AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 5800

OFFERED BY M__. _____

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Ban Surprise Billing Act''.

SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) by amending subsection (b) to read as follows:

''(b) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)),

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

"(A) without the need for any prior authorization determination;

"(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

"(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

"(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

"(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the require-

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

''(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

''(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively the amount by which the recognized amount for such services and year involved exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

''(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage,

respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

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

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

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with

clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group or individual market are audited by the Secretary or applicable State authority to ensure that—

"(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

"(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

"(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

"(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25

group health plans and health insurance issuers offering health insurance coverage in the group or individual market; and

''(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group or individual market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

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

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

''(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group or individual market shall use to determine the median contracted rate, differentiating by line of business;

''(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

''(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

''(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group or individual market.

Such rulemaking shall take into account payments that are made by such plan or issuer, re-

spectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

''(3) DEFINITIONS.—In this part:

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

''(B) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence

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

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent free-

standing emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

''(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, unless

each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

''(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

"(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

"(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) with respect to such items and services.

"(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 and to provide informed consent under such section, in accordance with applicable State law.

"(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent freestanding emergency department' means a facility that—

''(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

''(ii) provides any emergency services (as defined in subparagraph (C)).

''(E) MEDIAN CONTRACTED RATE.—

''(i) IN GENERAL.—The term 'median contracted rate' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering health insurance coverage in the group or individual market—

''(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respec-

tively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United

States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'median contracted rate' means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

''(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

''(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this

clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a

case with respect to which clause (ii) applies)) the term 'median contracted rate'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such

plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

''(iv) DEFINITIONS.—For purposes of this subparagraph:

''(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or serv-

ice is offered under such plan or health insurance coverage.

''(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—

''(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

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

erage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

''(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to

an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

"(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

"(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under appli-

cable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market—

''(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

''(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facil-

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

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514 of the Employee Retire-

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

''(J) STABILIZE.—The term 'to stabilize', with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).''; and

(2) by adding at the end the following new subsections:

''(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

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

and consent criteria of section 2799A–2(d)) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

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

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

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

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan or health insurance issuer of-

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

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group or individual market, is each of the following:

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm) of such Act).

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

''(V) Any other facility that provides items or services for which cov-

erage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

''(f) AIR AMBULANCE SERVICES.—

''(1) IN GENERAL.—In the case of a participant, beneficiary, or enrollee in a group health plan or health insurance coverage offered in the group or individual market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

''(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply

if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(C) the plan or coverage shall pay to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with subparagraphs (A) and (B)).

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

''(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group or individual market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.''.

(b) ERISA AMENDMENTS.—

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

''SEC. 716. CONSUMER PROTECTIONS.

''(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan or health insurance issuer offering group health insurance coverage requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer shall

permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

''(b) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

''(i) such services will be provided without imposing any requirement under

the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

''(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

''(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

''(iv) the group health plan or health insurance issuer, respectively, pays to such provider or facility, respectively, the

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

''(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of this Act and section 9815 of the Internal Revenue Code

of 1986, and other than applicable cost-sharing).

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

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering health insurance coverage in the group market are audited by the Secretary or applicable State authority to ensure that—

''(I) such plans and coverage are in compliance with the requirement of applying a median contracted rate under this section; and

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

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

''(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

''(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering health insurance coverage in the group market; and

''(II) may audit any group health plan or health insurance issuer offering health insurance coverage in the group market if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

''(iii) REPORTS.—Beginning for 2022, the Secretary shall annually submit to Congress information on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph.

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

''(i) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the median contracted rate, differentiating by line of business;

''(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

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

rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

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

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate.

''(3) DEFINITIONS.—In this section:

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

''(B) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an inde-

pendent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

''(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799A–

1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is

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

''(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

''(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

''(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

"(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

"(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent freestanding emergency department' means a facility that—

"(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

"(ii) provides any emergency services (as defined in subparagraph (C)).

"(E) MEDIAN CONTRACTED RATE.—

"(i) IN GENERAL.—The term 'median contracted rate' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance

issuer offering health insurance coverage in the group market—

''(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same line of business as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by such plan or such issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by

the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'median contracted rate' means, with respect to a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

''(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

''(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

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

market that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'median contracted rate'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rule-

making described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with

respect to such plan or coverage, has the meaning given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year

after such first sufficient information year or a subsequent year.

''(iv) DEFINITIONS.—For purposes of this subparagraph:

''(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

''(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

''(aa) in the case of an item or service for which the plan or

coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

''(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

''(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to

a group health plan or health insurance issuer offering health insurance coverage in the group market, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emer-

gency facility' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such

item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market—

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

with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, the amount determined in accordance with such law;

''(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively, such a nonparticipating provider or emergency facility, and such an item or service, an amount that is the median contracted rate (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a

State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or health insurance coverage offered by a health insurance issuer in the group market, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

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

''(c) ACCESS TO PEDIATRIC CARE.—

''(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, or health insurance coverage offered by a health insurance issuer in the group market, if the plan or issuer requires or pro-

vides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

''(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who spe-

cializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

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

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

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

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

''(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

''(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (b) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering health insurance coverage in the group market furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection

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

''(A) shall not impose on such participant or beneficiary a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (b)(3)(G)(ii));

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

''(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with re-

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

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or health insurance coverage offered in the group market, is each of the following:

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm) of such Act).

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

''(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

''(f) AIR AMBULANCE SERVICES.—

''(1) IN GENERAL.—In the case of a participant or beneficiary in a group health plan or health insurance coverage offered in the group market who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such subsection) with respect to such plan or coverage—

''(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance

rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and determined pursuant to subsection (b)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as de-

termined in accordance with subparagraphs (A) and (B)).

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

''(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering health insurance coverage in the group market that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.''.

(2) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following:

''Sec. 715. Additional market reforms.
''Sec. 716. Consumer protections.''.

(c) IRC AMENDMENTS.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 9816. CONSUMER PROTECTIONS.

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

"(b) COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan shall cover emergency services (as defined in paragraph (3)(C))—

"(A) without the need for any prior authorization determination;

"(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

"(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

''(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan;

''(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

''(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan, and year;

''(iv) the group health plan pays to such provider or facility, respectively, the

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

''(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

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

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

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with appropriate State agencies and the Secretary of Health and Human Services and the Secretary of Labor, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans are audited by the Secretary or applicable State authority to ensure that—

''(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

''(II) such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan described in clause (ii) of such paragraph (3)(E).

''(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

''(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans; and

''(II) may audit any group health plan if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan with either of the requirements described in subclauses (I) and (II) of such clause.

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

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

and Human Services, shall establish through rulemaking—

''(i) the methodology the group health plan shall use to determine the median contracted rate, differentiating by line of business;

''(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

''(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

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

Such rulemaking shall take into account payments that are made by such plan that are not on a fee-for-service basis. Such methodology

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

''(3) DEFINITIONS.—In this section:

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

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

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

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as

applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

''(ii) INCLUSION OF CERTAIN SERVICES OUTSIDE OF EMERGENCY DEPARTMENT.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799A–1, in the case of an individual enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished services described in clause (i) by a participating or nonparticipating provider or a participating or nonparticipating emergency facility to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in

subclause (II) are met, in addition to the items and services described in clause (i), items and services for which benefits are provided or covered under the plan or coverage, respectively, furnished by a nonparticipating provider or nonparticipating facility, regardless of the department of the hospital in which such individual is furnished such items or services, if, after such stabilization but during such visit in which such individual is so stabilized, the provider or facility determines that such items or services are needed.

''(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to an individual who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following:

''(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

''(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799A–2(d) of the Public Health Service Act with respect to such items and services.

''(cc) Such an individual is in a condition to receive (as determined in accordance with guidance issued by the Secretary) the information described in section 2799A–2 of the Public Health Service Act and to provide informed consent under such section, in accordance with applicable State law.

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'inde-

pendent freestanding emergency department' means a facility that—

''(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

''(ii) provides any emergency services (as defined in subparagraph (C)).

''(E) MEDIAN CONTRACTED RATE.—

''(i) IN GENERAL.—The term 'median contracted rate' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan—

''(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same line of business as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan) under such plans on January 31, 2019 for the same or a similar item or service that is provided by a pro-

vider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the median contracted rate determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'median contracted rate' means, with respect to a sponsor of a group health

plan in a geographic region in which such sponsor, respectively, did not offer any group health plan or health insurance coverage during 2019—

"(I) for the first year in which such group health plan is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

"(II) for each subsequent year such group health plan is offered in such region, the median contracted rate determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

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

plan that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (iv)(III)), in the first coverage year (as defined in clause (iv)(I)) for such item or service with respect to such plan) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'median contracted rate'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan), means such rate for such item or service determined by the sponsor through use of any database that is determined, in accordance with rulemaking described in paragraph

(2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (iv)(II)) for such item or service with respect to such plan), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning

given the term median contracted rate in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'on January 31, 2019' shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

"(iv) DEFINITIONS.—For purposes of this subparagraph:

"(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan.

"(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan—

"(aa) in the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor has such sufficient information to calculate the median of such contracted rates in the year

previous to such first subsequent year; and

"(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan for which the sponsor has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

"(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to a group health plan, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

"(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

"(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan for furnishing such item or service under the plan.

"(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan, with respect to the furnishing of such an item or service at such facility.

"(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service

and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan—

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

that has in effect a specified State law with respect to such plan; such a non-participating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

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

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a

State, an item or service furnished by a non-participating provider or emergency facility during a year and a group health plan, a State law that provides for a method for determining the amount of payment that is required to be covered by such a plan (to the extent such State law applies to such plan, subject to section 514 of the Employee Retirement Income Security Act of 1974) in the case of a participant or beneficiary covered under such plan and receiving such item or service from such a nonparticipating provider or emergency facility.

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

''(c) ACCESS TO PEDIATRIC CARE.—

''(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant or beneficiary under a group health plan, if the plan requires or provides for the designation of a participating primary care provider for the child, the plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the

child's primary care provider if such provider participates in the network of the plan or issuer.

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

''(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan described in paragraph (2) may not require authorization or referral by the plan or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

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

''(2) APPLICATION OF PARAGRAPH.—A group health plan described in this paragraph is a group health plan that—

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

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

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

''(A) waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan of treatment decisions.

''(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

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

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

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

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

''(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the recognized amount (as defined in subsection (b)(3)(H)) for such items and services and year involved exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan, any cost-sharing payments made by the partici-

pant or beneficiary (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan, with respect to the furnishing of such an item or service at the facility.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan, is each of the following:

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm) of such Act).

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

''(V) Any other facility that provides items or services for which coverage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

''(f) AIR AMBULANCE SERVICES.—

''(1) IN GENERAL.—In the case of a participant or beneficiary in a group health plan who receives air ambulance services from a nonparticipating provider (as defined in subsection (b)(3)(G)) with respect to such plan or coverage, if such services

would be covered if provided by a participating provider (as defined in such subsection) with respect to such plan—

"(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

"(B) such cost-sharing amounts shall be counted toward the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

"(C) the plan or coverage shall pay to such provider furnishing such services to such participant or beneficiary the amount by which the recognized amount (as defined in and deter-

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

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

''(g) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan that, pursuant to subsection (b)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor shall cover the cost for access to such database.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9815. Additional market reforms.
''Sec. 9816. Consumer protections.''.

(d) ADDITIONAL APPLICATION PROVISIONS.—

(1) APPLICATION TO FEHB.—

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

''(p) Each contract under this chapter shall require the carrier to comply with requirements described in the provisions of section 2719A of the Public Health Service Act and sections 2730 and 2731 of such Act, sections 716, 717, and 718 of the Employee Retirement Income Security Act of 1974, sections 9816, 9817, and 9818 of the Internal Revenue Code of 1986 (as applicable), and section 2(d) of the Ban Surprise Billing Act in the same manner as such provisions apply to a group health plan or health insurance issuer offering health insurance coverage, as described in such sections. The provisions of sections 2799A–1, 2799A–2, 2799A–3, and 2799A–4 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to a participant, beneficiary, or enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, as described in such sections.''.

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

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

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

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

(A) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which 2 or more such Secretaries have responsibility under this title (and the amendments made by this title) are admin-

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

(B) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(4) RULE OF CONSTRUCTION.—Nothing in this title, including the amendments made by this title may be construed as modifying, reducing, or eliminating—

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

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

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

SEC. 3. PREVENTING CERTAIN CASES OF BALANCE BILLING.

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

"PART D—HEALTH CARE PROVIDER REQUIREMENTS

"SEC. 2799A–1. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, emergency services for which any benefit is provided under such plan or coverage with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

''(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency

department of a hospital or independent free-standing emergency department shall not hold the participant, beneficiary, or enrollee liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974, and section 9816(b)(1)(C) of the Internal Revenue Code of 1986, as applicable); and

''(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C), section 716(b)(1)(C) of the Employee Retirement Income Security Act of 1974,

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

''(b) DEFINITION.—In this section, the term 'visit' shall have such meaning as applied to such term for purposes of section 2719A(e).

''SEC. 2799A–2. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 2799A–1 applies) for which any benefit is provided under such plan or coverage at a participating health care facility by a non-participating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing amount for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 2719A(e)(1), section

716(e)(1) of the Employee Retirement Income Security Act of 1974, and section 9816(e)(1) of the Internal Revenue Code of 1986, as applicable).

''(b) EXCEPTION.—

''(1) IN GENERAL.—Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider satisfies the notice and consent criteria of subsection (d).

''(2) ANCILLARY SERVICES DESCRIBED.—For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

''(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or nonphysician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

''(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

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

''(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

''(3) EXCEPTION.—The Secretary may, through rulemaking, establish a list (and update such list) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

''(c) CLARIFICATION.—In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a 'covered item or service'), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a cov-

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

''(d) NOTICE AND CONSENT TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—

''(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

''(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on the date on which the individual is furnished such items or services and, in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, on such date the appointment is made—

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

''(ii) a written notice in paper or electronic form (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

''(I) contains the information required under paragraph (2);

''(II) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that

is furnished by a participating provider or participating facility, as applicable with respect to such plan;

''(III) is available in the 15 most common languages in the geographic region of the applicable facility and, in the case the primary language of the beneficiary, participant, or enrollee, respectively, is not one of such 15 language, makes a good faith effort to also provide such notice orally in such primary language of the beneficiary, participant, or enrollee; and

''(IV) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, beneficiary, or en-

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

''(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility.

''(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(ii)(I), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, is each of the following:

''(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

''(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such

estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

''(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

''(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

''(3) CONSENT DESCRIBED TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Sec-

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

''(A) acknowledges that the participant, beneficiary, or enrollee has been—

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

''(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

''(B) documents the consent of the participant, beneficiary, or enrollee to be furnished such item or services by such provider or facility.

''(4) RULE OF CONSTRUCTION.—The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health in-

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

''(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(A)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 2-year period after the date on which such item or service is so furnished.

''(f) DEFINITIONS.—In this section:

''(1) The terms 'nonparticipating provider' and 'participating provider' have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

''(2) The term 'participating health care facility' has the meaning given such term in subsection (e)(2) of section 2719A.

''(3) The term 'nonparticipating facility' means—

''(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

''(B) with respect to services described in section 2719A(b)(3)(C)(ii) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the

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

''(4) The term 'participating facility' means—

''(A) with respect to emergency services (as defined in clause (i) of section 2719A(b)(3)(C)) that are not described in clause (ii) of such section and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

''(B) with respect to services that pursuant to clause (ii) of section 2719A(b)(3)(C) are included as emergency services (as defined in clause (i) of such section) and a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the fur-

nishing of such services under the plan or coverage, respectively.

"SEC. 2799A–3. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

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

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

"(2) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market with respect to which such provider or facility does not have a contractual relationship for furnishing

such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

''(b) GUIDANCE.—Not later than 6 months after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Labor, shall issue guidance on the requirements for the notice under this section.

''SEC. 2799A–4. AIR AMBULANCE SERVICES.

''In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market who is furnished on or after January 1, 2022, air ambulance services from a nonparticipating provider (as defined in section 2719A(b)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more

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

"SEC. 2799A–5. ENFORCEMENT.

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part (except section 2799A–5) to satisfy such requirements applicable to the provider or facility.

''(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements specified in paragraph (1) with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

''(3) NOTIFICATION OF SECRETARY OF LABOR.—A State may notify the Secretary of Labor of instances of violations of sections 2799A–1,

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

''(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—If a provider or facility is found to be in violation of a requirement specified in subsection (a)(1) by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

''(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision

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

''(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking conducted in consultation with the Secretary of Labor, establish a process to receive consumer complaints of violations of such provisions and resolve such complaints within 60 days of receipt of such complaints. Such process shall provide that the Secretary of Labor be informed of complaints by participants or beneficiaries under a group health plan or health insurance coverage offered by a health insurance issuer in the group market and any enforcement actions against providers resulting from such complaints, including the disposition of any such enforcement actions.

''(4) EXCEPTION.—The Secretary may waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, sections 2799A–1, 2799A–2, or 2799A–4 with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or partici-

pant, beneficiary, or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

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

''(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.''.

(b) SECRETARY OF LABOR INVESTIGATIVE AUTHORITY.—

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

"SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLATIONS OF CERTAIN HEALTH CARE PROVIDER REQUIREMENTS; COMPLAINT PROCESS.

"(a) INVESTIGATIVE AUTHORITY.—Upon receiving a notice from a State or the Secretary of Health and Human Services of violations of sections 2799A–1, 2799A–2, or 2799A–4 of the Public Health Service Act, the Secretary of Labor shall have the power to conduct an investigation to identify patterns of such violations with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan by a health insurance issuer in the group market. The Secretary may assist States, the Secretary of Health and Human Services, plans, or issuers to ensure that appropriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants or beneficiaries under a group health plan or health insurance coverage offered in connection with a group health plan by a health insurance issuer in the group market.

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

"(1) may receive complaints from participants and beneficiaries of group health plans or health insurance coverage offered in connection with such

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

''(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.''.

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

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

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

''(h) DISCLOSURE OF CERTAIN PROTECTIONS AGAINST BALANCE BILLING.—Each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, and (if applicable) post on a public website of such plan or issuer—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799A–1, 2799A–2 and

2799A–4 of the Public Health Service Act (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under subsections (b), (e), and (f); and

''(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.''.

SEC. 4. INDEPENDENT DISPUTE RESOLUTION PROCESS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this section, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (in this section referred to as the ''Secretaries'') shall jointly establish by regulation an independent dispute resolution process (in this section referred to as the ''IDR process'') under which, with respect to a payment made by a group health plan or health insurance issuer offering health insurance coverage in the group or individual market pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act, section 716 of the Employee Retirement Income Security Act of 1974, or section 9816 of the Internal Revenue Code of 1986 (as applicable) using the recognized amount (as defined in and determined pursuant to section 2719A(b)(3)(H)(ii) of the Public Health Service Act or subsection (b)(3)(H)(ii) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable) to a nonparticipating provider (as defined in subparagraph (G) of section 2719A(b)(3) of the Public Health Service Act or subparagraph (G) of subsection (b)(3) of section 716 of the Employee

Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable) or a nonparticipating emergency facility (as defined in subparagraph (F) of such section 2719A(b)(3) or such subsection (b)(3) of such section 716 or such section 9816, as applicable) with respect to an item or service (or, in the case of payment made under section 2719A(f)(1) of the Public Health Service Act or subsection (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986, as applicable, with respect to air ambulance services) furnished by such provider or facility—

(A) subject to subparagraph (B), the nonparticipating provider, nonparticipating emergency facility, or group health plan or health insurance issuer, respectively, may, not later than the date specified in paragraph (2), submit a request that such payment should be increased or decreased; and

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

ance with such paragraph an alternative payment to be applied, with respect to such request.

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

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

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

(3) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service (or air ambulance service) furnished by such provider, submit a request under the IDR process if such provider is exempt from the requirement under subsection (a) of section 2799A–2 of the Public Health

Service Act with respect to such item or service pursuant to subsection (e) of such section.

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

(1) TIMING REQUIREMENTS.—A request may not be submitted under the IDR process, with respect to items and services (or air ambulance services) furnished by a nonparticipating provider or nonparticipating emergency facility for which a group health plan or health insurance issuer offering health insurance coverage in the group or individual market made a payment pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) unless—

(A) in the case such request is being submitted by the nonparticipating provider or nonparticipating emergency facility—

(i) the provider or facility, respectively, filed, not later than 30 days after the date such payment is received by the provider or facility, respectively, an appeal

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

(ii) such request is not submitted before the sooner of the date on which such appeal has been resolved or the date that is 30 days after the date on which such appeal is so filed; or

(B) in the case such request is being submitted by the group health plan or health insurance issuer—

(i) the group health plan or health insurance issuer, respectively, not later than 30 days after such provider or facility, respectively, receives such payment, submits to such provider or facility, respectively, a notice that such plan or issuer, respectively, disputes the amount of such payment with respect to such items and services (or air ambulance services); and

(ii) such request is not submitted before the date that is 30 days after the date of the submission of such notice.

(2) MINIMUM MEDIAN CONTRACTED RATE.—A request may not be submitted under the IDR process, with respect to items and services (or air ambulance services) furnished in a geographic area by a nonparticipating provider or nonparticipating emergency facility for which a group health plan or health insurance issuer offering health insurance coverage in the group or individual market made a payment pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) unless—

(A) in the case such item or service is furnished during 2022, the median contracted rate (as defined in subsection (b)(3)(E) of section 2719A of the Public Health Service Act or subsection (b)(3)(E) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable)) for such year under such plan or such coverage with respect to each such item or service furnished by such a provider or such a facility in such area is at least

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

(B) in the case such item or service (or air ambulance services) is furnished during a subsequent year, the median contracted rate (as so defined) for such year under such plan or such coverage with respect to each such item or service furnished by such a provider or such a facility in such area is at least the amount applied under this paragraph for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(3) LIMITATION ON BATCHING OF ITEMS AND SERVICES IN A REQUEST.—A request may not be submitted under the IDR process by a nonparticipating provider, nonparticipating emergency facility, or a group health plan or health insurance issuer offering health insurance coverage in the group or individual market, with respect to multiple items and services (or multiple air ambulance services), unless—

(A) all such items and services (or air ambulance services) included in such request are furnished by the same provider or facility;

(B) payment for all such items and services (or air ambulance services) made pursuant to subsection (b)(1), (e)(1), or (f)(1) of section 2719A of the Public Health Service Act or subsection (b)(1), (e)(1), or (f)(1) of section 716 of the Employee Retirement Income Security Act of 1974 or section 9816 of the Internal Revenue Code of 1986 (as applicable) was made by a single group health plan or health insurance coverage;

(C) all such items and services (or air ambulance services) are related to the treatment of the same condition; and

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

(c) IDR ENTITIES.—

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

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

(2) CERTIFICATION.—

(A) IN GENERAL.—An entity wishing to participate in the IDR process under this section shall request certification from the Secretaries. The Secretaries shall determine whether or not to certify applicant entities, taking into consideration whether the entity is unbiased and unaffiliated with health insurance issuers, group health plans, health care facilities, and health care providers and free of conflicts of interest, in accordance with the Secretaries' rulemaking on determining criteria for conflicts of interest.

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

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

vider, nonparticipating emergency facility, group health plan, or health insurance issuer offering heath insurance coverage in the group or individual market for services furnished by such entity with respect to the resolution of a specified request of such provider, facility, plan, or issuer under the process described in subsection (a).

(3) SELECTION OF CERTIFIED IDR ENTITY.—The group health plan or health insurance issuer offering health insurance coverage in the group or individual market and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a request submitted under the IDR process shall agree on a certified IDR entity to resolve such request. In the case that such plan or issuer (as applicable) and such provider or facility (as applicable) cannot so agree, such an entity shall be selected by the Secretaries at random, in accordance with a manner and timeline specified by the Secretaries.

(d) PAYMENT DETERMINATION.—

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

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

(2) SETTLEMENT.—

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

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

(3) DETERMINATION OF ALTERNATIVE PAYMENT.—

(A) IN GENERAL.—The group health plan or health insurance issuer offering health insurance coverage in the group or individual market (as applicable) and the nonparticipating provider or nonparticipating emergency facility (as

applicable) involved shall, with respect to a request under the IDR process, each submit to the certified IDR entity selected under subsection (c)(3) for such request a final offer to be considered for the alternative payment to be applied with respect to items and services (or air ambulance services) which are the subject of the request. Such entity shall determine, in accordance with subparagraph (B), which such offer is the most reasonable and will be applied as the alternative payment.

(B) CONSIDERATIONS IN DETERMINATION.—

(i) IN GENERAL.—In determining which final offer is the alternative payment to be applied, the certified IDR entity selected under subsection (c)(3) for such request shall consider—

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

Code of 1986 (as applicable)) for the applicable year for items or services (or air ambulance services) that are comparable to the items and services (or air ambulance services) included in the request and that are furnished in the same geographic area (as defined by the Secretaries for purposes of such subsection) as such items and services (or air ambulance services) (not including any facility fees with respect to such rates); and

(II) in the case of items and services (other than air ambulances services), each circumstance described in clause (ii) with respect to which information is submitted by either party or, in the case of air ambulance services, each circumstance described in clause (iii) with respect to which information is submitted by either party.

(ii) ADDITIONAL CIRCUMSTANCES FOR CERTAIN ITEMS AND SERVICES.—For purposes of clause (i)(II), the circumstances

described in this clause are, with respect to items and services (other than air ambulance services) included in the request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer the following:

(I) The level of training, education, experience, and quality and outcomes measurements of the provider or facility that furnished such items and services (such as those endorsed by the consensus-based entity authorized under section 1890 of the Social Security Act).

(II) The market share held by the provider or facility, or the plan or issuer, in the geographic area in which the item or service was provided.

(III) Any other extenuating circumstances with respect to the furnishing of such items and services that relate to the acuity of the individual receiving such items and serv-

ices or the complexity of furnishing such items and services to such individual.

(iii) ADDITIONAL CIRCUMSTANCES FOR AIR AMBULANCE SERVICES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the request under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer the following:

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

(II) Any other extenuating circumstances with respect to the furnishing of such services that relate to the acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, education, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(iv) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which final offer is the alternative payment amount to be applied with respect to items and services (or air ambulance services) furnished by a provider or facility and included in the request under the IDR process, the certified IDR entity selected under subsection (c)(3) with respect to such request shall not consider the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799A–1, 2799A–2, or 2799A–4 of the Public Health Service Act (as applicable) not applied.

(C) EFFECTS OF DETERMINATION.—

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

(ii) LIMITATION ON CERTAIN SUBSEQUENT IDR CLAIMS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to a request submitted under subsection (a)(1)(A) and the two parties involved with such request, the party that submitted such initial request may not submit during the 90-day period following such determination a subsequent request under such subsection involving the same other party to such request with respect to such an item or service (or air ambulance service) that was the subject of such initial request.

(D) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a request made by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market and submitted to a certified IDR entity—

(i) if such entity makes a determination with respect to such request under subparagraph (A), the party whose offer is not chosen under such clause shall be responsible for paying all fees charged by such entity; and

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

(E) PAYMENT.—Not later than 30 days after the date on which a determination described in subparagraph (B) is made with respect to a request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market—

(i) in the case that the alternative payment determined to be applied is greater than the amount paid with respect to such request, such plan or issuer (as applicable) shall pay directly to the provider or facility (as applicable) the difference be-

tween such alternative payment and the amount so paid; and

(ii) in the case that the alternative payment determined to be applied is less than the amount paid with respect to such request, such provider or facility (as applicable) shall pay directly to the plan or issuer (as applicable) the difference between the amount so paid and such alternative payment.

(e) PUBLICATION OF INFORMATION RELATING TO DISPUTES.—

(1) PUBLICATION OF INFORMATION.—For 2022 and each subsequent year, the Secretaries shall make available on the public website of the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury—

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

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

(C) the number of such requests with respect to which a final determination was made under subsection (d)(3)(A); and

(D) the information described in paragraph (2) for each request with respect to which such a determination was so made.

(2) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a request under the IDR process of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health insurance coverage in the group or individual market—

(A) a description of each item and service (or air ambulance service) included in such request;

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

(C) the amount of the offer submitted under subsection (d)(3)(A) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable)

expressed as a percentage of the median contracted rate;

(D) whether the offer selected by the certified IDR entity under such subsection to be the alternative payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the median contracted rate;

(E) the category and practice specialty of each such provider or facility involved in furnishing such items and services (or, in the case of air ambulance services, the ambulance vehicle type, including the clinical capability level of such vehicle); and

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

(3) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretaries such information as the Secretaries determine necessary for the Secretaries to carry out the provisions of this subsection.

(f) ENFORCEMENT.—

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

(2) APPLICATION.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the first sentence of subsection (c)(1)) shall apply with respect to a civil monetary penalty imposed under this subsection in the same manner as such provisions apply with respect to a penalty or proceeding under subsection (a) of such section, except that any reference to ''the Secretary'' in such provisions shall be treated as a reference to ''the Secretaries''.

(g) DEFINITIONS.—In this subsection, the terms ''group health plan'', ''group market'', ''health insurance issuer'', ''health insurance coverage'', ''individual health insurance coverage'', ''group health insurance coverage'', and ''individual market'' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

(h) REPORT.—Not later than December 31, 2023, the Comptroller General of the United States shall conduct a study and submit to Congress a report on the IDR process established under this section. Such study and report shall include an analysis of potential financial relationships between providers and facilities that utilize the IDR process and private equity investment firms.

SEC. 5. ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury (the Secretaries) shall jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

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

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

(2) The Secretary of Health and Human Services, or the Secretary's designee.

(3) The Secretary of the Treasury, or the Secretary's designee.

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

(A) Each relevant Federal agency, as determined by the Secretaries.

(B) State insurance regulators.

(C) Health insurance providers.

(D) Patient advocacy groups.

(E) Consumer advocacy groups.

(F) State and local governments.

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

(5) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry.

(6) Up to an additional 2 representatives otherwise not described in paragraphs (1) through (5), as determined necessary and appropriate by the Secretaries.

(c) CONSULTATION.—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders, including those not otherwise included under subsection (b), while conducting the review described in subsection (a).

(d) RECOMMENDATIONS.—The advisory committee shall make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers. The recommendations shall address, at a minimum—

(1) options, best practices, and identified standards to prevent instances of balance billing;

(2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and

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

(e) REPORT.—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions a report containing the recommendations made under subsection (d).

SEC. 6. IMPROVING PROVIDER DIRECTORIES.

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

"SEC. 2730. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) NETWORK STATUS OF PROVIDERS.—

''(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

''(A) establish business processes to ensure that all enrollees in such plan or coverage receive proof of a health care provider's network status, based on what a plan or issuer knows or should know—

''(i) upon a telephone inquiry by an enrollee—

''(I) through a written electronic communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by

such participant, beneficiary, or enrollee for such information;

''(II) through an oral communication from the plan or issuer to the enrollee, as soon as practicable and not later than 1 business day after such inquiry is made by such enrollee for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the enrollee's file for a minimum of 2 years; and

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

''(B) include in any print directory—

''(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that enrollees or prospective enrollees should consult the group health plan's or issuer's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

"(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

"(2) GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.—Beginning on the date that is one year after the date of the enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall establish business processes to—

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

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

"(b) COST-SHARING LIMITATIONS.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not apply, and shall

ensure that no provider applies, cost-sharing to an enrollee for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such enrollee, or health care provider referring such enrollee, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the enrollee not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the enrollee relied on the information described in subsection (a)(1) for which such enrollee provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

''(c) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility

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

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.''.

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

''SEC. 717. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) NETWORK STATUS OF PROVIDERS.—

''(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall—

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

''(i) upon a telephone inquiry by a participant or beneficiary—

''(I) through a written electronic communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

''(II) through an oral communication from the plan or issuer to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information, which communication shall be documented by such plan or issuer, and such documentation shall be kept in the participant's or beneficiary's file for a minimum of 2 years; and

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

''(B) include in any print directory—

''(i) a disclosure that the information included in the directory is accurate as of

the date of the last data update and that participants or beneficiaries or prospective participants or beneficiaries should consult the group health plan's or issuer's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

''(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

''(2) GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan (or health insurance coverage offered in connection with such a plan) shall establish business processes to—

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

''(B) remove any provider from such online directory search tool if such provider has not

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

''(b) COST-SHARING LIMITATIONS.—A group health plan (or health insurance coverage offered in connection with such a plan) shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that

the provider is an in-network provider, if the provider was out-of-network at the time the treatment or service involved was received.

''(c) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.''.

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

''SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) NETWORK STATUS OF PROVIDERS.—

''(1) IN GENERAL.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall—

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

''(i) upon a telephone inquiry by a participant or beneficiary—

''(I) through a written electronic communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information;

''(II) through an oral communication from the plan to the participant or beneficiary, as soon as practicable and not later than 1 business day after such inquiry is made by such participant or beneficiary for such information, which communication shall be documented by such plan, and such documentation shall be kept in the participant's or beneficiary's file for a minimum of 2 years; and

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

''(B) include in any print directory—

''(i) a disclosure that the information included in the directory is accurate as of the date of the last data update and that participants or beneficiaries or prospective participants or beneficiaries should consult the group health plan's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information; and

''(ii) a list of the categories of providers of ancillary services for which the plan or coverage has no in-network providers.

''(2) GROUP HEALTH PLAN BUSINESS PROCESSES.—Beginning on the date that is one year after the date of enactment of this section, a group health plan shall establish business processes to—

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

''(B) remove any provider from such online directory search tool if such provider has not

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

''(b) COST-SHARING LIMITATIONS.—A group health plan shall not apply, and shall ensure that no provider applies, cost-sharing to a participant or beneficiary for treatment or services provided by a health care provider in excess of the normal cost-sharing applied for such treatment or services provided in-network (including any balance bill issued by the health care provider involved), if such participant or beneficiary, or health care provider referring such participant or beneficiary, demonstrates (based on the electronic, written information described in subsection (a)(1)(A)(i)(I), the oral confirmation described in subsection (a)(1)(A)(i)(II) received by the participant or beneficiary not more than 30 days before the date the treatment or services were received, or a copy of the online provider directory described in subsection (a)(1)(A)(ii) on a date not more than 30 days before the date the treatment or services were received), that the participant or beneficiary relied on the information described in subsection (a)(1) for which such participant or beneficiary provides such documentation, that indicated that the provider is an in-network provider, if the provider was out-

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

''(c) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan involved.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.''.

(d) CLERICAL AMENDMENTS.—

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

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

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

''Sec. 9817. Protecting patients and improving the accuracy of provider directory information.''.

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

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

(2) by inserting after section 2799A–4 the following new section:

"SEC. 2799A–5. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER BUSINESS PROCESSES.—A health care provider shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable). Such providers shall submit provider directory information to a plan or issuers, at a minimum—

''(1) when the provider begins a network agreement with a plan or with an issuer with respect to certain coverage;

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

''(3) when there are material changes to the content of provider directory information described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); and

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

''(b) ENFORCEMENT.—

''(1) CIVIL PENALTIES.—

''(A) IN GENERAL.—Subject to paragraph (2), a health care provider that violates a requirement under subsection (a) or takes actions that prevent a group health plan or health insurance issuer from complying with subsection (a)(1) or (b) of sections 2730, 717 of the Employee Retirement Income Security Act of 1974, or 9817 of the Internal Revenue Code of 1986 (as applicable) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

''(B) SAFE HARBOR.—The Secretary may waive the penalty described under paragraph (1) with respect to a health care provider that unknowingly violates section 2730(b)(1), section 717(b)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(b)(1) of the Internal Revenue Code of 1986 (as applicable) with respect to an enrollee if such provider rescinds the bill involved and, if applicable, reimburses the enrollee within 30 days of the date on which the provider billed the enrollee in violation of such subsection.

''(C) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(2) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or serv-

ices provided in-network, as prohibited under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Revenue Code of 1986 (as applicable) and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

''(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

''(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2730(a)(1), section 717(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9817(a)(1) of the Internal Revenue Code of 1986 (as applicable); or

''(2) that the plan or issuer bear financial responsibility, including under section 2730(b), section 717(b) of the Employee Retirement Income Security Act of 1974, or section 9817(b) of the Internal Rev-

enue Code of 1986 (as applicable) for providing inaccurate network status information to an enrollee.

''(d) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, and telephone numbers of individual health care providers, and the names, addresses, and telephone numbers of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.''.

SEC. 7. INCREASING TRANSPARENCY IN HEALTH COVERAGE.

(a) DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION FOR BROKERS AND CONSULTANTS TO EMPLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN PLANS ON THE INDIVIDUAL MARKET.—

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

(A) by striking ''(2) Contracting or making'' and inserting ''(2)(A) Contracting or making''; and

(B) by adding at the end the following:

''(B)(i) No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable within the meaning of this paragraph unless the requirements of this subparagraph are met.

''(ii)(I) For purposes of this subparagraph:

''(aa) The term 'covered plan' means a group health plan as defined section 733(a).

''(bb) The term 'covered service provider' means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of the enactment of the Ban Surprise Billing Act, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:

''(AA) Brokerage services, for which the covered service provider, an affiliate, or

a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

''(BB) Consulting, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits ad-

ministration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

''(cc) The term 'affiliate', with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

''(dd)(AA) The term 'compensation' means anything of monetary value, but does not include non-monetary compensation valued at $250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Ban Surprise Billing Act, as appropriate) or less, in the ag-

gregate, during the term of the contract or arrangement.

"(BB) The term 'direct compensation' means compensation received directly from a covered plan.

"(CC) The term 'indirect compensation' means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under a contract or arrangement with a subcontractor.

"(ee) The term 'responsible plan fiduciary' means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

"(ff) The term 'subcontractor' means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive $1,000 (or such amount as the Secretary may establish in regulations to account

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

''(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate. Any such description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

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

iate or a subcontractor that is performing one or more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

''(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

''(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

''(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

''(III) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

''(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects

to receive in connection with the services described in subclause (I)—

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

''(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

''(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

''(cc) Identification of the services for which the indirect compensation will be received, if applicable.

''(dd) Identification of the payer of the indirect compensation.

''(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction

basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

''(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

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

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

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

''(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

''(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary cir-

cumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

''(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

''(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

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

provider disclosed the information required to be disclosed.

''(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.

''(cc) If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (II) and (III).

''(II) A notice described in subclause (I)(cc) shall contain—

''(aa) the name of the covered plan;

''(bb) the plan number used for the annual report on the covered plan;

''(cc) the plan sponsor's name, address, and employer identification number;

''(dd) the name, address, and telephone number of the responsible plan fiduciary;

''(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

"(ff) a description of the services provided to the covered plan;

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

"(hh) the date on which such information was requested in writing from the covered service provider; and

"(ii) a statement as to whether the covered service provider continues to provide services to the plan.

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

"(aa) The covered service provider's refusal to furnish the information requested by the written request described in subclause (I)(bb); or

"(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

"(IV) If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information re-

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

''(ix) Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.''.

(2) APPLICABILITY OF EXISTING REGULATIONS.—Nothing in the amendments made by paragraph (1) shall be construed to affect the applicability of section 2550.408b–2 of title 29, Code of Federal Regulations (or any successor regulations), with respect to any applicable entity other than a covered plan or a covered service provider (as defined in section 408(b)(2)(B)(ii) of the Employee Retirement Income Security Act of 1974, as amended by paragraph (1)).

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

"SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL MARKET COVERAGE.

"(a) IN GENERAL.—A health insurance issuer offering individual health insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

"(b) DISCLOSURE.—A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

"(1) made prior to the individual finalizing plan selection; and

"(2) included on any documentation confirming the individual's enrollment.

"(c) REPORTING.—A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

''(d) RULEMAKING.—Not later than 1 year after the date of enactment of the Ban Surprise Billing Act, the Secretary shall finalize, through notice-and-comment rulemaking, the form and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.''.

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

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

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

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

''(i) STANDARDIZED REPORTING FORMAT.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish a standardized reporting format for the reporting, by group health plans (or health insurance coverage offered in connection with such a plan) to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans or coverage in the standardized reporting format.

''(2) DEFINITION.—In this subsection, the term 'State All Payer Claims Database' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.''.

SEC. 8. ACCESS TO COST-SHARING INFORMATION.

(a) INSURER AND PLAN REQUIREMENTS.—

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

"SEC. 2731. PROVISION OF COST-SHARING INFORMATION.

''A group health plan or a health insurance issuer offering group or individual health insurance coverage shall provide a participant, beneficiary, or enrollee in the plan or coverage with a good faith estimate of the enrollee's cost-sharing (including deductibles, copayments, and coinsurance) for which the participant, beneficiary, or enrollee may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant, beneficiary, or enrollee.''.

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

"SEC. 718. PROVISION OF COST-SHARING INFORMATION.

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

ticipant or beneficiary in the plan or coverage with a good faith estimate of the participant's or beneficiary's cost-sharing (including deductibles, copayments, and coinsurance) for which the participant or beneficiary may be responsible for paying with respect to a specific health care service (including any service that is reasonably expected to be provided in conjunction with such specific service), as soon as practicable and not later than 2 business days after a request for such information by a participant or beneficiary.''.

(3) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 6(c), is further amended by adding at the end the following:

''SEC. 9818. PROVISION OF COST-SHARING INFORMATION.

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

(4) CLERICAL AMENDMENTS.—

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

"Sec. 718. Provision of cost-sharing information.".

(B) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 8(b)(4), is further amended by adding at the end the following new item:

"Sec. 9818. Provision of cost-sharing information.".

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

"SEC. 2799A–6. PROVISION OF COST-SHARING INFORMATION.

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

erage the following information, together with accurate and complete information about the participant's, beneficiary's, or enrollee's coverage under the applicable plan or coverage:

''(1) As soon as practicable and not later than 2 business days after the participant, beneficiary, or enrollee requests such information, a good faith estimate of the expected participant, beneficiary, or enrollee cost-sharing for the provision of a particular health care service (including any service that is reasonably expected to be provided in conjunction with such specific service).

''(2) As soon as practicable and not later than 2 business days after a participant, beneficiary, or enrollee requests such information, the contact information for any ancillary providers for a scheduled health care service.''.

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

SEC. 9. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.

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

''(g) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to enrollees in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

''(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall issue guidance to implement paragraph (1).''.

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

amended by adding at the end the following new subsection:

''(j) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan or coverage the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan or coverage.

''(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of the Treasury, shall issue guidance to implement paragraph (1).''.

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

''(h) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—

"(1) IN GENERAL.—A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any plan or insurance identification card issued to participants or beneficiaries in the plan the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitation that apply to such plan.

"(2) GUIDANCE.—The Secretary, in consultation with the Secretary of Health and Human Services and Secretary of Labor, shall issue guidance to implement paragraph (1).".

(d) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2022.

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