I

116TH CONGRESS
2D SESSION

H. R. 8098

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

IN THE HOUSE OF REPRESENTATIVES

AUGUST 25, 2020

Mr. BANKS introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the ‘‘Hospital Competition
5 Act of 2020’’.

6 **SEC. 2. HOSPITAL CONSOLIDATION.**

7 (a) AUTHORIZATION OF APPROPRIATIONS.—There is
8 authorized to be appropriated $160,000,000 to the Fed-
9 eral Trade Commission to hire staff to investigate, as con-

1 sistent with the Sherman Antitrust Act and other relevant
2 Federal laws, anti-competitive mergers and practices
3 under such laws to the extent such mergers and practices
4 relate to providers of inpatient and outpatient health care
5 services, as defined by the Secretary of Health and
6 Human Services.

7 (b) MEDICARE ADVANTAGE RATES APPLIED TO CER-
8 TAIN HHI HOSPITALS.—

9 (1) IN GENERAL.—Section 1866(a) of the So-
10 cial Security Act (42 U.S.C. 1395cc(a)) is amend-
11 ed—

12 (A) in paragraph (1)—

13 (i) in subparagraph (X), by striking
14 ''and'' at the end;

15 (ii) in subparagraph (Y), by striking
16 the period at the end and inserting '';
17 and''; and

18 (iii) by inserting after subparagraph
19 (Y) the following new subparagraph:

20 ''(Z) subject to paragraph (4), in the case
21 of a hospital located in a county whose popu-
22 lation density is above the median population
23 density for all counties in the United States
24 with respect to which there is a Herfindahl-
25 Hirschman Index (HHI) of greater than 4,000,

1 to apply the average reimbursement rate with
2 respect to individuals (regardless of whether
3 such an individual is entitled to or eligible for
4 benefits under this title, but excluding individ-
5 uals eligible for medical assistance under a
6 State plan under title XIX) furnished items and
7 services at such hospital that would be billable
8 under this title for such items and services if
9 furnished by such hospital to an individual en-
10 rolled under part C.''; and

11 (B) by adding at the end the following new
12 paragraph:

13 ''(4)(A) The requirement under paragraph
14 (1)(Z) shall not apply in the case of a hospital in a
15 hospital referral region if—

16 ''(i) the HRR market share of such hos-
17 pital (as determined under subparagraph (B))
18 is less than 0.15; or

19 ''(ii) the hospital is located in a rural area
20 (as defined in section 1886(d)(2)(D));

21 ''(B) For purposes of subparagraph (A), the
22 HRR market share of a hospital in a hospital refer-
23 ral region is equal to—

24 ''(i) the total revenue of the hospital, di-
25 vided by

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

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

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

1 (1) PART A.—Section 1814(l)(1) of the Social
2 Security Act (42 U.S.C. 1395f(l)(1)) is amended by
3 inserting ''(or, for 2021, 102, plus 1 percentage
4 point for each subsequent year through 2029, and
5 110 for each subsequent year thereafter)'' after
6 ''101''.

7 (2) PART B.—Section 1834(g)(1) of such Act
8 (42 U.S.C. 1395m(g)(1)) is amended by inserting
9 ''(or, for 2021, 102, plus 1 percentage point for each
10 subsequent year through 2029, and 110 for each
11 subsequent year thereafter)'' after ''101''.

12 **SEC. 3. PRICE TRANSPARENCY.**

13 Section 1866 of the Social Security Act (42 U.S.C.
14 1395cc), as amended by section 401, is further amended—
15 (1) in subsection (a)(1)—
16 (A) in subparagraph (Y), by striking
17 ''and'' at the end;
18 (B) in subparagraph (Z), by striking the
19 period at the end and inserting ''; and''; and
20 (C) by inserting after subparagraph (Z)
21 the following new subparagraph:
22 ''(AA) in the case of a hospital, to comply with
23 the requirement under subsection (l).''; and
24 (2) by adding at the end the following new sub-
25 section:

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

shoppable services that are the most highly utilized in a hospital-based setting.

"(3) STANDARDIZED DIGITAL REPORTING SYSTEM.—Not later than January 1, 2021, the Secretary shall establish a standardized digital system for purposes of paragraph (1).".

SEC. 4. REPEALING ELIGIBILITY OF CERTAIN ACOS.

(a) IN GENERAL.—Section 1899(b)(1) of the Social Security Act (42 U.S.C. 1395jjj(b)(1)) is amended by striking subparagraphs (C) through (E).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2021.

SEC. 5. OFF-CAMPUS PROVIDER-BASED DEPARTMENT MEDICARE SITE NEUTRAL PAYMENT.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(x) OFF-CAMPUS PROVIDER-BASED DEPARTMENT SITE NEUTRAL PAYMENT.—

"(1) IN GENERAL.—With respect to items and services furnished in an off-campus provider-based department, payment under this section for such items and services shall be the amount determined under the fee schedule under section 1848 for such

1 items and services furnished if furnished in a physi-
2 cian office setting.

3 "(2) OFF-CAMPUS PROVIDER-BASED DEPART-
4 MENT.—For purposes of this subsection, the term
5 'off-campus provider-based department' has such
6 meaning as specified by the Secretary.".

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall apply with respect to items and serv-
9 ices furnished on or after January 1, 2021.

10 **SEC. 6. REPEAL OF HEALTH CARE REFORM PROVISIONS**
11 **LIMITING MEDICARE EXCEPTION TO THE**
12 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
13 **FERRALS FOR HOSPITALS.**

14 Sections 6001 and 10601 of the Patient Protection
15 and Affordable Care Act (Public Law 111–148; 124 Stat.
16 684, 1005) and section 1106 of the Health Care and Edu-
17 cation Reconciliation Act of 2010 (Public Law 111–152;
18 124 Stat. 1049) are repealed and the provisions of law
19 amended by such sections are restored as if such sections
20 had never been enacted.

21 **SEC. 7. ADVISORY GROUP ON REDUCING BURDEN OF HOS-**
22 **PITAL ADMINISTRATIVE REQUIREMENTS.**

23 (a) IN GENERAL.—Not later than January 1, 2021,
24 the Secretary of Health and Human Services shall convene
25 an advisory group to provide, in accordance with this sec-

1 tion, recommendations on ways the Federal Government
2 could reduce the burden of administrative requirements on
3 hospitals.

4 (b) RECOMMENDATIONS.—Not later than January 1,
5 2022, the advisory board convened under this section
6 shall—

7 (1) submit to the Secretary of Health and
8 Human Services recommendations described under
9 subsection (a) for executive action and any rec-
10 ommendations for State actions for potential consid-
11 eration in making grants under section 2(c) to
12 States; and

13 (2) submit to Congress recommendations de-
14 scribed under subsection (a) for legislative proposals.

15 (c) MEMBERSHIP.—The advisory board under this
16 section shall consist of the following members:

17 (1) Three representatives of companies that
18 have—

19 (A) geographically distributed workforces;

20 (B) at least 10,000 employees; and

21 (C) no more than 10 percent of such em-
22 ployees in any single State.

23 (2) Three representatives of health insurance
24 issuers and health plans, consisting of—

1 (A) one representative of for-profit health
2 insurance issuers and health plans with at least
3 20,000,000 enrollees in the employer-sponsored
4 market;
5 (B) one representative of non-profit health
6 insurance issuers and health plans operating in
7 at least 5 States; and
8 (C) one representative of non-profit health
9 insurance issuers and health plans operating in
10 a rural State (as defined by the Census Bu-
11 reau).
12 (3) Seven public policy experts in the field of
13 hospital consolidation.

14 **SEC. 8. AUTHORITY OF FEDERAL TRADE COMMISSION**
15 **OVER CERTAIN TAX-EXEMPT ORGANIZA-**
16 **TIONS.**

17 Section 4 of the Federal Trade Commission Act (15
18 U.S.C. 44) is amended, in the undesignated paragraph re-
19 lating to the definition of the term ''Corporation''—
20 (1) by striking '', and any'' and inserting '',
21 any''; and
22 (2) by inserting before the period at the end the
23 following: '', and any organization described in sec-
24 tion 501(c)(3) of the Internal Revenue Code of 1986

1 that is exempt from taxation under section 501(a) of
2 such Code''.

3 **SEC. 9. LEVELING THE PLAYING FIELD BETWEEN PRO-**
4 **VIDERS AND PAYERS.**

5 (a) EXEMPTION.—It shall not be a violation of the
6 antitrust laws for one or more private health insurer
7 issuers or their designated agents to jointly negotiate
8 prices of particular hospital services with a hospital pro-
9 vider with regards to the reimbursement policies of the
10 insurers for those services.

11 (b) DEFINITIONS.—For purposes of this section:

12 (1) ANTITRUST LAWS.—The term ''antitrust
13 laws'' has the meaning given it in subsection (a) of
14 the 1st section of the Clayton Act (15 U.S.C. 12(a)),
15 except that such term includes section 5 of the Fed-
16 eral Trade Commission Act (15 U.S.C. 45) to the
17 extent such section 5 applies to unfair methods of
18 competition.

19 (2) HEALTH INSURANCE ISSUER.—The term
20 ''health insurance issuer'' means an insurance com-
21 pany, insurance service, or insurance organization
22 (including a health maintenance organization, as de-
23 fined in subparagraph (C)) which is licensed to en-
24 gage in the business of insurance in a State and
25 which is subject to State law which regulates insur-

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

1 amended by section 103, is amended by adding at the end
2 the following:

3 **"SEC. 2729B. INCREASING TRANSPARENCY BY REMOVING**
4 **GAG CLAUSES ON PRICE AND QUALITY IN-**
5 **FORMATION.**

6 "(a) INCREASING PRICE AND QUALITY TRANS-
7 PARENCY FOR PLAN SPONSORS AND GROUP AND INDI-
8 VIDUAL MARKET AND CONSUMERS.—

9 "(1) GROUP HEALTH PLANS.—A group health
10 plan or health insurance issuer offering group health
11 insurance coverage may not enter into an agreement
12 with a health care provider, network or association
13 of providers, third-party administrator, or other
14 service provider offering access to a network of pro-
15 viders that would directly or indirectly restrict a
16 group health plan or health insurance issuer from—

17 "(A) providing provider-specific cost or
18 quality of care information, through a consumer
19 engagement tool or any other means, to refer-
20 ring providers, the plan sponsor, enrollees, or
21 eligible enrollees of the plan or coverage;

22 "(B) electronically accessing de-identified
23 claims and encounter data for each enrollee in
24 the plan or coverage, upon request and con-
25 sistent with the privacy regulations promul-

1 gated pursuant to section 264(c) of the Health
2 Insurance Portability and Accountability Act,
3 the amendments to this Act made by the Ge-
4 netic Information Nondiscrimination Act of
5 2008, and the Americans with Disabilities Act
6 of 1990, with respect to the applicable health
7 plan or health insurance coverage, including, on
8 a per claim basis—

9 "(i) financial information, such as the
10 allowed amount, or any other claim-related
11 financial obligations included in the pro-
12 vider contract;

13 "(ii) provider information, including
14 name and clinical designation;

15 "(iii) service codes; or

16 "(iv) any other data element normally
17 included in claim or encounter transactions
18 when received by a plan or issuer; or

19 "(C) sharing data described in subpara-
20 graph (A) or (B) with a business associate as
21 defined in section 160.103 of title 45, Code of
22 Federal Regulations (or successor regulations),
23 consistent with the privacy regulations promul-
24 gated pursuant to section 264(c) of the Health
25 Insurance Portability and Accountability Act,

1 the amendments to this Act made by the Ge-
2 netic Information Nondiscrimination Act of
3 2008, and the Americans with Disabilities Act
4 of 1990.

5 "(2) INDIVIDUAL HEALTH INSURANCE COV-
6 ERAGE.—A health insurance issuer offering indi-
7 vidual health insurance coverage may not enter into
8 an agreement with a health care provider, network
9 or association of providers, or other service provider
10 offering access to a network of providers that would
11 directly or indirectly restrict the health insurance
12 issuer from—

13 "(A) providing provider-specific price or
14 quality of care information, through a consumer
15 engagement tool or any other means, to refer-
16 ring providers, enrollees, or eligible enrollees of
17 the plan or coverage; or

18 "(B) sharing, for plan design, plan admin-
19 istration, and plan, financial, legal, and quality
20 improvement activities, data described in sub-
21 paragraph (A) with a business associate as de-
22 fined in section 160.103 of title 45, Code of
23 Federal Regulations (or successor regulations),
24 consistent with the privacy regulations promul-
25 gated pursuant to section 264(c) of the Health

1 Insurance Portability and Accountability Act,
2 the amendments to this Act made by the Ge-
3 netic Information Nondiscrimination Act of
4 2008, and the Americans with Disabilities Act
5 of 1990.

6 "(3) CLARIFICATION REGARDING PUBLIC DIS-
7 CLOSURE OF INFORMATION.—Nothing in paragraph
8 (1)(A) or (2)(A) prevents a health care provider,
9 network or association of providers, or other service
10 provider from placing reasonable restrictions on the
11 public disclosure of the information described in
12 such paragraphs (1) and (2).

13 "(4) ATTESTATION.—A group health plan or a
14 health insurance issuer offering group or individual
15 health insurance coverage shall annually submit to,
16 as applicable, the applicable authority described in
17 section 2723 or the Secretary of Labor, an attesta-
18 tion that such plan or issuer is in compliance with
19 the requirements of this subsection.

20 "(5) RULE OF CONSTRUCTION.—Nothing in
21 this section shall be construed to otherwise limit
22 group health plan, plan sponsor, or health insurance
23 issuer access to data currently permitted under the
24 privacy regulations promulgated pursuant to section
25 264(c) of the Health Insurance Portability and Ac-

1 countability Act, the amendments to this Act made
2 by the Genetic Information Nondiscrimination Act of
3 2008, and the Americans with Disabilities Act of
4 1990.''.

5 **SEC. 11. BANNING ANTICOMPETITIVE TERMS IN FACILITY**
6 **AND INSURANCE CONTRACTS THAT LIMIT AC-**
7 **CESS TO HIGHER QUALITY, LOWER COST**
8 **CARE.**

9 (a) IN GENERAL.—Section 2729B of the Public
10 Health Service Act, as added by section 301, is amended
11 by adding at the end the following:

12 ''(b) PROTECTING HEALTH PLANS NETWORK DE-
13 SIGN FLEXIBILITY.—

14 ''(1) IN GENERAL.—A group health plan or a
15 health insurance issuer offering group or individual
16 health insurance coverage shall not enter into an
17 agreement with a provider, network or association of
18 providers, or other service provider offering access to
19 a network of service providers if such agreement, di-
20 rectly or indirectly—

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

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

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

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

6 "(3) EXCEPTION FOR CERTAIN GROUP MODEL
7 ISSUERS.—Paragraph (1)(A) shall not apply to a
8 group health plan or health insurance issuer offering
9 group or individual health insurance coverage with
10 respect to—

11 "(A) a health maintenance organization
12 (as defined in section 2791(b)(3)), if such
13 health maintenance organization operates pri-
14 marily through exclusive contracts with multi-
15 specialty physician groups, nor to any arrange-
16 ment between such a health maintenance orga-
17 nization and its affiliates; or

18 "(B) a value-based network arrangement,
19 such as an exclusive provider network, account-
20 able care organization, center of excellence, a
21 provider sponsored health insurance issuer that
22 operates primarily through aligned multi-spe-
23 cialty physician group practices or integrated
24 health systems, or such other similar network

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

1 by cost or quality or steer enrollees to centers of excel-
2 lence, or other pay-for-performance programs.

3 "(f) CLARIFICATION WITH RESPECT TO ANTITRUST
4 LAWS.—Compliance with this section does not constitute
5 compliance with the antitrust laws, as defined in sub-
6 section (a) of the first section of the Clayton Act (15
7 U.S.C. 12(a)).".

8 (b) EFFECTIVE DATE.—Section 2729B of the Public
9 Health Service Act (as added by section 301 and amended
10 by subsection (a)) shall apply with respect to any contract
11 entered into on or after the date that is 18 months after
12 the date of enactment of this Act. With respect to an ap-
13 plicable contract that is in effect on the date of enactment
14 of this Act, such section 2729B shall apply on the earlier
15 of the date of renewal of such contract or 3 years after
16 such date of enactment.

17 **SEC. 12. DESIGNATION OF A NONGOVERNMENTAL, NON-**
18 **PROFIT TRANSPARENCY ORGANIZATION TO**
19 **LOWER AMERICANS' HEALTH CARE COSTS.**

20 (a) IN GENERAL.—Subpart C of title XXVII of the
21 Public Health Service Act (42 U.S.C. 300gg–91 et seq.),
22 as amended by section 102, is further amended by adding
23 at the end the following:

"SEC. 2796. DESIGNATION OF A NONGOVERNMENTAL, NONPROFIT TRANSPARENCY ORGANIZATION TO LOWER AMERICANS' HEALTH CARE COSTS.

"(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, not later than 1 year after the date of enactment of the Hospital Competition Act of 2020, shall enter into contracts with at least 2 nonprofit entities to support the establishment and maintenance of a database that receives and utilizes health care claims information and related information and issues reports that are available to the public and authorized users, and are submitted to the Department of Health and Human Services.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The database established under subsection (a) shall—

"(A) improve transparency by using de-identified health care data to—

"(i) inform patients about the cost, quality, and value of their care;

"(ii) assist providers and hospitals, as they work with patients, to make informed choices about care;

"(iii) enable providers, hospitals, and communities to improve services and outcomes for patients by benchmarking their

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

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

1 the following rules (and any successors of
2 such rules) shall apply to the activities
3 under this section of an entity receiving a
4 contract under subsection (a):

5 "(I) The Privacy Rule under part
6 160 and subparts A and E of part
7 164 of title 45, Code of Federal Regu-
8 lations (or any successor regulations).

9 "(II) The Security Rule under
10 part 160 and subparts A and C of
11 part 164 of such title 45 (or any suc-
12 cessor regulations).

13 "(III) The Breach Notification
14 Rule under part 160 and subparts A
15 and D of part 164 of such title 45 (or
16 any successor regulations).

17 "(ii) SUPPLEMENTAL REGULA-
18 TIONS.—In order to ensure data privacy
19 and security and the notification of
20 breaches, the Secretary may issue such
21 supplemental regulations on the subjects of
22 the rules listed under clause (i) as the Sec-
23 retary determines appropriate to address
24 differences between the activities described

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

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

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

"(B) MEMBERSHIP.—

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

1 plans. Such members shall serve 3-year
2 terms on a staggered basis. Vacancies on
3 the Committee shall be filled by appoint-
4 ment consistent with this subsection not
5 later than 3 months after the vacancy
6 arises.

7 "(ii) COMPOSITION.—In accordance
8 with clause (i)—

9 "(I) the Secretary, in consulta-
10 tion with the Secretary of Labor, shall
11 appoint to the Committee—

12 "(aa) 1 member selected by
13 the Secretary, in coordination
14 with the Secretary of Labor, to
15 serve as the chair of the Com-
16 mittee;

17 "(bb) the Assistant Sec-
18 retary for Planning and Evalua-
19 tion of the Department of Health
20 and Human Services, or a des-
21 ignee of such Assistant Sec-
22 retary;

23 "(cc) 1 representative of the
24 Centers for Medicare & Medicaid
25 Services;

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

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

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

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

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

1 and may be renewed after a subsequent competitive
2 bidding process under this section.
3 ''(5) TRANSITION OF CONTRACT.—If the Sec-
4 retary, following a competitive process at the end of
5 the contract period, selects a new entity to maintain
6 the database, all data shall be transferred to the new
7 entity according to a schedule and process to be de-
8 termined by the Secretary. Upon termination of a
9 contract, no entity may keep data held by the data-
10 base or disclose such data to any entity other than
11 the entity so designated by the Secretary. The Sec-
12 retary shall include enforcement terms in any con-
13 tract with an organization chosen under this section,
14 to ensure the timely transfer of all data, and any as-
15 sociated code or algorithms, to a new entity in the
16 event of contract termination.
17 ''(d) RECEIVING HEALTH INFORMATION.—
18 ''(1) REQUIREMENTS.—
19 ''(A) IN GENERAL.—The Secretary of
20 Labor shall ensure that the applicable self-in-
21 sured group health plan, through its third-party
22 administrator, pharmacy benefit manager, or
23 other entity designated by the group health
24 plan, as applicable, electronically submits all

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

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

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

administrator administers, including such plans that are not applicable self-insured group health plans, as described in paragraph (2).

"(4) RECEIVING OTHER INFORMATION.—

"(A) MEDICARE DATA.—The Secretary, through rulemaking, shall ensure that the data made available to such entity is available to qualified entities under section 1874(e) of the Social Security Act is made available to each entity awarded a contract under subsection (a).

"(B) STATE DATA.—An entity awarded a contract under subsection (a) shall collect data from State all payer claims databases that seek access to the database established under this section.

"(5) AVAILABILITY OF DATA.—An entity required to submit data under this subsection may not place any restrictions on the use of such data by authorized users.

"(e) USES OF INFORMATION.—

"(1) IN GENERAL.—An entity awarded a contract under subsection (a) shall make the database available to users who are authorized under this subsection, without charge, and reports and analyses

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

1 of quality improvement or cost-contain-
2 ment, a description of the intended uses
3 for such data.
4 "(C) REQUIREMENTS.—
5 "(i) RESEARCH.—Upon approval of
6 an application for research purposes under
7 subparagraph (B)(i), the authorized user
8 shall enter into a data use and confiden-
9 tiality agreement with an entity awarded a
10 contract under subsection (a), which shall
11 include a prohibition on attempts to re-
12 identify and disclose individually identifi-
13 able health information.
14 "(ii) QUALITY IMPROVEMENT AND
15 COST-CONTAINMENT.—In consultation with
16 the Committee described in subsection
17 (b)(3), the Secretary shall, through rule-
18 making, establish the form and manner in
19 which authorized users described in sub-
20 paragraph (B)(ii) may access data. Data
21 provided to such authorized users shall be
22 provided in a form and manner such that
23 users may not obtain individually identifi-
24 able price information with respect to di-
25 rect competitors. Upon approval, such au-

1 thorized user shall enter into a data use
2 and confidentiality agreement with the en-
3 tity.

4 ‘‘(iii) CUSTOMIZED REPORTS.—Em-
5 ployers and employer organizations may
6 request customized reports from an entity
7 awarded a contract under subsection (a),
8 at cost, subject to the requirements of this
9 section with respect to privacy and secu-
10 rity.

11 ‘‘(iv) NON-CUSTOMIZED REPORTS.—
12 An entity awarded a contract under sub-
13 section (a), in consultation with the Com-
14 mittee, shall make available to all author-
15 ized users aggregate data sets, free of
16 charge.

17 ‘‘(f) FUNDING.—

18 ‘‘(1) INITIAL FUNDING.—There are authorized
19 to be appropriated, and there are appropriated, out
20 of monies in the Treasury not otherwise appro-
21 priated, $20,000,000 for fiscal year 2020, for the
22 implementation of the initial contract and establish-
23 ment of the database under this section.

24 ‘‘(2) ONGOING FUNDING.—There are author-
25 ized to be appropriated $15,000,000 for each of fis-

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

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

1 years 2020 through 2029 for the purpose of award-
2 ing grants to States under this subsection.
3 "(i) EXEMPTION FROM PUBLIC DISCLOSURE.—
4 "(1) IN GENERAL.—Claims data provided to
5 the database, and the database itself shall not be
6 considered public records and shall be exempt from
7 public disclosure requirements.
8 "(2) RESTRICTIONS ON USES FOR CERTAIN
9 PROCEEDINGS.—Data disclosed to authorized users
10 shall not be subject to discovery or admission as
11 public information, or evidence in judicial or admin-
12 istrative proceedings without consent of the affected
13 parties.
14 "(j) INDIVIDUALLY IDENTIFIABLE HEALTH INFOR-
15 MATION DEFINED.—The term 'individually identifiable
16 health information' has the meaning given such term in
17 section 1171(6) of the Social Security Act.
18 "(k) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion shall be construed to affect or modify enforcement
20 of the privacy, security, or breach notification rules pro-
21 mulgated under section 264(c) of the Health Insurance
22 Portability and Accountability Act of 1996 (or successor
23 regulations).".
24 (b) GAO REPORT.—

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

1 **SEC. 13. PROTECTING PATIENTS AND IMPROVING THE AC-**
2 **CURACY OF PROVIDER DIRECTORY INFOR-**
3 **MATION.**

4 (a) IN GENERAL.—Subpart II of part A of title
5 XXVII of the Public Health Service Act (42 U.S.C.
6 300gg–11 et seq.), as amended by sections 301 and 302,
7 is further amended by adding at the end the following:

8 **"SEC. 2729C. PROTECTING PATIENTS AND IMPROVING THE**
9 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
10 **MATION.**

11 "(a) NETWORK STATUS OF PROVIDERS.—
12 "(1) IN GENERAL.—Beginning on the date that
13 is one year after the date of enactment of this sec-
14 tion, a group health plan or a health insurance
15 issuer offering group or individual health insurance
16 coverage shall—
17 "(A) establish business processes to ensure
18 that all enrollees in such plan or coverage re-
19 ceive proof of a health care provider's network
20 status, based on what a plan or issuer knows or
21 could reasonably know—
22 "(i) through a written electronic com-
23 munication from the plan or issuer to the
24 enrollee, as soon as practicable and not
25 later than 1 business day after a telephone

1 inquiry is made by such enrollee for such
2 information;

3 “(ii) through an oral confirmation,
4 documented by such issuer or coverage,
5 and kept in the enrollee’s file for a min-
6 imum of 2 years; and

7 “(iii) in real-time through an online
8 health care provider directory search tool
9 maintained by the plan or issuer; and

10 “(B) include in any print directory a dis-
11 closure that the information included in the di-
12 rectory is accurate as of the date of the last
13 data update and that enrollees or prospective
14 enrollees should consult the group health plan
15 or issuer’s electronic provider directory on its
16 website or call a specified customer service tele-
17 phone number to obtain the most current pro-
18 vider directory information.

19 “(2) GROUP HEALTH PLAN AND HEALTH IN-
20 SURANCE ISSUER BUSINESS PROCESSES.—Beginning
21 on the date that is one year after the date of enact-
22 ment of the Hospital Competition Act of 2020, a
23 group health plan or a health insurance issuer offer-
24 ing group or individual health insurance coverage
25 shall establish business processes to—

1 "(A) verify and update, at least once every
2 90 days, the provider directory information for
3 all providers included in the online health care
4 provider directory search tool described in para-
5 graph (1)(A)(iii); and
6 "(B) remove any provider from such online
7 directory search tool if such provider has not
8 verified the directory information within the
9 previous 6 months or the plan or issuer has
10 been unable to verify the provider's network
11 participation.
12 "(b) COST-SHARING LIMITATIONS.—
13 "(1) IN GENERAL.—A group health plan or a
14 health insurance issuer offering group or individual
15 health insurance coverage shall not apply, and shall
16 ensure that no provider applies cost-sharing to an
17 enrollee for treatment or services provided by a
18 health care provider in excess of the normal cost-
19 sharing applied for in-network care (including any
20 balance bill issued by the health care provider in-
21 volved), if such enrollee, or health care provider re-
22 ferring such enrollee, demonstrates (based on the
23 electronic, written information described in sub-
24 section (a)(1)(A)(i), the oral confirmation described
25 in subsection (a)(1)(A)(ii), or a copy of the online

provider directory described in subsection (a)(1)(A)(iii) on the date the enrollee attempted to obtain the provider's network status) that the enrollee relied on the information described in subsection (a)(1), if the provider's network status or directory information on such directory was incorrect at the time the treatment or services involved was provided.

"(2) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee in violation of paragraph (1), 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) 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 subsection (a)(1). Such providers shall submit provider directory information to a plan or issuers, at a minimum—

1 "(1) when the provider begins a network agree-
2 ment with a plan or with an issuer with respect to
3 certain coverage;
4 "(2) when the provider terminates a network
5 agreement with a plan or with an issuer with respect
6 to certain coverage;
7 "(3) when there are material changes to the
8 content of provider directory information described
9 in subsection (a)(1); and
10 "(4) every 90 days throughout the duration of
11 the network agreement with a plan or issuer.
12 "(d) ENFORCEMENT.—
13 "(1) IN GENERAL.—Subject to paragraph (2), a
14 health care provider that violates a requirement
15 under subsection (c) or takes actions that prevent a
16 group health plan or health insurance issuer from
17 complying with subsection (a)(1) or (b) shall be sub-
18 ject to a civil monetary penalty of not more than
19 $10,000 for each act constituting such violation.
20 "(2) SAFE HARBOR.—The Secretary may waive
21 the penalty described under paragraph (1) with re-
22 spect to a health care provider that unknowingly vio-
23 lates subsection (b)(1) with respect to an enrollee if
24 such provider rescinds the bill involved and, if appli-
25 cable, reimburses the enrollee within 30 days of the

1 date on which the provider billed the enrollee in vio-
2 lation of such subsection.

3 ''(3) PROCEDURE.—The provisions of section
4 1128A of the Social Security Act, other than sub-
5 sections (a) and (b) and the first sentence of sub-
6 section (c)(1) of such section, shall apply to civil
7 money penalties under this subsection in the same
8 manner as such provisions apply to a penalty or pro-
9 ceeding under section 1128A of the Social Security
10 Act.

11 ''(e) SAVINGS CLAUSE.—Nothing in this section shall
12 prohibit a provider from requiring in the terms of a con-
13 tract, or contract termination, with a group health plan
14 or health insurance issuer—

15 ''(1) that the plan or issuer remove, at the time
16 of termination of such contract, the provider from a
17 directory of the plan or issuer described in sub-
18 section (a)(1); or

19 ''(2) that the plan or issuer bear financial re-
20 sponsibility, including under subsection (b), for pro-
21 viding inaccurate network status information to an
22 enrollee.

23 ''(f) DEFINITION.—For purposes of this section, the
24 term 'provider directory information' includes the names,
25 addresses, specialty, and telephone numbers of individual

1 health care providers, and the names, addresses, and tele-
2 phone numbers of each medical group, clinic, or facility
3 contracted to participate in any of the networks of the
4 group health plan or health insurance coverage involved.
5 ‘‘(g) RULE OF CONSTRUCTION.—Nothing in this sec-
6 tion shall be construed to preempt any provision of State
7 law relating to health care provider directories or network
8 adequacy.’’.
9 (b) EFFECTIVE DATE.—Section 2729C of the Public
10 Health Service Act, as added by subsection (a), shall take
11 effect with respect to plan years beginning on or after the
12 date that is 18 months after the date of enactment of this
13 Act.

14 **SEC. 14. TIMELY BILLS FOR PATIENTS.**

15 (a) IN GENERAL.—
16 (1) AMENDMENT.—Part P of title III of the
17 Public Health Service Act (42 U.S.C. 280g et seq.)
18 is amended by adding at the end the following:

19 **‘‘SEC. 399V–7. TIMELY BILLS FOR PATIENTS.**

20 ‘‘(a) IN GENERAL.—The Secretary shall require—
21 ‘‘(1) health care facilities, or in the case of
22 practitioners providing services outside of such a fa-
23 cility, practitioners, to provide to patients a list of
24 services rendered during the visit to such facility or
25 practitioner, and, in the case of a facility, the name

of the provider for each such service, upon discharge or end of the visit or by postal or electronic communication as soon as practicable and not later than 5 calendar days after discharge or date of visit; and

"(2) health care facilities and practitioners to furnish all adjudicated bills to the patient as soon as practicable, but not later than 45 calendar days after discharge or date of visit.

"(b) PAYMENT AFTER BILLING.—No patient may be required to pay a bill for health care services any earlier than 35 days after the postmark date of a bill for such services.

"(c) EFFECT OF VIOLATION.—

"(1) NOTIFICATION AND REFUND REQUIREMENTS.—

"(A) PROVIDER LISTS.—If a facility or practitioner fails to provide a patient a list as required under subsection (a)(1), such facility or practitioner shall report such failure to the Secretary.

"(B) BILLING.—If a facility or practitioner bills a patient after the 45-calendar-day period described in subsection (a)(2), such facility or practitioner shall—

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

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

1 (2) RULEMAKING.—Not later than 1 year after
2 the date of enactment of this Act, the Secretary
3 shall promulgate final regulations to define the term
4 ''extenuating circumstance'' for purposes of section
5 399V–7(c)(3)(B) of the Public Health Service Act,
6 as added by paragraph (1).

7 (b) GROUP HEALTH PLAN AND HEALTH INSURANCE
8 ISSUER REQUIREMENTS.—Subpart II of part A of title
9 XXVII of the Public Health Service Act (42 U.S.C.
10 300gg–11), as amended by section 304, is further amend-
11 ed by adding at the end the following:

12 **''SEC. 2729D. TIMELY BILLS FOR PATIENTS.**

13 ''(a) IN GENERAL.—A group health plan or health
14 insurance issuer offering group or individual health insur-
15 ance coverage shall have in place business practices with
16 respect to in-network facilities and practitioners to ensure
17 that claims are adjudicated in order to facilitate facility
18 and practitioner compliance with the requirements under
19 section 399V–7(a).

20 ''(b) CLARIFICATION.—Nothing in subsection (a) pro-
21 hibits a provider and a group health plan or health insur-
22 ance issuer from establishing in a contract the timeline
23 for submission by either party to the other party of billing
24 information, adjudication, sending of remittance informa-
25 tion, or any other coordination required between the pro-

1 vider and the plan or issuer necessary for meeting the
2 deadline described in section 399V–7(a)(2).''.
3 (c) EFFECTIVE DATE.—The amendments made by
4 subsections (a) and (b) shall take effect 6 months after
5 the date of enactment of this Act.

6 **SEC. 15. GOVERNMENT ACCOUNTABILITY OFFICE STUDY**
7 **ON PROFIT- AND REVENUE-SHARING IN**
8 **HEALTH CARE.**

9 (a) STUDY.—Not later than 1 year after the date of
10 enactment of this Act, the Comptroller General of the
11 United States shall conduct a study to—
12 (1) describe what is known about profit- and
13 revenue-sharing relationships in the commercial
14 health care markets, including those relationships
15 that—
16 (A) involve one or more—
17 (i) physician groups that practice
18 within a hospital included in the profit- or
19 revenue-sharing relationship, or refer pa-
20 tients to such hospital;
21 (ii) laboratory, radiology, or pharmacy
22 services that are delivered to privately in-
23 sured patients of such hospital;
24 (iii) surgical services;

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

1 **SEC. 16. ENSURING ENROLLEE ACCESS TO COST-SHARING**
2 **INFORMATION.**

3 (a) IN GENERAL.—Subpart II of part A of title
4 XXVII of the Public Health Service Act (42 U.S.C.
5 300gg–11 et seq.), as amended by section 306, is further
6 amended by adding at the end the following:

7 **"SEC. 2729F. PROVISION OF COST-SHARING INFORMATION.**

8 "(a) PROVIDER DISCLOSURES.—A provider that is
9 in-network with respect to a group health plan or a health
10 insurance issuer offering group or individual health insur-
11 ance coverage shall provide to an enrollee in the plan or
12 coverage who submits a request for the information de-
13 scribed in paragraph (1) or (2), together with accurate
14 and complete information about the enrollee's coverage
15 under the applicable plan or coverage—

16 "(1) as soon as practicable and not later than
17 2 business days after the enrollee requests such in-
18 formation, a good faith estimate of the expected en-
19 rollee cost-sharing for the provision of a particular
20 health care service (including any service that is rea-
21 sonably expected to be provided in conjunction with
22 such specific service); and

23 "(2) as soon as practicable and not later than
24 2 business days after an enrollee requests such in-
25 formation, the contact information for any ancillary
26 providers for a scheduled health care service.

1 "(b) INSURER DISCLOSURES.—A group health plan
2 or a health insurance issuer offering group or individual
3 health insurance coverage shall provide an enrollee in the
4 plan or coverage with a good faith estimate of the enroll-
5 ee's cost-sharing (including deductibles, copayments, and
6 coinsurance) for which the enrollee would be responsible
7 for paying with respect to a specific health care service
8 (including any service that is reasonably expected to be
9 provided in conjunction with such specific service), as soon
10 as practicable and not later than 2 business days after
11 a request for such information by an enrollee.

12 "(c) ENFORCEMENT.—

13 "(1) IN GENERAL.—Subject to paragraph (2), a
14 health care provider that violates a requirement
15 under subsection (a) shall be subject to a civil mone-
16 tary penalty of not more than $10,000 for each act
17 constituting such violation.

18 "(2) PROCEDURE.—The provisions of section
19 1128A of the Social Security Act, other than sub-
20 sections (a) and (b) and the first sentence of sub-
21 section (c)(1) of such section, shall apply to civil
22 money penalties under this subsection in the same
23 manner as such provisions apply to a penalty or pro-
24 ceeding under section 1128A of the Social Security
25 Act.".

(b) EFFECTIVE DATE.—Section 2729G of the Public Health Service Act, as added by subsection (a), shall apply with respect to plan years beginning on or after the date that is 18 months after the date of enactment of this Act.

SEC. 17. GROUP HEALTH PLAN REPORTING REQUIREMENTS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 303, is further amended by adding at the end the following:

"SEC. 2797. GROUP HEALTH PLAN REPORTING.

"(a) IN GENERAL.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, not later than March 1 of each year, the following information with respect to the health plan in the previous plan year:

"(1) The beginning and end dates of the plan year.

"(2) The number of enrollees.

"(3) Each State in which the plan is offered.

"(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the issuer, and the total number of paid claims for each such drug.

"(5) The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug.

"(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan in each such plan year.

"(7) Total spending on health care services by such group health plan, broken down by—

"(A) the type of costs, including—

"(i) hospital costs;

"(ii) health care provider and clinical service costs;

"(iii) costs for prescription drugs; and

"(iv) other medical costs; and

"(B) spending on prescription drugs by—

"(i) the health plan; and

"(ii) the enrollees.

"(8) The average monthly premium—

"(A) paid by employers on behalf of enrollees; and

"(B) paid by enrollees.

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

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

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