applies)) the
15 term ‘median contracted rate’—

16 “(I) for an item or service fur-
17 nished during 2022 (or, in the case of
18 a newly covered item or service, dur-
19 ing the first coverage year for such
20 item or service with respect to such
21 plan), means such rate for such item
22 or service determined by the sponsor
23 through use of any database that is
24 determined, in accordance with rule-
25 making described in paragraph

1 (2)(B), to not have any conflicts of in-
2 terest and to have sufficient informa-
3 tion reflecting allowed amounts paid
4 to a health care provider or facility for
5 relevant services furnished in the ap-
6 plicable geographic region (such as a
7 State all-payer claims database);

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

22 “(III) for an item or service fur-
23 nished in the first sufficient informa-
24 tion year for such item or service with
25 respect to such plan, has the meaning

1 given the term median contracted rate
2 in clause (i)(I), except that in apply-
3 ing such clause to such item or serv-
4 ice, the reference to ‘furnished during
5 2022’ shall be treated as a reference
6 to furnished during such first suffi-
7 cient information year, the reference
8 to ‘on January 31, 2019’ shall be
9 treated as a reference to in such suffi-
10 cient information year, and the in-
11 crease described in such clause shall
12 not be applied; and

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

1 “(iv) DEFINITIONS.—For purposes of
2 this subparagraph:

3 “(I) FIRST COVERAGE YEAR.—
4 The term ‘first coverage year’ means,
5 with respect to a group health plan
6 and an item or service for which cov-
7 erage is not offered in 2019 under
8 such plan or coverage, the first year
9 after 2019 for which coverage for
10 such item or service is offered under
11 such plan.

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

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

1 previous to such first subsequent
2 year; and

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

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

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

1 “(i) NONPARTICIPATING EMERGENCY
2 FACILITY.—The term ‘nonparticipating
3 emergency facility’ means, with respect to
4 an item or service and a group health plan,
5 an emergency department of a hospital, or
6 an independent freestanding emergency de-
7 partment, that does not have a contractual
8 relationship directly or indirectly with the
9 plan for furnishing such item or service
10 under the plan.

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

21 “(G) NONPARTICIPATING PROVIDERS; PAR-
22 TICIPATING PROVIDERS.—

23 “(i) NONPARTICIPATING PROVIDER.—
24 The term ‘nonparticipating provider’
25 means, with respect to an item or service

1 and a group health plan, a physician or
2 other health care provider who is acting
3 within the scope of practice of that pro-
4 vider’s license or certification under appli-
5 cable State law and who does not have a
6 contractual relationship with the plan or
7 issuer, respectively, for furnishing such
8 item or service under the plan.

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

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

24 “(i) subject to clause (iii), in the case
25 of such item or service furnished in a State

1 that has in effect a specified State law
2 with respect to such plan; such a non-
3 participating provider or emergency facil-
4 ity; and such an item or service, the
5 amount determined in accordance with
6 such law;

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

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

24 “(I) SPECIFIED STATE LAW.—The term
25 ‘specified State law’ means, with respect to a

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

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

18 “(c) ACCESS TO PEDIATRIC CARE.—

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

1 child's primary care provider if such provider par-
2 ticipates in the network of the plan or issuer.

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

7 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
8 COLOGICAL CARE.—

9 “(1) GENERAL RIGHTS.—

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

1 “(B) OBSTETRICAL AND GYNECOLOGICAL
2 CARE.—A group health plan described in para-
3 graph (2) shall treat the provision of obstetrical
4 and gynecological care, and the ordering of re-
5 lated obstetrical and gynecological items and
6 services, pursuant to the direct access described
7 under subparagraph (A), by a participating
8 health care professional who specializes in ob-
9 stetrics or gynecology as the authorization of
10 the primary care provider.

11 “(2) APPLICATION OF PARAGRAPH.—A group
12 health plan described in this paragraph is a group
13 health plan that—

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

16 “(B) requires the designation by a partici-
17 pant or beneficiary of a participating primary
18 care provider.

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

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

1 “(B) preclude the group health plan in-
2 volved from requiring that the obstetrical or
3 gynecological provider notify the primary care
4 health care professional or the plan of treat-
5 ment decisions.

6 “(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
7 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
8 PARTICIPATING FACILITIES.—

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

23 “(A) shall not impose on such participant
24 or beneficiary a cost-sharing amount (expressed
25 as a copayment amount or coinsurance rate) for

1 such items and services so furnished that is
2 greater than the cost-sharing amount that
3 would apply under such plan had such items or
4 services been furnished by a participating pro-
5 vider (as defined in subsection (b)(3)(G)(ii));

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

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

22 “(D) shall count toward any in-network
23 deductible and in-network out-of-pocket maxi-
24 mums (as applicable) applied under the plan,
25 any cost-sharing payments made by the partici-

1 pant or beneficiary (and such in-network de-
2 ductible shall be applied) with respect to such
3 items and services so furnished in the same
4 manner as if such cost-sharing payments were
5 with respect to items and services furnished by
6 a participating provider.

7 “(2) DEFINITIONS.—In this section:

8 “(A) PARTICIPATING HEALTH CARE FACIL-
9 ITY.—

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

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

22 “(I) A hospital (as defined in
23 1861(e) of the Social Security Act).

24 “(II) A hospital outpatient de-
25 partment.

1 “(III) A critical access hospital
2 (as defined in section 1861(mm) of
3 such Act).

4 “(IV) An ambulatory surgical
5 center (as defined in section
6 1833(i)(1)(A) of such Act).

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

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

20 “(f) AIR AMBULANCE SERVICES.—

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

1 would be covered if provided by a participating pro-
2 vider (as defined in such subsection) with respect to
3 such plan—

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

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

22 “(C) the plan or coverage shall pay to such
23 provider furnishing such services to such partici-
24 ipant or beneficiary the amount by which the
25 recognized amount (as defined in and deter-

1 mined pursuant to subsection (b)(3)(H)(ii)) for
2 such services and year involved exceeds the
3 cost-sharing amount imposed under the plan for
4 such services (as determined in accordance with
5 subparagraphs (A) and (B)).

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

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

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

“Sec. 9815. Additional market reforms.

“Sec. 9816. Consumer protections.”.

22 (d) ADDITIONAL APPLICATION PROVISIONS.—

23 (1) APPLICATION TO FEHB.—

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

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

1 (B) EFFECTIVE DATE.—The amendment
2 made by this paragraph shall apply with respect
3 to contracts entered into or renewed for con-
4 tract years beginning on or after January 1,
5 2022.

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

10 “(5) APPLICATION OF ADDITIONAL PROVI-
11 SIONS.—Subsections (b), (e), (f), (g), and (h) of sec-
12 tion 2719A of the Public Health Service Act shall
13 apply to grandfathered health plans for plan years
14 beginning on or after January 1, 2022.”.

15 (3) COORDINATION.—The Secretary of the
16 Treasury, the Secretary of Health and Human Serv-
17 ices, and the Secretary of Labor shall ensure,
18 through the execution of an interagency memo-
19 randum of understanding among such Secretaries,
20 that—

21 (A) regulations, rulings, and interpreta-
22 tions issued by such Secretaries relating to the
23 same matter over which 2 or more such Secre-
24 taries have responsibility under this title (and
25 the amendments made by this title) are admin-

1 istered so as to have the same effect at all
2 times; and

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

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

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

21 (B) the requirements under section
22 1866(a)(1)(U) of the Social Security Act (42
23 U.S.C. 1395cc(a)(1)(U)).

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

4 **SEC. 3. PREVENTING CERTAIN CASES OF BALANCE BILL-**
5 **ING.**

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

9 **“PART D—HEALTH CARE PROVIDER**
10 **REQUIREMENTS**

11 **“SEC. 2799A-1. BALANCE BILLING IN CASES OF EMERGENCY**
12 **SERVICES.**

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

23 “(1) in the case that the hospital or inde-
24 pendent freestanding emergency department is a
25 nonparticipating emergency facility, the emergency

1 department of a hospital or independent free-
2 standing emergency department shall not hold the
3 participant, beneficiary, or enrollee liable for a pay-
4 ment amount for such emergency services so fur-
5 nished that is more than the cost-sharing amount
6 for such services (as determined in accordance with
7 clauses (ii) and (iii) of section 2719A(b)(1)(C), sec-
8 tion 716(b)(1)(C) of the Employee Retirement In-
9 come Security Act of 1974, and section
10 9816(b)(1)(C) of the Internal Revenue Code of
11 1986, as applicable); and

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

1 and section 9816(b)(1)(C) of the Internal Revenue
2 Code of 1986, as applicable).

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

6 **“SEC. 2799A-2. BALANCE BILLING IN CASES OF NON-EMER-
7 GENCY SERVICES PERFORMED BY NON-
8 PARTICIPATING PROVIDERS AT CERTAIN
9 PARTICIPATING FACILITIES.**

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

1 716(e)(1) of the Employee Retirement Income Security
2 Act of 1974, and section 9816(e)(1) of the Internal Rev-
3 enue Code of 1986, as applicable).

4 “(b) EXCEPTION.—

5 “(1) IN GENERAL.—Subsection (a) shall not
6 apply with respect to items or services (other than
7 ancillary services described in paragraph (2)) fur-
8 nished by a nonparticipating provider to a partici-
9 pant, beneficiary, or enrollee of a group health plan
10 or health insurance coverage offered by a health in-
11 surance issuer in the group or individual market, if
12 the provider satisfies the notice and consent criteria
13 of subsection (d).

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

18 “(A) subject to paragraph (3), items and
19 services related to emergency medicine, anesthe-
20 siology, pathology, radiology, and neonatology,
21 whether or not provided by a physician or non-
22 physician practitioner, and items and services
23 provided by assistant surgeons, hospitalists, and
24 intensivists;

1 “(B) subject to paragraph (3), diagnostic
2 services (including radiology and laboratory
3 services);

4 “(C) items and services provided by such
5 other specialty practitioners, as the Secretary
6 specifies through rulemaking; and

7 “(D) items and services provided by a non-
8 participating provider if there is no partici-
9 pating provider who can furnish such item or
10 service at such facility.

11 “(3) EXCEPTION.—The Secretary may, through
12 rulemaking, establish a list (and update such list) of
13 advanced diagnostic laboratory tests, which shall not
14 be included as an ancillary service described in para-
15 graph (2) and with respect to which subsection (a)
16 would apply.

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

1 ered item or service shall not include an ancillary service
2 described in subsection (b)(2).

3 “(d) NOTICE AND CONSENT TO BE TREATED BY A
4 NONPARTICIPATING PROVIDER OR NONPARTICIPATING
5 FACILITY.—

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

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

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

3 “(ii) a written notice in paper or elec-
4 tronic form (and including electronic notifi-
5 cation, as practicable) specified by the Sec-
6 retary, not later than July 1, 2021,
7 through guidance (which shall be updated
8 as determined necessary by the Secretary)
9 that—

10 “(I) contains the information re-
11 quired under paragraph (2);

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

1 is furnished by a participating pro-
2 vider or participating facility, as ap-
3 plicable with respect to such plan;

4 “(III) is available in the 15 most
5 common languages in the geographic
6 region of the applicable facility and, in
7 the case the primary language of the
8 beneficiary, participant, or enrollee,
9 respectively, is not one of such 15 lan-
10 guage, makes a good faith effort to
11 also provide such notice orally in such
12 primary language of the beneficiary,
13 participant, or enrollee; and

14 “(IV) is signed and dated by the
15 participant, beneficiary, or enrollee (or
16 by an authorized representative of the
17 participant, beneficiary, or enrollee)
18 and, with respect to items or services
19 to be furnished by such a provider
20 that are not poststabilization services
21 described in section
22 2719A(b)(3)(C)(ii), is so signed and
23 dated not less than 72 hours prior to
24 the participant, beneficiary, or en-

1 rollee being furnished such items or
2 services by such provider; and

3 “(B) obtains from the participant, bene-
4 ficiary, or enrollee (or from such an authorized
5 representative) the consent described in para-
6 graph (3) to be treated by a nonparticipating
7 provider or nonparticipating facility.

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

16 “(A) Notification, as applicable, that the
17 health care provider is a nonparticipating pro-
18 vider with respect to the health plan or the
19 health care facility is a nonparticipating facility
20 with respect to the health plan.

21 “(B) Notification of the good faith esti-
22 mated amount that such provider or facility
23 may charge the participant, beneficiary, or en-
24 rollee for such items and services involved, in-
25 cluding a notification that the provision of such

1 estimate or consent to be treated under para-
2 graph (3) does not constitute a contract with
3 respect to the charges estimated for such items
4 and services.

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

12 “(D) Information about whether prior au-
13 thorization or other care management limita-
14 tions may be required in advance of receiving
15 such items or services at the facility.

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

1 retary through rulemaking, in consultation with the
2 Secretary of Labor, that—

3 “(A) acknowledges that the participant,
4 beneficiary, or enrollee has been—

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

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

18 “(B) documents the consent of the partici-
19 pant, beneficiary, or enrollee to be furnished
20 such item or services by such provider or facil-
21 ity.

22 “(4) RULE OF CONSTRUCTION.—The consent
23 described in paragraph (3), with respect to a partici-
24 pant, beneficiary, or enrollee of a group health plan
25 or health insurance coverage offered by a health in-

1 surance issuer in the group or individual market,
2 shall constitute only consent to the receipt of the in-
3 formation provided pursuant to this subsection and
4 shall not constitute a contractual agreement of the
5 participant, beneficiary, or enrollee to any estimated
6 charge or amount included in such information.

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

21 “(f) DEFINITIONS.—In this section:

22 “(1) The terms ‘nonparticipating provider’ and
23 ‘participating provider’ have the meanings given
24 such terms, respectively, in subsection (b)(3) of sec-
25 tion 2719A.

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

4 “(3) The term ‘nonparticipating facility’
5 means—

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

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

1 furnishing of such services under the plan or
2 coverage, respectively.

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

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

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

1 nishing of such services under the plan or cov-
2 erage, respectively.

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

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

13 “(1) the requirements and prohibitions of such
14 provider or facility under sections 2799A–1, 2799A–
15 2, and 2799A–4 (relating to prohibitions on balance
16 billing in certain circumstances);

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

1 such item or service under the plan or coverage, re-
2 spectively, after receiving payment from the plan or
3 coverage, respectively, for such item or service and
4 any applicable cost-sharing payment from such par-
5 ticipant, beneficiary, or enrollee; and

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

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

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

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

1 than the cost-sharing amount for such service (as deter-
2 mined in accordance with paragraphs (1) and (2) of sec-
3 tion 2719A(f), section 716(f) of the Employee Retirement
4 Income Security Act of 1974, or section 9816(f) of the
5 Internal Revenue Code of 1986, as applicable).

6 **“SEC. 2799A-5. ENFORCEMENT.**

7 “(a) STATE ENFORCEMENT.—

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

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

23 “(3) NOTIFICATION OF SECRETARY OF
24 LABOR.—A State may notify the Secretary of Labor
25 of instances of violations of sections 2799A-1,

1 2799A–2, or 2799A–4 with respect to participants
2 or beneficiaries under a group health plan or health
3 insurance coverage offered by a health insurance
4 issuer in the group market and any enforcement ac-
5 tions taken against providers or facilities as a result
6 of such violations, including the disposition of any
7 such enforcement actions.

8 “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

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

24 “(2) LIMITATION.—The provisions of para-
25 graph (1) shall apply to enforcement of a provision

1 (or provisions) specified in subsection (a)(1) only as
2 provided under subsection (a)(2).

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

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

1 pant, beneficiary, or enrollee, as applicable, in an
2 amount equal to the difference between the amount
3 billed and the amount allowed to be billed under the
4 provision, plus interest, at an interest rate deter-
5 mined by the Secretary.

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

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

16 (b) SECRETARY OF LABOR INVESTIGATIVE AUTHOR-
17 ITY.—

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

1 **“SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLA-**
2 **TIONS OF CERTAIN HEALTH CARE PROVIDER**
3 **REQUIREMENTS; COMPLAINT PROCESS.**

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

21 “(b) COMPLAINT PROCESS.—Not later than January
22 1, 2022, the Secretary shall establish a process under
23 which the Secretary—

24 “(1) may receive complaints from participants
25 and beneficiaries of group health plans or health in-
26 surance coverage offered in connection with such

1 plans relating to alleged violations of the sections
2 specified in subsection (a); and

3 “(2) transmits such complaints to States or the
4 Secretary of Health and Human Services (as deter-
5 mined appropriate by the Secretary) for potential
6 enforcement actions.”.

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

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

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

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

22 “(1) information in plain language on—

23 “(A) the requirements and prohibitions ap-
24 plied under sections 2799A–1, 2799A–2 and

1 2799A–4 of the Public Health Service Act (re-
2 relating to prohibitions on balance billing in cer-
3 tain circumstances);

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

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

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

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

25 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this section, the Sec-
3 retary of Health and Human Services, the Secretary
4 of Labor, and the Secretary of the Treasury (in this
5 section referred to as the “Secretaries”) shall jointly
6 establish by regulation an independent dispute reso-
7 lution process (in this section referred to as the
8 “IDR process”) under which, with respect to a pay-
9 ment made by a group health plan or health insur-
10 ance issuer offering health insurance coverage in the
11 group or individual market pursuant to subsection
12 (b)(1), (e)(1), or (f)(1) of section 2719A of the Pub-
13 lic Health Service Act, section 716 of the Employee
14 Retirement Income Security Act of 1974, or section
15 9816 of the Internal Revenue Code of 1986 (as ap-
16 plicable) using the recognized amount (as defined in
17 and determined pursuant to section
18 2719A(b)(3)(H)(ii) of the Public Health Service Act
19 or subsection (b)(3)(H)(ii) of section 716 of the Em-
20 ployee Retirement Income Security Act of 1974 or
21 section 9816 of the Internal Revenue Code of 1986,
22 as applicable) to a nonparticipating provider (as de-
23 fined in subparagraph (G) of section 2719A(b)(3) of
24 the Public Health Service Act or subparagraph (G)
25 of subsection (b)(3) of section 716 of the Employee

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

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

22 (B) in the case a settlement described in
23 subsection (d)(2) is not reached with respect to
24 such request, an entity certified and selected
25 under subsection (c) shall determine in accord-

1 ance with such paragraph an alternative pay-
2 ment to be applied, with respect to such re-
3 quest.

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

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

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

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

1 Service Act with respect to such item or service pur-
2 suant to subsection (e) of such section.

3 (b) REQUIREMENTS FOR REQUESTS TO BE ELIGIBLE
4 FOR SUBMISSION UNDER IDR PROCESS.—

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

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

22 (i) the provider or facility, respec-
23 tively, filed, not later than 30 days after
24 the date such payment is received by the
25 provider or facility, respectively, an appeal

1 under the appeals process of the group
2 health plan or health insurance issuer, the
3 subject of which includes the payment for
4 such items and services (or air ambulance
5 services); and

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

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

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

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

1 (2) MINIMUM MEDIAN CONTRACTED RATE.—A
2 request may not be submitted under the IDR proc-
3 ess, with respect to items and services (or air ambu-
4 lance services) furnished in a geographic area by a
5 nonparticipating provider or nonparticipating emer-
6 gency facility for which a group health plan or
7 health insurance issuer offering health insurance
8 coverage in the group or individual market made a
9 payment pursuant to subsection (b)(1), (e)(1), or
10 (f)(1) of section 2719A of the Public Health Service
11 Act or subsection (b)(1), (e)(1), or (f)(1) of section
12 716 of the Employee Retirement Income Security
13 Act of 1974 or section 9816 of the Internal Revenue
14 Code of 1986 (as applicable) unless—

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

1 \$750 (or, in the case of air ambulance services,
2 is at least \$25,000); or

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

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

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

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

14 (C) all such items and services (or air am-
15 bulance services) are related to the treatment of
16 the same condition; and

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

22 (c) IDR ENTITIES.—

23 (1) PROCESS OF CERTIFICATION.—The process
24 described in subsection (a) shall include a certifi-

1 cation process under which eligible entities may be
2 certified to carry out the IDR process.

3 (2) CERTIFICATION.—

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

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

21 (C) FEE LIMITATIONS.—For purposes of
22 subparagraph (B), the fee limitations described
23 in this subparagraph are limitations established
24 by the Secretaries for the amount a certified
25 IDR entity may charge a nonparticipating pro-

1 vider, nonparticipating emergency facility,
2 group health plan, or health insurance issuer
3 offering health insurance coverage in the group
4 or individual market for services furnished by
5 such entity with respect to the resolution of a
6 specified request of such provider, facility, plan,
7 or issuer under the process described in sub-
8 section (a).

9 (3) SELECTION OF CERTIFIED IDR ENTITY.—

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

22 (d) PAYMENT DETERMINATION.—

23 (1) TIMING.—A certified IDR entity selected
24 under subsection (c)(3) with respect to a request
25 under the IDR process shall, subject to paragraph

1 (2), not later than 30 days after being so selected,
2 determine the alternative payment that should be
3 made for items and services (or air ambulance serv-
4 ices) included in such request in accordance with
5 paragraph (3).

6 (2) SETTLEMENT.—

7 (A) IN GENERAL.—If such entity deter-
8 mines that a settlement between the group
9 health plan or issuer, as applicable, and the
10 provider or facility, as applicable, is likely with
11 respect to a request under the IDR process, the
12 entity may direct the parties to attempt, for a
13 period not to exceed 10 days, a good faith nego-
14 tiation for a settlement of such request.

15 (B) TIMING.—The period for a settlement
16 described in subparagraph (A) shall accrue to-
17 ward the 30-day period described in paragraph
18 (1).

19 (3) DETERMINATION OF ALTERNATIVE PAY-
20 MENT.—

21 (A) IN GENERAL.—The group health plan
22 or health insurance issuer offering health insur-
23 ance coverage in the group or individual market
24 (as applicable) and the nonparticipating pro-
25 vider or nonparticipating emergency facility (as

1 applicable) involved shall, with respect to a re-
2 quest under the IDR process, each submit to
3 the certified IDR entity selected under sub-
4 section (c)(3) for such request a final offer to
5 be considered for the alternative payment to be
6 applied with respect to items and services (or
7 air ambulance services) which are the subject of
8 the request. Such entity shall determine, in ac-
9 cordance with subparagraph (B), which such
10 offer is the most reasonable and will be applied
11 as the alternative payment.

12 (B) CONSIDERATIONS IN DETERMINA-
13 TION.—

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

19 (I) the median contracted rates
20 (as defined in subsection (b)(3)(E) of
21 section 2719A of the Public Health
22 Service Act or subsection (b)(3)(E) of
23 section 716 of the Employee Retirement
24 Income Security Act of 1974 or
25 section 9816 of the Internal Revenue

1 Code of 1986 (as applicable)) for the
2 applicable year for items or services
3 (or air ambulance services) that are
4 comparable to the items and services
5 (or air ambulance services) included
6 in the request and that are furnished
7 in the same geographic area (as de-
8 fined by the Secretaries for purposes
9 of such subsection) as such items and
10 services (or air ambulance services)
11 (not including any facility fees with
12 respect to such rates); and

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

23 (ii) ADDITIONAL CIRCUMSTANCES FOR
24 CERTAIN ITEMS AND SERVICES.—For pur-
25 poses of clause (i)(II), the circumstances

1 described in this clause are, with respect to
2 items and services (other than air ambu-
3 lance services) included in the request
4 under the IDR process of a nonpartici-
5 pating provider, nonparticipating emer-
6 gency facility, group health plan, or health
7 insurance issuer the following:

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

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

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

1 ices or the complexity of furnishing
2 such items and services to such indi-
3 vidual.

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

12 (I) The quality and outcomes
13 measurements of the provider that
14 furnished such services.

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

22 (III) The training, education, ex-
23 perience, and quality of the medical
24 personnel that furnished such serv-
25 ices.

1 (IV) Ambulance vehicle type, in-
2 cluding the clinical capability level of
3 such vehicle.

4 (V) Population density of the
5 pick up location (such as urban, sub-
6 urban, rural, or frontier).

7 (iv) PROHIBITION ON CONSIDERATION
8 OF BILLED CHARGES.—In determining
9 which final offer is the alternative payment
10 amount to be applied with respect to items
11 and services (or air ambulance services)
12 furnished by a provider or facility and in-
13 cluded in the request under the IDR proc-
14 ess, the certified IDR entity selected under
15 subsection (c)(3) with respect to such re-
16 quest shall not consider the amount that
17 would have been billed by such provider or
18 facility with respect to such items and
19 services had the provisions of section
20 2799A–1, 2799A–2, or 2799A–4 of the
21 Public Health Service Act (as applicable)
22 not applied.

23 (C) EFFECTS OF DETERMINATION.—

1 (i) IN GENERAL.—A determination of
2 a certified IDR entity under subparagraph
3 (A) shall be binding.

4 (ii) LIMITATION ON CERTAIN SUBSE-
5 QUENT IDR CLAIMS.—In the case of a de-
6 termination of a certified IDR entity under
7 subparagraph (A), with respect to a re-
8 quest submitted under subsection (a)(1)(A)
9 and the two parties involved with such re-
10 quest, the party that submitted such initial
11 request may not submit during the 90-day
12 period following such determination a sub-
13 sequent request under such subsection in-
14 volving the same other party to such re-
15 quest with respect to such an item or serv-
16 ice (or air ambulance service) that was the
17 subject of such initial request.

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

1 (i) if such entity makes a determina-
2 tion with respect to such request under
3 subparagraph (A), the party whose offer is
4 not chosen under such clause shall be re-
5 sponsible for paying all fees charged by
6 such entity; and

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

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

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

1 tween such alternative payment and the
2 amount so paid; and

3 (ii) in the case that the alternative
4 payment determined to be applied is less
5 than the amount paid with respect to such
6 request, such provider or facility (as appli-
7 cable) shall pay directly to the plan or
8 issuer (as applicable) the difference be-
9 tween the amount so paid and such alter-
10 native payment.

11 (e) PUBLICATION OF INFORMATION RELATING TO
12 DISPUTES.—

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

19 (A) the number of requests submitted
20 under the IDR process during such year;

21 (B) the practice size of the providers and
22 facilities submitting requests under the IDR
23 process during such year;

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

4 (D) the information described in para-
5 graph (2) for each request with respect to
6 which such a determination was so made.

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

15 (A) a description of each item and service
16 (or air ambulance service) included in such re-
17 quest;

18 (B) the geography in which the items and
19 services (or air ambulance services) included in
20 such request were provided;

21 (C) the amount of the offer submitted
22 under subsection (d)(3)(A) by the group health
23 plan or health insurance issuer (as applicable)
24 and by the nonparticipating provider or non-
25 participating emergency facility (as applicable)

1 expressed as a percentage of the median con-
2 tracted rate;

3 (D) whether the offer selected by the cer-
4 tified IDR entity under such subsection to be
5 the alternative payment applied was the offer
6 submitted by such plan or issuer (as applicable)
7 or by such provider or facility (as applicable)
8 and the amount of such offer so selected ex-
9 pressed as a percentage of the median con-
10 tracted rate;

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

17 (F) the identity of the group health plan or
18 health insurance issuer, provider, or facility,
19 with respect to the request.

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

1 (f) ENFORCEMENT.—

2 (1) IN GENERAL.—Any health care provider,
3 health care facility, group health plan, or health in-
4 surance issuer offering group or individual health in-
5 surance coverage that violates a provision of this
6 section shall be subject to a civil monetary penalty
7 in an amount not to exceed \$10,000 for each such
8 violation.

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

19 (g) DEFINITIONS.—In this subsection, the terms
20 “group health plan”, “group market”, “health insurance
21 issuer”, “health insurance coverage”, “individual health
22 insurance coverage”, “group health insurance coverage”,
23 and “individual market” have the meanings given such
24 terms, respectively, in section 2791 of the Public Health
25 Service Act.

1 (h) REPORT.—Not later than December 31, 2023,
2 the Comptroller General of the United States shall con-
3 duct a study and submit to Congress a report on the IDR
4 process established under this section. Such study and re-
5 port shall include an analysis of potential financial rela-
6 tionships between providers and facilities that utilize the
7 IDR process and private equity investment firms.

8 **SEC. 5. ADVISORY COMMITTEE ON GROUND AMBULANCE**
9 **AND PATIENT BILLING.**

10 (a) IN GENERAL.—Not later than 60 days after the
11 date of enactment of this Act, the Secretary of Labor, Sec-
12 retary of Health and Human Services, and the Secretary
13 of the Treasury (the Secretaries) shall jointly establish an
14 advisory committee for the purpose of reviewing options
15 to improve the disclosure of charges and fees for ground
16 ambulance services, better inform consumers of insurance
17 options for such services, and protect consumers from bal-
18 ance billing.

19 (b) COMPOSITION OF THE ADVISORY COMMITTEE.—
20 The advisory committee shall be composed of the following
21 members:

22 (1) The Secretary of Labor, or the Secretary's
23 designee.

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

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

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

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

7 (B) State insurance regulators.

8 (C) Health insurance providers.

9 (D) Patient advocacy groups.

10 (E) Consumer advocacy groups.

11 (F) State and local governments.

12 (G) Physician specializing in emergency,
13 trauma, cardiac, or stroke.

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

17 (6) Up to an additional 2 representatives other-
18 wise not described in paragraphs (1) through (5), as
19 determined necessary and appropriate by the Secre-
20 taries.

21 (c) CONSULTATION.—The advisory committee shall,
22 as appropriate, consult with relevant experts and stake-
23 holders, including those not otherwise included under sub-
24 section (b), while conducting the review described in sub-
25 section (a).

1 (d) RECOMMENDATIONS.—The advisory committee
2 shall make recommendations with respect to disclosure of
3 charges and fees for ground ambulance services and insur-
4 ance coverage, consumer protection and enforcement au-
5 thorities of the Departments of Labor, Health and Human
6 Services, and the Treasury and State authorities, and the
7 prevention of balance billing to consumers. The rec-
8 ommendations shall address, at a minimum—

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

11 (2) steps that can be taken by State legisla-
12 tures, State insurance regulators, State attorneys
13 general, and other State officials as appropriate,
14 consistent with current legal authorities regarding
15 consumer protection; and

16 (3) legislative options for Congress to prevent
17 balance billing.

18 (e) REPORT.—Not later than 180 days after the date
19 of the first meeting of the advisory committee, the advi-
20 sory committee shall submit to the Secretaries, and the
21 Committees on Education and Labor, Energy and Com-
22 merce, and Ways and Means of the House of Representa-
23 tives and the Committees on Finance and Health, Edu-
24 cation, Labor, and Pensions a report containing the rec-
25 ommendations made under subsection (d).

1 **SEC. 6. IMPROVING PROVIDER DIRECTORIES.**

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

5 **“SEC. 2730. PROTECTING PATIENTS AND IMPROVING THE**
6 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
7 **MATION.**

8 “(a) NETWORK STATUS OF PROVIDERS.—

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

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

19 “(i) upon a telephone inquiry by an
20 enrollee—

21 “(I) through a written electronic
22 communication from the plan or
23 issuer to the enrollee, as soon as prac-
24 ticable and not later than 1 business
25 day after such inquiry is made by

1 such participant, beneficiary, or en-
2 rollee for such information;

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

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

16 “(B) include in any print directory—

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

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

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

12 “(A) verify and update, at least once every
13 90 days, the provider directory information for
14 all providers included in the online health care
15 provider directory search tool described in para-
16 graph (1)(A)(ii); and

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

23 “(b) COST-SHARING LIMITATIONS.—A group health
24 plan or a health insurance issuer offering group or indi-
25 vidual health insurance coverage shall not apply, and shall

1 ensure that no provider applies, cost-sharing to an enrollee
2 for treatment or services provided by a health care pro-
3 vider in excess of the normal cost-sharing applied for such
4 treatment or services provided in-network (including any
5 balance bill issued by the health care provider involved),
6 if such enrollee, or health care provider referring such en-
7 rollee, demonstrates (based on the electronic, written in-
8 formation described in subsection (a)(1)(A)(i)(I), the oral
9 confirmation described in subsection (a)(1)(A)(i)(II) re-
10 ceived by the enrollee not more than 30 days before the
11 date the treatment or services were received, or a copy
12 of the online provider directory described in subsection
13 (a)(1)(A)(ii) on a date not more than 30 days before the
14 date the treatment or services were received), that the en-
15 rollee relied on the information described in subsection
16 (a)(1) for which such enrollee provides such documenta-
17 tion, that indicated that the provider is an in-network pro-
18 vider, if the provider was out-of-network at the time the
19 treatment or service involved was received.

20 “(c) DEFINITION.—For purposes of this section, the
21 term ‘provider directory information’ includes the names,
22 addresses, specialty, and telephone numbers of individual
23 health care providers, and the names, addresses, and tele-
24 phone numbers of each medical group, clinic, or facility

1 contracted to participate in any of the networks of the
2 group health plan or health insurance coverage involved.

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

6 (b) **ERISA.**—Subpart B of part 7 of subtitle B of
7 title I of the Employee Retirement Income Security Act
8 of 1974 (29 U.S.C. 1185 et seq.), as amended by section
9 2, is further amended by adding at the end the following:

10 **“SEC. 717. PROTECTING PATIENTS AND IMPROVING THE**
11 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
12 **MATION.**

13 “(a) **NETWORK STATUS OF PROVIDERS.**—

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

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

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

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

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

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

23 “(B) include in any print directory—

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

1 the date of the last data update and that
2 participants or beneficiaries or prospective
3 participants or beneficiaries should consult
4 the group health plan's or issuer's elec-
5 tronic provider directory on its website or
6 call a specified customer service telephone
7 number to obtain the most current pro-
8 vider directory information; and

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

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

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

24 “(B) remove any provider from such online
25 directory search tool if such provider has not

1 verified the directory information within the
2 previous 6 months or the plan or issuer has
3 been unable to verify the provider's network
4 participation.

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

1 the provider is an in-network provider, if the provider was
2 out-of-network at the time the treatment or service in-
3 volved was received.

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

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

14 **“SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE**
15 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
16 **MATION.**

17 “(a) NETWORK STATUS OF PROVIDERS.—

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

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

1 “(i) upon a telephone inquiry by a
2 participant or beneficiary—

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

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

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

25 “(B) include in any print directory—

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

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

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

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

24 “(B) remove any provider from such online
25 directory search tool if such provider has not

1 verified the directory information within the
2 previous 6 months or the plan or issuer has
3 been unable to verify the provider’s network
4 participation.

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

1 of-network at the time the treatment or service involved
2 was received.

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

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

13 (d) CLERICAL AMENDMENTS.—

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

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

19 (2) IRC.—The table of sections for subchapter
20 B of chapter 100 of the Internal Revenue Code of
21 1986, as amended by section 2, is further amended
22 by adding at the end the following new item:

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

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

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

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

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

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

22 “(1) when the provider begins a network agree-
23 ment with a plan or with an issuer with respect to
24 certain coverage;

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

4 “(3) when there are material changes to the
5 content of provider directory information described
6 in section 2730(a)(1), section 717(a)(1) of the Em-
7 ployee Retirement Income Security Act of 1974, or
8 section 9817(a)(1) of the Internal Revenue Code of
9 1986 (as applicable); and

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

12 “(b) ENFORCEMENT.—

13 “(1) CIVIL PENALTIES.—

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

1 “(B) SAFE HARBOR.—The Secretary may
2 waive the penalty described under paragraph
3 (1) with respect to a health care provider that
4 unknowingly violates section 2730(b)(1), section
5 717(b)(1) of the Employee Retirement Income
6 Security Act of 1974, or section 9817(b)(1) of
7 the Internal Revenue Code of 1986 (as applica-
8 ble) with respect to an enrollee if such provider
9 rescinds the bill involved and, if applicable, re-
10 imburses the enrollee within 30 days of the date
11 on which the provider billed the enrollee in vio-
12 lation of such subsection.

13 “(C) PROCEDURE.—The provisions of sec-
14 tion 1128A of the Social Security Act, other
15 than subsections (a) and (b) and the first sen-
16 tence of subsection (c)(1) of such section, shall
17 apply to civil money penalties under this sub-
18 section in the same manner as such provisions
19 apply to a penalty or proceeding under section
20 1128A of the Social Security Act.

21 “(2) REFUNDS TO ENROLLEES.—If a health
22 care provider submits a bill to an enrollee based on
23 cost-sharing for treatment or services provided by
24 the health care provider that is in excess of the nor-
25 mal cost-sharing applied for such treatment or serv-

1 ices provided in-network, as prohibited under section
2 2730(b), section 717(b) of the Employee Retirement
3 Income Security Act of 1974, or section 9817(b) of
4 the Internal Revenue Code of 1986 (as applicable)
5 and the enrollee pays such bill, the provider shall re-
6 imburse the enrollee for the full amount paid by the
7 enrollee in excess of the in-network cost-sharing
8 amount for the treatment or services involved, plus
9 interest, at an interest rate determined by the Sec-
10 retary.

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

15 “(1) that the plan or issuer remove, at the time
16 of termination of such contract, the provider from a
17 directory of the plan or issuer described in section
18 2730(a)(1), section 717(a)(1) of the Employee Re-
19 tirement Income Security Act of 1974, or section
20 9817(a)(1) of the Internal Revenue Code of 1986
21 (as applicable); or

22 “(2) that the plan or issuer bear financial re-
23 sponsibility, including under section 2730(b), section
24 717(b) of the Employee Retirement Income Security
25 Act of 1974, or section 9817(b) of the Internal Rev-

1 enue Code of 1986 (as applicable) for providing in-
2 accurate network status information to an enrollee.

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

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

13 **SEC. 7. INCREASING TRANSPARENCY IN HEALTH COV-**
14 **ERAGE.**

15 (a) DISCLOSURE OF DIRECT AND INDIRECT COM-
16 PENSATION FOR BROKERS AND CONSULTANTS TO EM-
17 PLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN
18 PLANS ON THE INDIVIDUAL MARKET.—

19 (1) GROUP HEALTH PLANS.—Section 408(b)(2)
20 of the Employee Retirement Income Security Act of
21 1974 (29 U.S.C. 1108(b)(2)) is amended—

22 (A) by striking “(2) Contracting or mak-
23 ing” and inserting “(2)(A) Contracting or mak-
24 ing”; and

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

1 “(B)(i) No contract or arrangement for services
2 between a covered plan and a covered service pro-
3 vider, and no extension or renewal of such a contract
4 or arrangement, is reasonable within the meaning of
5 this paragraph unless the requirements of this sub-
6 paragraph are met.

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

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

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

24 “(AA) Brokerage services, for which
25 the covered service provider, an affiliate, or

1 a subcontractor reasonably expects to re-
2 ceive indirect compensation or direct com-
3 pensation described in item (dd), provided
4 to a covered plan with respect to selection
5 of insurance products (including vision and
6 dental), recordkeeping services, medical
7 management vendor, benefits administra-
8 tion (including vision and dental), stop-loss
9 insurance, pharmacy benefit management
10 services, wellness services, transparency
11 tools and vendors, group purchasing orga-
12 nization preferred vendor panels, disease
13 management vendors and products, compli-
14 ance services, employee assistance pro-
15 grams, or third party administration serv-
16 ices.

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

1 ministration selection (including vision and
2 dental), stop-loss insurance, pharmacy ben-
3 efit management services, wellness design
4 and management services, transparency
5 tools, group purchasing organization agree-
6 ments and services, participation in and
7 services from preferred vendor panels, dis-
8 ease management, compliance services, em-
9 ployee assistance programs, or third party
10 administration services.

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

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

1 gregate, during the term of the contract or ar-
2 rangement.

3 “(BB) The term ‘direct compensation’
4 means compensation received directly from a
5 covered plan.

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

14 “(ee) The term ‘responsible plan fiduciary’
15 means a fiduciary with authority to cause the
16 covered plan to enter into, or extend or renew,
17 the contract or arrangement.

18 “(ff) The term ‘subcontractor’ means any
19 person or entity (or an affiliate of such person
20 or entity) that is not an affiliate of the covered
21 service provider and that, pursuant to a con-
22 tract or arrangement with the covered service
23 provider or an affiliate, reasonably expects to
24 receive \$1,000 (or such amount as the Sec-
25 retary may establish in regulations to account

1 for inflation since the date of enactment of the
2 Ban Surprise Billing Act, as appropriate) or
3 more in compensation for performing one or
4 more services described in item (bb) under a
5 contract or arrangement with the covered plan.

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

23 “(III) No person or entity is a ‘covered service
24 provider’ within the meaning of subclause (I)(bb)
25 solely on the basis of providing services as an affil-

1 iate or a subcontractor that is performing one or
2 more of the services described in subitem (AA) or
3 (BB) of such subclause under the contract or ar-
4 rangement with the covered plan.

5 “(iii) A covered service provider shall disclose to
6 a responsible plan fiduciary, in writing, the fol-
7 lowing:

8 “(I) A description of the services to be pro-
9 vided to the covered plan pursuant to the con-
10 tract or arrangement.

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

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

23 “(IV)(aa) A description of all indirect com-
24 pensation that the covered service provider, an
25 affiliate, or a subcontractor reasonably expects

1 to receive in connection with the services de-
2 scribed in subclause (I)—

3 “(AA) including compensation from a
4 vendor to a brokerage firm based on a
5 structure of incentives not solely related to
6 the contract with the covered plan; and

7 “(BB) not including compensation re-
8 ceived by an employee from an employer
9 on account of work performed by the em-
10 ployee.

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

16 “(cc) Identification of the services for
17 which the indirect compensation will be re-
18 ceived, if applicable.

19 “(dd) Identification of the payer of the in-
20 direct compensation.

21 “(V) A description of any compensation
22 that will be paid among the covered service pro-
23 vider, an affiliate, or a subcontractor, in con-
24 nection with the services described in subclause
25 (I) if such compensation is set on a transaction

1 basis (such as commissions, finder's fees, or
2 other similar incentive compensation based on
3 business placed or retained), including identi-
4 fication of the services for which such com-
5 pensation will be paid and identification of the
6 payers and recipients of such compensation (in-
7 cluding the status of a payer or recipient as an
8 affiliate or a subcontractor), regardless of
9 whether such compensation also is disclosed
10 pursuant to subclause (III) or (IV).

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

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

22 “(v)(I) A covered service provider shall disclose
23 the information required under clauses (iii) and (iv)
24 to the responsible plan fiduciary not later than the
25 date that is reasonably in advance of the date on

1 which the contract or arrangement is entered into,
2 and extended or renewed.

3 “(II) A covered service provider shall disclose
4 any change to the information required under clause
5 (iii) and (iv) as soon as practicable, but not later
6 than 60 days from the date on which the covered
7 service provider is informed of such change, unless
8 such disclosure is precluded due to extraordinary cir-
9 cumstances beyond the covered service provider’s
10 control, in which case the information shall be dis-
11 closed as soon as practicable.

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

19 “(II) The covered service provider shall disclose
20 the information required under clause (iii)(I) reason-
21 ably in advance of the date upon which such respon-
22 sible plan fiduciary or covered plan administrator
23 states that it is required to comply with the applica-
24 ble reporting or disclosure requirement, unless such
25 disclosure is precluded due to extraordinary cir-

1 cumstances beyond the covered service provider's
2 control, in which case the information shall be dis-
3 closed as soon as practicable.

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

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

22 “(aa) The responsible plan fiduciary did
23 not know that the covered service provider
24 failed or would fail to make required disclosures
25 and reasonably believed that the covered service

1 provider disclosed the information required to
2 be disclosed.

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

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

14 “(II) A notice described in subclause (I)(cc)
15 shall contain—

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

17 “(bb) the plan number used for the annual
18 report on the covered plan;

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

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

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

1 “(ff) a description of the services provided
2 to the covered plan;

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

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

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

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

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

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

20 “(IV) If the covered service provider fails to
21 comply with the written request under subclause
22 (I)(bb) within 90 days of such request, the respon-
23 sible plan fiduciary shall determine whether to ter-
24 minate or continue the contract or arrangement
25 under section 404. If the requested information re-

1 lates to future services and is not disclosed promptly
2 after the end of the 90-day period, the responsible
3 plan fiduciary shall terminate the contract or ar-
4 rangement as expeditiously as possible, consistent
5 with such duty of prudence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(i) STANDARDIZED REPORTING FORMAT.—

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

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

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

24 (a) INSURER AND PLAN REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

1 (4) CLERICAL AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

