

BAN SURPRISE BILLING ACT

DECEMBER 2, 2020.—Ordered to be printed

Mr. SCOTT of Virginia, from the Committee on Education and Labor, submitted the following

R E P O R T

[To accompany H.R. 5800]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 5800) to end surprise medical billing and increase transparency in health coverage, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

	Page
Purpose and Summary .....	47
Committee Action .....	49
Committee Views .....	50
Section-by-Section Analysis .....	58
Explanation of Amendments .....	61
Application of Law to the Legislative Branch .....	61
Unfunded Mandate Statement .....	61
Earmark Statement .....	61
Roll Call Votes .....	61
Statement of Performance Goals and Objectives .....	67
Duplication of Federal Programs .....	67
Hearings .....	67
Statement of Oversight Findings and Recommendations of the Committee .....	67
New budget Authority and CBO Cost Estimate .....	67
Committee Cost Estimate .....	69
Changes in Existing Law Made by the Bill, as Reported .....	69

The amendment is as follows:  
 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 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, 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, 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 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 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 non-emergency 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, 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 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 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 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 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 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 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 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 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 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 Retirement 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 offering 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 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, 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 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 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 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 non-emergency 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 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 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 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 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 rule-making 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 provides 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 specializes 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 pri-

mary 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 respect 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 cov-

ered 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, co-insurance 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 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 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 partici-

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 non-emergency 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—

“(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 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 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 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; 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, 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 given 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 participant 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 determined 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 administered 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 freestanding 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 NONPARTICIPATING 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 nonparticipating 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 non-physician 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 covered 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 enrollee 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 Secretary 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 insurance 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 furnishing 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 participant, 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 accordance 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)(i); 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 certification 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 provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering health 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 fa-

cility (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 ambulance 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 services or the complexity of furnishing such items and services to such individual.

(IV) A demonstration of good faith efforts (or lack of good faith efforts) made by the provider or facility (as applicable) or the plan or issuer (as applicable).

(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 between 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);

(D) the average response time under the process, after the first sign of billing discrepancies between the providers, facilities, group health plans, and health insurance issuers involved in the process during such year;

(E) information comparing the average period for resolving such a billing discrepancy between such a provider, facility, plan, or issuer during such year and the average period for resolving such a discrepancy between such parties during the most recent year before the date of the enactment of this Act; and

(F) 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 anal-

ysis 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 5 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 ben-

eficiary 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 sec-

tion 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 services 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 Revenue 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 administration 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 aggregate, 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 affiliate 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 circumstances 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 relates 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.—

(A) 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.), 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 participant 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. For purposes of the previous sentence, the Secretary shall develop and make available in multiple languages (as specified by the Secretary) a model form that is in easily understandable language and format.”.

(B) APPLICATION.—The amendment made by subparagraph (A) shall apply regardless of whether the model form described in the section 718 proposed to be added by such subparagraph has been developed or made available.

(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 coverage 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.

**SEC. 10. CONTINUITY OF CARE.**

(a) 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.), as amended by sections 2, 6, and 8, is further amended by adding at the end the following:

**“SEC. 719. CONTINUITY OF CARE.**

“(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

“(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan and with respect to a health care pro-

vider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

“(A) such contractual relationship is terminated (as defined in paragraph (b));

“(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

“(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

“(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

“(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual’s right to elect continued transitional care from such provider or facility under this section;

“(B) provide such individual with an opportunity to notify the plan or issuer of the individual’s need for transitional care; and

“(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual’s status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

“(i) the 90-day period beginning on such date; or

“(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

“(b) DEFINITIONS.—In this section:

“(1) CONTINUING CARE PATIENT.—The term ‘continuing care patient’ means an individual who, with respect to a provider or facility—

“(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

“(B) is undergoing a course of institutional or inpatient care from the provider or facility;

“(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

“(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

“(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

“(2) SERIOUS AND COMPLEX CONDITION.—The term ‘serious and complex condition’ means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

“(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

“(B) in the case of a chronic illness or condition, a condition that—

“(i) is life-threatening, degenerative, potentially disabling, or congenital; and

“(ii) requires specialized medical care over a prolonged period of time.

“(3) TERMINATED.—The term ‘terminated’ includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.”.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001), as amended by sections 2, 6, and 8, is further amended by inserting after the item relating to section 718 the following new item:

“Sec. 719. Continuity of care.”.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2021.

**SEC. 11. REPORT BY COMPTROLLER GENERAL ON ACCESS TO HEALTH CARE PROVIDERS.**

Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report—

(1) on the effect of the provisions of, including amendments made by, this Act on access to health care providers, including in rural and underserved communities and health professional shortage areas (as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e)); and

(2) including—

(A) an analysis of access to health care in the communities and areas described in paragraph (1) and the extent of provider shortages in such communities and areas; and

(B) legislative and regulatory recommendations to address any such shortage.

**SEC. 12. REPORT BY COMPTROLLER GENERAL ON ADEQUACY OF PROVIDER NETWORKS.**

Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report on the adequacy of provider networks in group health plans and group and individual health insurance coverage, including legislative recommendations to improve the adequacy of such networks.

**SEC. 13. IMPLEMENTING PROTECTIONS AGAINST PROVIDER NONDISCRIMINATION.**

Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall issue interim final rules implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg–5(a)). The Secretaries shall accept and consider public comments on any interim final rule issued pursuant to this subsection for a period of 60 days after the date of such issuance.

## PURPOSE AND SUMMARY

The Ban Surprise Billing Act is comprehensive, bipartisan legislation that makes several major reforms to protect consumers from surprise medical bills and improve transparency in health coverage. Surprise medical bills arise when a consumer covered by a health plan is unexpectedly treated by an out-of-network provider and is required to pay the difference between what the plan pays and the provider’s charge. The issue of surprise bills, which can often expose a consumer to thousands of dollars of unforeseen medical costs, is widespread. In 2017, one in six Americans covered by an employer-sponsored plan received a surprise medical bill for out-of-network care despite having health insurance.<sup>1</sup> One in ten elective hospital admissions and one in five admissions from emergency departments result in surprise bills.<sup>2</sup>

First, the *Ban Surprise Billing Act* protects participants, beneficiaries, and enrollees in group health plans and coverage in the group or individual markets from surprise medical bills. To ensure that consumers are held harmless under the terms of their plan or coverage, it limits cost-sharing to the in-network rate: (1) in emergency situations, whenever a participant, beneficiary, or enrollee receives out-of-network emergency care without having a choice of provider; and (2) in non-emergency settings, when out-of-network care from certain ancillary providers is chosen without the individ-

<sup>1</sup> Rachel Bluth, *1 In 6 Insured Hospital Patients Get a Surprise Bill for Out-Of-Network Care*, Kaiser Health News (June 20, 2019), <https://khn.org/news/1-in-6-insured-hospital-patients-get-a-surprise-bill-for-out-of-network-care/>.

<sup>2</sup> Christopher Garmon & Benjamin Chartock, *One in Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, 36 Health Affairs 177 (2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0970>.

ual's knowledge. It also extends these protections to patients who receive services from air ambulance providers.

Second, the *Ban Surprise Billing Act* includes strong prohibitions on balance billing by providers. Balance billing occurs when a patient is held financially liable for the difference between a provider's billed charge and the allowed amount under a health plan. The legislation prohibits out-of-network providers or facilities from balance billing patients in all emergency situations and in non-emergency situations by ancillary providers. It limits balance billing for elective out-of-network care at in-network facilities to situations in which a patient has a choice of an in-network provider at the facility and if the out-of-network provider complies with strong notice-and-consent requirements. Violations of these prohibitions on balance billing by providers will be enforced primarily by the states, who retain authority to regulate insurance coverage, and secondarily by the Secretary of Health and Human Services, subject to oversight by the Secretary of Labor regarding violations impacting participants and beneficiaries under group health plans or coverage.

Third, in order to resolve payment disputes between providers and health plans, the *Ban Surprise Billing Act* employs a hybrid approach that relies upon both a market-based benchmark payment and an Independent Dispute Resolution (IDR) process. For claims under \$750 (under \$25,000 for air ambulance claims), payment for out-of-network care will be based on the median contracted rate for similar services in the geographic area. For claims of at least \$750 (\$25,000 for air ambulance claims), the benchmark rate may serve as the payment amount or, alternatively, either the provider or plan may elect to utilize the binding IDR process to determine a fair payment amount. Importantly, guardrails—including a prohibition on consideration of provider billed charges by IDR entities—are put into effect to reduce costs for patients and prevent inflationary effects on health care costs.

Fourth, the *Ban Surprise Billing Act* takes additional steps to improve transparency in health coverage. For example, it requires group health plans and issuers offering coverage in the group or individual markets to establish business processes to verify and update provider directories and protect consumers from using inaccurate or out-of-date directory information. It improves the availability of information regarding cost-sharing on insurance cards. It requires brokers and consultants to disclose to group health plan sponsors and individual market consumers whether they have received any direct or indirect compensation for referrals. The *Ban Surprise Billing Act* also requires the Secretary of Labor to develop a standardized form to facilitate group health plans' information reporting to state All-Payer Claims Databases. These and other reforms will meaningfully improve the quality and affordability of care while increasing transparency in coverage and empowering patients to make informed decisions about their care.

Finally, the bill is drafted in a legally sound manner that will ensure its requirements are enforceable and fully protect participants, beneficiaries, and enrollees in group health plans and coverage in the group and individual markets from surprise medical bills. All provisions of the *Ban Surprise Billing Act* that are intended to apply to plans covered by the *Employee Retirement In-*

come Security Act of 1974 (ERISA) are drafted as explicit amendments to ERISA, resolving any question as to their applicability and enforceability by the Secretary of Labor.

#### COMMITTEE ACTION

##### 116TH CONGRESS

On April 2, 2019, the Committee on Education and Labor’s (the Committee) Subcommittee on Health, Employment, Labor, and Pensions held the first ever Congressional hearing on surprise billing entitled “Examining Surprise Billing: Protecting Patients from Financial Pain” (April 2nd Subcommittee Hearing). The hearing explored the causes of surprise billing, the impact of surprise medical bills on consumers, and the policies needed to both protect consumers and improve transparency in health coverage. The Committee heard testimony from Ms. Christen Linke Young, Fellow, USC Brookings Schaeffer Initiative on Health Policy, Washington, DC; Ms. Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, Washington, DC; Mr. Frederick Isasi, Executive Director, Families USA, Washington, DC; and Dr. Jack Hoadley, Research Professor Emeritus, Georgetown University Health Policy Institute, McCourt School of Public Policy, McLean, VA.

On February 7, 2020, Congressman Robert C. “Bobby” Scott (D–VA–3), Chairman of the Committee on Education and Labor, introduced H.R. 5800, the *Ban Surprise Billing Act*, with Congresswoman Virginia Foxx (R–NC–5), Ranking Member of the Committee on Education and Labor, as an original cosponsor.

On February 11, 2020, the Committee marked up H.R. 5800 and ordered it to be reported favorably, as amended, to the House of Representatives by a vote of 32 Yeas and 13 Nays.

At the markup, the Committee considered the following amendments to H.R. 5800:

- Congressman Scott offered an Amendment in the Nature of a Substitute (ANS) that made minor technical corrections to the bill. The ANS also requires the Comptroller General to conduct a study of the IDR process established by the bill and analyze potential financial relationships between providers or facilities that utilize the IDR process and private equity firms. The ANS, as amended with further amendments described below, was adopted by voice vote.

- Congresswoman Donna Shalala (D–FL–27) offered an amendment allowing for care begun with an in-network provider to continue at the in-network rate for 90 days if the provider leaves the network. The amendment was adopted by voice vote.

- Congressman Greg Murphy (R–NC–3) offered an amendment requiring certain provider directory documents to be retained by health plans for five years. The amendment was adopted by voice vote.

- Congresswoman Shalala offered an amendment requiring a rulemaking on provider nondiscrimination requirements. The amendment was adopted by voice vote.

- Congressman Murphy offered an amendment providing that the IDR process established under the bill must require public disclosure of the average response time following a billing discrepancy

and the average time to resolve a billing discrepancy. The amendment was adopted by voice vote.

- Congresswoman Ilhan Omar (D–MN–5) offered an amendment requiring the Secretary of Labor to submit a template for disseminating cost-sharing information. The amendment was adopted by voice vote.

- Congressman Phil Roe (R–TN–1) offered an amendment striking the air ambulance provisions of the bill. The amendment was defeated by a vote of 8 Yeas and 37 Nays.

- Congresswoman Kim Schrier (D–WA–8) offered an amendment requiring the Comptroller General to conduct a study of network adequacy in health plans and coverage. The amendment was adopted by voice vote.

- Congressman Roe offered an amendment striking the median contracted rate benchmark and substituting “commercially reasonable” rates. The amendment was defeated by a vote of 15 Yeas and 30 Nays.

- Congresswoman Susie Lee (D–NV–3) offered an amendment requiring the Comptroller General to conduct a study of provider access in underserved areas. The amendment was adopted by voice vote.

- Congressman Roe offered an amendment striking the median contracted rate benchmark and substituting “previously contracted” rates. The amendment was defeated by a vote of 16 Yeas and 29 Nays.

- Congresswoman Schrier offered an amendment adding good faith efforts to contract as a consideration for IDR entities. The amendment was adopted by voice vote.

- Congressman Lloyd Smucker (R–PA–11) offered an amendment allowing for the continuation of certain contracting practices, notwithstanding the enactment of the *Ban Surprise Billing Act*. The amendment was withdrawn.

- Congressman Joe Morelle (D–NY–25) offered an ANS substituting the text of H.R. 5826, the *Consumer Protections Against Surprise Medical Bills Act of 2020*, in place of the text of H.R. 5800. The amendment was withdrawn.

- Congressman Morelle offered an amendment to strike the threshold for claims to be eligible for the IDR process. The amendment was defeated by a vote of 15 Yeas and 30 Nays.

## COMMITTEE VIEWS

### INTRODUCTION

As the Committee of jurisdiction over employer-sponsored health coverage, a central goal in developing and advancing the Ban Surprise Billing Act is to ensure that reforms apply throughout the health care system—not only in the individual market, but also to the approximately 157 million Americans who are covered through a workplace health plan.<sup>3</sup> In addition, while meaningfully improving the affordability of care for millions, the bill was carefully crafted to strike a balance between the various concerns of stakeholders—including providers, hospitals, labor unions, health insur-

<sup>3</sup>Kaiser Family Foundation, *Health Insurance Coverage of the Total Population*, <https://www.kff.org/other/state-indicator/total-population/> (last visited Feb. 23, 2020) (Covering the 2018 timeframe.).

ers, and employers—many of whom have divergent views on how to effectively address the issue of surprise billing.

While striking a careful balance between the concerns of stakeholders, the *Ban Surprise Billing Act* puts consumers and patients first, and has been commended by dozens of advocacy groups. A coalition of twenty-three patient organizations, including the American Heart Association, American Lung Association, and American Cancer Society, applauded the bill for its “robust protections for all patients in all health settings. . . . Importantly, these protections extend to patients covered by employer-sponsored plans.”<sup>4</sup> Similarly, the No Surprises coalition, a group of thirteen consumer organizations, including Families USA, National Consumers League, and Consumer Reports, highlighted the bill’s strong protections against growth in health care premiums: “With health care costs a primary concern for America’s families, we strongly prefer the benchmark approach taken by the Education and Labor [Committee] as the most effective cost control mechanism available.”<sup>5</sup>

#### BACKGROUND ON SURPRISE MEDICAL BILLS

Surprise medical bills occur when consumers covered by health insurance are subject to higher-than-expected out-of-pocket costs when they receive care from a provider who is outside their plan’s network. These costs can include cost-sharing at out-of-network rates under their health plan as well as balance bills from a provider requiring the consumer to pay the difference between the provider’s out-of-network charge and the amount, if any, that the plan will pay for the item or service. The rise of managed care plans, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans, in which the insurer contracts with a network of doctors, hospitals, or other health care providers, has placed an increasing number of consumers at risk of receiving surprise bills.<sup>6</sup>

Situations in which patients have little or no control over whether a provider is in- or out-of-network can arise in both emergency and non-emergency situations. Patients in emergency settings often receive care at a hospital that is not in their plan’s network or are transported by an out-of-network ambulance. Non-emergency situations can also lead to surprise bills when patients receive care at a facility that is in-network but unknowingly receive services by out-of-network providers. Among the most common non-emergency services that result in surprise out-of-network bills are pathology, radiology, anesthesiology, and other ancillary health services for

<sup>4</sup>Press Release, ALS Association, et al. (Feb. 11, 2020), <https://rarediseases.org/wp-content/uploads/2020/02/NORD-2020-EdLabor-SMB-Markup-STMT-FINAL.pdf>.

<sup>5</sup>Letter from No Surprises: People Against Surprise Medical Bills to the Honorable Robert C. “Bobby” Scott, Chairman, Committee on Education and Labor, et al. (Feb. 11, 2020) (on file with Committee).

<sup>6</sup>Over the past three decades, the number of individuals enrolled in a conventional health insurance arrangement through their employer has declined from 73 percent of workers to approximately ten percent. By 2018, approximately 49 percent of individuals with employer-sponsored coverage were enrolled in a PPO, 16 percent in an HMO, and six percent in a POS plan. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-5-market-shares-of-health-plans/> (last visited May 20, 2020).

which the patient did not have an opportunity to choose the provider or was unaware the care was being provided at all.<sup>7</sup>

THE PREVALENCE AND FINANCIAL IMPACT OF SURPRISE MEDICAL BILLS

Surprise medical bills are widespread in private health coverage, impacting consumers in both the group and individual markets. In 2017, one in six Americans covered by an employer-sponsored plan received a surprise medical bill for out-of-network care despite having health insurance.<sup>8</sup> One in ten elective hospital admissions and one in five admissions to emergency departments result in surprise bills.<sup>9</sup> Services particularly likely to be out-of-network include ambulance transportation, including more than half of all emergency ground ambulance transports<sup>10</sup> and nearly 70 percent of air ambulance transports.<sup>11</sup>

The financial liability imposed on patients by surprise medical bills can be staggering. A series of articles published by Vox in 2019 drew substantial public attention to the devastating stories of patients who have received surprise bills; among the most shocking was a spinal surgery patient who received a bill of \$101,000 despite having confirmed that her surgeon was in-network.<sup>12</sup> These unexpected medical bills can result in financial ruin, as nearly four in ten American adults are unable to cover a \$400 emergency expense,<sup>13</sup> yet the average surprise balance bill by emergency physicians in 2014 and 2015 was an estimated \$620 greater than the Medicare rate for the same service.<sup>14</sup> The ever-present threat of out-of-pocket medical expenses contributes to the fact that approximately two-thirds of consumers have expressed a fear that they will not be able to afford an unanticipated medical expense for themselves or a family member.<sup>15</sup> These costs have further negative impacts on when and how patients receive needed care, often resulting in care delays and negatively affecting patient choices.<sup>16</sup>

Surprise medical bills have devastating financial impacts on Americans and on their ability to afford needed health care. Consumers, who are subject to these bills through no fault of their own, should not be liable for unexpected and unreasonable out-of-

<sup>7</sup>Loren Adler et al., *Stopping Surprise Medical Bills: Federal Action Is Needed*, Health Affairs (Feb. 1, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170201.058570/full/>.

<sup>8</sup>Rachel Bluth, *supra* note 1.

<sup>9</sup>Christopher Garmon & Benjamin Chartock, *supra* note 2.

<sup>10</sup>*Id.*

<sup>11</sup>U.S. Gov't Accountability Off., GAO-19-292, *Air Ambulances: Available Data Show Privately-Insured Patients Are at Financial Risk* 16 (2019), <https://www.gao.gov/assets/700/697684.pdf>.

<sup>12</sup>Sarah Kliff, *A Spinal Surgery, a \$101,000 Bill, and a New Law to Prevent More Surprises*, Vox (Mar. 19, 2019 8:00AM), <https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york>.

<sup>13</sup>Board of Governors of the Federal Reserve System, *Economic Well-Being of U.S. Households in 2018* 21 (2019), <https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf>.

<sup>14</sup>Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 *New England Journal of Medicine* 1915 (2016), [http://zackcooper.com/sites/default/files/paper-files/NEJM\\_surprise\\_billing.pdf](http://zackcooper.com/sites/default/files/paper-files/NEJM_surprise_billing.pdf).

<sup>15</sup>Jordan Rau, *Surprise Medical Bills Are What Americans Fear Most in Paying for Health Care*, Kaiser Health News (Sept. 5, 2018), <https://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care/>.

<sup>16</sup>According to one survey, 45 percent of individuals, the majority of whom are covered by health insurance, report that they have delayed or avoided receiving health care due to high out-of-pocket costs. Kyle T. Smith et al., *Access Is Necessary but Not Sufficient: Factors Influencing Delay and Avoidance of Health Care Services*, 3 *Medical Decision Making Policy & Practice* 1 (2018). See also Benjamin Chartock et al., *Consumers' Responses To Surprise Medical Bills In Elective Situations*, 38 *Health Affairs* 425 (2019).

pocket costs. There is substantial bipartisan interest in reducing the burden of surprise medical bills on consumers. In addition, there has been a growing sentiment among health care stakeholders that surprise billing must be addressed at the federal level, although opinions differ regarding the appropriate approach to do so.

#### SURPRISE BILLING REPRESENTS A MARKET FAILURE

Economists generally regard the practice of surprise medical billing as arising from a failure in the health care market, which causes providers—particularly in certain specialties—to have little or no incentive to contract to join a health plan’s network due to a number of unique circumstances. These providers face highly inelastic demands for their services because patients lack the ability to meaningfully choose or refuse care, such as during an emergency or when ancillary services are provided of which a patient may not even be aware. They also often hold substantial market power, resulting in one or only very few providers available to provide critical items or services in a geographic area. These circumstances enable some providers to charge amounts for their services that exceed the marginal cost of producing those services and resulting in compensation far above what is needed to sustain their practice.

The presence of this market failure in certain provider specialties is strongly supported by evidence reflecting the highly inflated payment rates for these services. For example, in comparison to the amount paid by Medicare for similar items or services, the median billed charge for emergency medicine is 465 percent of the Medicare rate; similar disparities are present for pathology (343 percent), diagnostic radiology (402 percent), and anesthesiology (551 percent).<sup>17</sup> These inflated payment rates are, in turn, reflected in the cost of in-network care. While the average in-network physician is paid at 128 percent of Medicare rates, in-network payments for emergency medicine (306 percent), radiology (200 percent), and anesthesiology (344 percent) far exceed Medicare rates.<sup>18</sup> These costs are directly felt through higher out-of-pocket expenses and exorbitant surprise bills for out-of-network care, as well as by all consumers who share in rising overall health care costs through higher premiums.

The financial opportunity from inflated out-of-network prices has made health care an attractive market for private equity firms, hedge funds, and venture capital firms.<sup>19</sup> For example, private equity deals related to health care more than doubled between 2008 and 2018,<sup>20</sup> and private equity firms now own the two largest physician staffing companies, which together account for 30 percent of

<sup>17</sup> *Examining Surprise Billing: Protecting Patients from Financial Pain Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong. (2019) (written testimony of Christen Linke Young, Fellow, USC–Brookings Schaeffer Initiative on Health Policy at 17) [hereinafter Young Testimony].

<sup>18</sup> Young Testimony at 9.

<sup>19</sup> Rachel Bluth & Emmarie Huetteman, *Investors’ Deep-Pocket Push to Defend Surprise Medical Bills*, Kaiser Health News (Sept. 11, 2019), <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/>.

<sup>20</sup> Samantha Liss, *Private Equity Sees Ripe Opportunity in Healthcare this Year*, Health Care Dive (Mar. 25, 2019), <https://www.healthcaredive.com/news/private-equity-sees-ripe-opportunity-in-healthcare-this-year/548831/>.

the physician-staffing market.<sup>21</sup> Research on one large private equity-owned firm showed that when it entered a hospital network, out-of-network billing rates increased by more than 81 percentage points.<sup>22</sup>

#### EXISTING STATE LAWS AND THE NEED FOR FEDERAL ACTION

A number of states have taken significant steps to address surprise medical bills through consumer protection laws that shield patients from surprise billing in the individual, small group, and fully-insured group markets. In total, about half of the states in the U.S. have enacted at least some form of surprise billing legislation; however, most Americans live in states that have not enacted laws that are considered comprehensive by experts.<sup>23</sup> Federal action is necessary to ensure that patients throughout the country are protected from unexpected costs arising from surprise billing practices.

Moreover, states are unable to protect consumers fully in employer-sponsored plans from surprise bills because ERISA prohibits states from regulating self-insured group health plans, which cover more than 60 percent of people enrolled in employer-sponsored health plans.<sup>24</sup> ERISA contains a broad preemption clause providing that federal law “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>25</sup> States are therefore unable to apply their surprise medical bill laws to millions of their residents, and as a result, a federal legislative response is necessary.

#### THE CENTRAL ROLE OF ERISA IN ENSURING SURPRISE BILLING PROTECTIONS APPLY

The *Patient Protection and Affordable Care Act* (ACA)<sup>26</sup> made a number of major changes to the private health insurance market through amendments to Part A of title XXVII of the *Public Health Service Act* (PHSA).<sup>27</sup> These provisions, insofar as they impact group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, are incorporated by reference into ERISA through Section 715 of ERISA.<sup>28</sup>

However, serious questions exist as to whether amendments to Part A of title XXVII of the PHSA enacted subsequent to the ACA are automatically incorporated into ERISA. A recent decision by the Supreme Court of the United States, *Jam v. International Finance Corp.*,<sup>29</sup> articulated an approach to statutory interpretation that would suggest that subsequent amendments are not automati-

<sup>21</sup> *Id.*

<sup>22</sup> Zack Cooper et al., National Bureau of Economic Research, Surprise! Out-of-Network Billing for Emergency Care in the United States 2018 23 (2019) <https://www.nber.org/papers/w23623.pdf>.

<sup>23</sup> Jack Hoadley et al., *State Efforts to Protect Consumers from Balance Billing*, Commonwealth Fund (Jan. 18, 2019), <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.

<sup>24</sup> 2018 *Employer Health Benefits Survey, Section 10: Plan Funding*, Kaiser Family Foundation (Oct. 3, 2018), <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/> (last visited June 5, 2020).

<sup>25</sup> 29 U.S.C. § 1144.

<sup>26</sup> 42 U.S.C. § 18001 et seq.

<sup>27</sup> 42 U.S.C. §§ 300gg et seq.

<sup>28</sup> 29 U.S.C. § 1185d. Note that a similar provision incorporates Part A of title XXVII of the *Public Health Service Act* into the Internal Revenue Code. 26 U.S.C. § 9815.

<sup>29</sup> 139 S. Ct. 759 (2019).

cally incorporated. In that decision, Chief Justice Roberts distinguished between two scenarios in which a statute incorporates external law by reference. In situations in which “a statute refers to a general subject, the statute adopts the law on that subject as it exists whenever a question under the statute arises.”<sup>30</sup> However, the Court drew a clear distinction “when a statute [] refers to another statute by specific title or section number.”<sup>31</sup> In such situations, the referring statute “in effect cuts and pastes the referenced statute as it existed when the referring statute was enacted, without any subsequent amendments.”<sup>32</sup>

Although the statute at issue in *Jam* was the *International Organizations Immunities Act*, the principle of statutory interpretation articulated by the Court is directly applicable to title XXVII of the PHS Act and the incorporation by reference provision of ERISA. Because Section 715 of ERISA *specifically* references “the provisions of part A of title XXVII of the Public Health Service Act,” the Court’s reasoning in *Jam* suggests that ERISA only incorporates the law in Part A of title XXVII of the PHS Act as it stood on the date of enactment of the ACA on March 23, 2010. Therefore, in order for subsequent amendments to Part A of title XXVII of the PHS Act to apply to ERISA, the amendments must be drafted directly to ERISA. Therefore, the *Ban Surprise Billing Act* is drafted in this manner in order to protect consumers comprehensively and unequivocally from surprise bills.

COMPREHENSIVE PROTECTIONS ARE NEEDED TO PROTECT CONSUMERS FULLY

There is widespread agreement that any surprise billing solution must comprehensively protect consumers by “taking the consumer out of the middle” of surprise billing disputes. Since a large share of American consumers have very little financial cushion—as noted above, about 40 percent could not afford an unexpected \$400 emergency expense in 2018—surprise medical bills can lead to financial stress, debt, damaged credit, and bankruptcy.<sup>33</sup> The fact that individual consumers are ill-equipped to bear the risk of large, unpredictable costs underpins the notion of insurance in the market for health care. Consumers do not need to receive an exorbitant bill themselves to be negatively affected by surprise billing practices; when plans pay high out-of-network bills, these costs are passed on to all consumers in the form of higher premiums.<sup>34</sup>

At the April 2nd Subcommittee Hearing, witnesses discussed several critical issues Congress must address to provide comprehensive protections for consumers from surprise medical billing. First, in order to hold a consumer truly harmless from the financial devastation of surprise bills, health plans must provide that cost-sharing be limited to in-network amounts in surprise billing situations to ensure that the patient is treated as if they were seeing an in-network provider.<sup>35</sup> Second, a surprise billing solution must pro-

<sup>30</sup> *Id.* at 769.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> Federal Reserve Board, *supra* note 13.

<sup>34</sup> Young Testimony at 2.

<sup>35</sup> *Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor,*

hibit providers from sending balance bills to patients for amounts in excess of their in-network cost-sharing under the plan.<sup>36</sup> Third, in order to resolve disputes between providers and plans over payments, legislation must establish a fair payment amount.<sup>37</sup>

In addition, witnesses and Members noted that measures to improve transparency in health coverage could serve as important complements to surprise billing legislation. Specifically, improvements to provider directories—described as “notoriously inaccurate” by Dr. Jack Hoadley during his testimony—were mentioned as potentially beneficial for consumers.<sup>38</sup> Further measures to improve transparency, such as including additional information regarding coverage on insurance cards, were also raised by Members such as Congressman Roe in his written questions for the hearing record.<sup>39</sup> However, witnesses emphasized that improvements to transparency, though helpful, are not substitutes for a comprehensive solution to the underlying issue of surprise medical billing.<sup>40</sup>

#### RESOLVING PAYMENT DISPUTES BETWEEN PROVIDERS AND HEALTH PLANS

A key element of any solution to address surprise billing comprehensively is the payment rate, which is the amount that payers must remit to providers for out-of-network items and services. Two payment rate options have emerged as the predominant contenders to correct the market failure associated with surprise billing: (1) the benchmark rate model, and (2) the IDR process, also referred to as arbitration. Under a benchmark rate model, payments to providers for out-of-network items and services default to a pre-determined amount, such as a percentage of the Medicare rate (typically 125 percent of Medicare) or the median contracted (in-network) rate in the geographic area where the service took place.<sup>41</sup> In contrast, the IDR process is mediated by a third-party arbitrator, and legislation typically specifies guidance or criteria for the arbitrator to consider. A common approach is to use “baseball-style” arbitra-

116th Cong. (2019) (written testimony of Frederick Isasi, Executive Director, Families USA, Washington, DC at 6).

<sup>36</sup>*Id.*

<sup>37</sup>*Id.*

<sup>38</sup>H. Comm. on Educ. & Labor, *Examining Surprise Billing: Protecting Patients from Financial Pain*, YouTube (Apr. 7, 2019), <https://www.youtube.com/watch?v=HyUd2-YPN0> (see 46:33).

<sup>39</sup>*Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong 194–95 (response to Committee Member questions by Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council).

<sup>40</sup>*Examining Surprise Billing: Protecting Patients from Financial Pain, Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. & Labor*, 116th Cong. (2019) 202 (response to Committee Member questions by Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy) (“Enhanced transparency about cost-sharing can be useful, but I do not believe it will provide a meaningful tool to address surprise out-of-network billing.”).

<sup>41</sup>When the benchmark is set at a negotiated rate such as the median in-network rate, it is typically linked to previously agreed-upon rates (such as 2019 rates) and linked to inflation thereafter, which prevents providers from influencing their own pay. Examples of recent federal legislation that rely exclusively on benchmark rates are the *Lower Health Care Costs Act* (S. 1895), which passed the Senate Health, Education, Labor, and Pensions (HELP) Committee on June 26, 2019, by a vote of 20–3, and the *No Surprises Act* (H.R. 3630), as introduced in the U.S. House of Representatives on June 9, 2019. Both bills set benchmark rates at the median contracted (in-network) rate, although H.R. 3630 was amended in the Committee on Energy and Commerce to allow for limited arbitration for disputed bills for which the median in-network rate is at least \$1,250.

tion, under which each side submits a price, and the arbitrator chooses one, with both sides bound by the decision.<sup>42</sup>

Both approaches “take the consumer out of the middle” of surprise billing disputes. Both also offer the opportunity to tether payment rates for surprise out-of-network bills directly to market-based prices, curbing cost growth relative to the status quo. For example, the commonly considered median in-network benchmark rate is a market-based price; it reflects negotiations between providers and insurers in a local health care market. An IDR process may also partially reflect market-based prices if the arbitrator is instructed under the legislation to consider a market-derived price such as the median in-network rate, although the IDR process entails some additional administrative costs. However, some IDR process proposals would have the arbitrator consider non-market-based rates such as providers’ billed charges,<sup>43</sup> which may drive up consumer costs.<sup>44</sup>

Of the two options, evidence indicates that benchmark rates will generally slow the rapid growth of health care costs, both by lowering costs in the near term relative to the status quo and by slowing the rate of health care cost inflation in future years.<sup>45</sup> Benchmark rates achieve this primarily by removing providers’ incentives and ability to charge very high out-of-network prices,<sup>46</sup> thus reducing providers’ bargaining power to negotiate or demand higher prices of health plans,<sup>47</sup> the costs of which insurers typically pass on to consumers.<sup>48</sup> Slower growth in health care costs will, in turn,

<sup>42</sup>An example of federal legislation that relies on the arbitration approach is the *Consumer Protections Against Surprise Medical Bills Act of 2020* (H.R. 5826) which was reported by the House Ways and Means Committee on February 12, 2020, by voice vote. The bill allows arbitration to take place if the payer and provider fail to negotiate a solution within 30 days; it instructs the arbitrator to consider the median in-network rate for the item or service, among other criteria.

<sup>43</sup>For example, under New York’s surprise billing law, arbitration entities are instructed to consider several factors in baseball-style arbitration, including the 80th percentile of billed charges. Loren Adler, *Experience with New York’s Arbitration Process for Surprise Out-of-network Bills*, Brookings Institution (Oct. 24, 2019), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

<sup>44</sup>Loren Adler et al., *Rep. Ruiz’s Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs And Deficits*, Health Affairs Blog (July 16, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190716.355260/full/>; see also David Hyman & Benedic Ippolito, *Arbitration not the Answer to Fix Surprise Medical Billing*, Real Clear Policy (Feb. 12, 2019), [https://www.realclearpolicy.com/articles/2019/02/12/arbitration\\_not\\_the\\_answer\\_to\\_fix\\_surprise\\_medical\\_billing\\_111042.html](https://www.realclearpolicy.com/articles/2019/02/12/arbitration_not_the_answer_to_fix_surprise_medical_billing_111042.html).

<sup>45</sup>For example, the Congressional Budget Office (CBO) estimates that the surprise billing provisions of the Senate HELP Committee bill, which sets the benchmark rate at the relevant median in-network payment rate, would reduce commercial insurance premiums by an average of one percent nationwide and decrease deficits by \$25 billion over 10 years relative to the status quo. Of this \$25 billion, approximately \$24 billion stems from increased tax revenue due to lower premiums for tax-privileged employment-based insurance, while over \$1 billion stems from reduced federal spending. Congressional Budget Office, S.1895, *Lower Health Care Costs Act 3* (2019), [https://www.cbo.gov/system/files/2019-07/s1895\\_0.pdf](https://www.cbo.gov/system/files/2019-07/s1895_0.pdf). By contrast, while CBO has not published a formal assessment of an IDR process model, CBO reportedly has stated that establishing a system similar to New York’s at the national level would increase the federal deficit by “double digit billions” over a ten-year period. Rachana Pradhan, *More States Crack Down on Vaping*, Politico (Sep. 25, 2019), <https://www.politico.com/newsletters/politico-pulse/2019/09/25/more-states-crack-down-on-vaping-757620>.

<sup>46</sup>Michelle Andrews, *California Surprise-Billing Law Protects Patients but Aggravates Many Doctors*, California Healthline (Dec. 4, 2019), <https://californiahealthline.org/news/california-surprise-billing-law-protects-patients-but-aggravates-many-doctors/>.

<sup>47</sup>Loren Adler et al., Brookings, *State Approaches to Mitigating Surprise Out-of-Network Billing* at 9 (2019), [https://www.brookings.edu/wp-content/uploads/2019/02/Adler\\_et\\_al\\_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf](https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et_al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf).

<sup>48</sup>See Glenn Melnick, *Blame Emergency Rooms for the Out-of-Control Cost of Health Care*, New York Times (Sept. 5, 2018), <https://www.nytimes.com/2018/09/05/opinion/emergency-rooms-cost-insurance.html>. Furthermore, benchmarking obviates the additional administrative costs in-

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reduce growth in consumers' premiums and government spending on health care.

The IDR process, on the other hand, has the potential advantage of allowing payment rates “to vary more for specific circumstances and potentially adjust more easily over time.”<sup>49</sup> This added flexibility may be particularly merited in high-stakes and complex situations in which a market-based benchmark such as the median in-network rate is less likely to reflect or be monetarily close to the cost of furnishing the item or service.

There is a wide range of opinions among various stakeholders about which approach to payment rates is optimal. To bridge this divide, the *Ban Surprise Billing Act* incorporates a hybrid approach that will ensure that an efficient, market-based payment benchmark is employed, while providing for a noninflationary IDR mechanism for cases in which claims of at least \$750 (or \$25,000 for air ambulance services). This strikes an appropriate balance between the views of various stakeholders and is designed to reduce premiums and the deficit.

#### CONCLUSION

H.R. 5800, the *Ban Surprise Billing Act*, protects consumers from the financial devastation of surprise medical billing through a targeted and balanced approach that carefully weighs the needs of all stakeholders with divergent views on the issue. Most importantly, the legislation provides robust protections from surprise medical bills for workers and families across the country.

#### SECTION-BY-SECTION ANALYSIS

##### *Sec. 1. Short title*

This section states that the Act may be cited as the *Ban Surprise Billing Act*.

##### *Sec. 2. Preventing surprise medical bills*

This section establishes consumer protections in the group and individual markets to protect participants, beneficiaries, and enrollees from surprise medical bills. It limits cost-sharing owed under a health plan or coverage to the in-network rate whenever a participant, beneficiary, or enrollee receives out-of-network emergency care, including air ambulance services and non-emergency care provided by out-of-network ancillary providers. It also requires that the costs of out-of-network care received in a situation where a surprise bill would have occurred in either emergency or non-emergency settings be counted toward the in-network deductible or out-of-pocket limit under the plan or coverage.

This section provides that the recognized amount under the plan or coverage for certain out-of-network items or services will be determined based on a market-based benchmark of the median contracted rate for similar services in the geographic area. The methodology for determining the benchmark will be established by the

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urers face under an arbitration model which, if high enough, could “undermine the effectiveness of the policy by leading insurers to simply accede to providers’ demands rather than pursue arbitration,” causing insurers to pass increased costs on to consumers, again leading to health care cost inflation. Loren Adler et al., *supra* note 47.

<sup>49</sup> Loren Adler et al., *supra* note 47.

Secretaries of Health and Human Services, Labor, and the Treasury (“Secretaries”) and the Secretaries shall establish a process whereby plans or providers may file complaints of violations of the requirements for determining the benchmark payment. Plans and issuers will be subject to audit by the Secretaries to ensure compliance with these requirements. The audit process specified in the bill is not intended to limit, restrict, or otherwise interfere with the Secretary of Labor’s existing investigative and enforcement authority under Part 5 of ERISA, including the Secretary’s authority to conduct additional audits regarding the median contracted rate and any other provisions of the bill.

This section also provides that in determining the allowed amount under the plan or coverage, state laws for determining the payment amount may remain in effect with respect to plans and coverage within the jurisdiction of states, including amounts determined under an All-Payer Model Agreement under Section 1115A of the *Social Security Act*. In cases in which no applicable state law is in effect, the allowed amount will be the median of the in-network rate recognized by the plan or issuer for a similar item or service provided in the same geographic region.

### *Sec. 3. Preventing certain cases of balance billing*

This section prohibits out-of-network facilities and providers, including air ambulance providers, from engaging in balance billing of a participant, beneficiary, or enrollee in a group or individual health plan or coverage. In emergency situations, providers are prohibited from holding a participant, beneficiary, or enrollee liable for an amount greater than the cost-sharing owed under the plan or coverage. In non-emergency situations, ancillary providers are prohibited from holding a participant, beneficiary, or enrollee liable for an amount greater than the cost-sharing owed under the plan or coverage. This section further specifies that such ancillary services include emergency medicine, anesthesiology, pathology, radiology, neonatology, and certain diagnostic services. In addition, in cases in which no in-network provider can furnish the item or service at the facility, such out-of-network services will be treated as ancillary services.

In cases in which elective out-of-network care is sought, this section requires that out-of-network providers and facilities provide notice to a participant, beneficiary, or enrollee of their network status and a good faith estimate of charges that may be applied for the out-of-network care. In order for the item or service to be treated as out-of-network, this information must be provided at the time an appointment is scheduled and the consent of the patient must be obtained at least 72 hours in advance of when the items or services are furnished.

This section also provides for state enforcement under the Act of provider requirements and the prohibition on balance billing. In cases in which states fail to implement the requirements and do not substantially enforce the prohibitions, this section provides that the Secretary of Health and Human Services shall have the authority to apply, with respect to a facility or provider, a civil monetary penalty of up to \$10,000 per violation. In addition, this section requires states and the Secretary of Health and Human Services to inform the Secretary of Labor of violations of requirements impact-

ing individuals in group health plans or coverage and any enforcement actions, including the disposition of such actions.

*Sec. 4. Independent dispute resolution*

This section requires the Secretaries of Health and Human Services, the Treasury, and Labor to jointly establish an Independent Dispute Resolution (IDR) process to determine payment amounts. The Secretaries shall jointly certify such IDR entities, subject to standards to prevent conflicts of interest and financial relationships between certified entities and either providers or plans. This section permits providers and payers to elect to utilize the IDR process for any amounts for which the median contracted rate is at least \$750 (\$25,000 for air ambulance services).

This section authorizes certified IDR entities to consider several factors in determining payment amounts, including the median contracted rate for a similar item or service furnished in the same geographic area, the level of training and experience of the provider, and extenuating circumstances such as the complexity of the specific case or the acuity of the patient. It prohibits IDR entities from considering the billed charges of the provider for the item or service.

*Sec. 5. Advisory committee on ground ambulance and patient billing*

This section requires the Secretaries of Health and Human Services, Labor, and the Treasury to establish an advisory committee to develop recommendations to protect consumers from ground ambulance balance bills.

*Sec. 6. Improving provider directories*

This section requires group health plans and issuers offering coverage in the group or individual markets to establish business processes to verify and update provider directories and to respond to inquiries with respect to the network status of a provider within one business day of a request. It limits cost-sharing to the in-network rate when a participant, beneficiary, or enrollee relied in good faith on out-of-date provider directories under the plan or coverage.

*Sec. 7. Improving transparency in health coverage*

This section requires brokers and consultants to disclose to group health plan sponsors and consumers enrolled in coverage in the individual market whether they have received any direct or indirect compensation for referrals.

This section also requires the Secretary of Labor to develop a standardized form to allow group health plans and issuers to report information to state All-Payer Claims Databases.

*Sec. 8. Access to cost-sharing information*

This section requires providers, group health plans, and issuers offering coverage in the group or individual markets to provide to a participant, beneficiary, or enrollee a good faith estimate of cost-sharing owed for a health care service within two business days of a request.

*Sec. 9. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations*

This section requires group health plans and issuers offering coverage in the group or individual markets to include on insurance identification cards the amount of the in-network and out-of-network deductibles and out-of-pocket limitations under the plan or coverage.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the descriptive portions of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Pursuant to section 102(b)(3) of the *Congressional Accountability Act*, Pub. L. No. 104–1, H.R. 5800, as amended, does not apply to terms and conditions of employment or to access to public services or accommodations within the legislative branch.

UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the *Congressional Budget and Impoundment Control Act* (as amended by Section 101(a)(2) of the *Unfunded Mandates Reform Act*, Pub. L. No. 104 4), the Committee adopts as its own the estimate of and statement regarding federal mandates in H.R. 5800, as amended, prepared by the Director of the Congressional Budget Office.

EARMARK STATEMENT

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 5800 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as described in clauses 9(e), 9(f), and 9(g) of rule XXI.

ROLL CALL VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that the following roll call votes occurred during the Committee's consideration of H.R. 5800:

Date: 2/11/2020

**COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE**

Roll Call: 1      Bill: H.R. 5800      Amendment Number: 7

Disposition: defeated by a vote of 8-37

Sponsor/Amendment: Roe/ Strikes air ambulance provision

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)		X	
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLAN (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)		X		Mr. CLINE (VA)		X	
Ms. WILD (PA)		X		Mr. FULCHER (ID)		X	
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)		X		Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)	X		
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)		X		Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)		X	
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)		X					
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 8

Nos: 37

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

\*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

\*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

**COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE**

Roll Call: 2      Bill: H.R. 5800      Amendment Number: 9

Disposition: defeated by a vote of 15-30

Sponsor/Amendment: Roe /Changes median in-network to "commercially reasonable" rates

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GÜTHRIE (KY)		X	
Mr. SABLAN (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 15

Nos: 30      Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

\*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

\*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

## COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 3

Bill: H.R. 5800

Amendment Number: 11

Disposition: defeated by a vote of 16-29

Sponsor/Amendment: Roe /Changes median in-network to "previously contracted" rates

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLAN (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)		X	
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)	X						
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 16

Nos: 29

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

\*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

\*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

## COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 4 Bill: H.R. 5800 Amendment Number: 15

Disposition: defeated by a vote of 15-30

Sponsor/Amendment: Morelle/ Deletes the threshold for arbitration

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)		X		Mrs. FOXX (NC) (Ranking)		X	
Mrs. DAVIS (CA)		X		Mr. ROE (TN)	X		
Mr. GRIJALVA (AZ)		X		Mr. THOMPSON (PA)	X		
Mr. COURNTEY (CT)		X		Mr. WALBERG (MI)		X	
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)		X	
Mr. SABLAN (MP)		X		Mr. BYRNE (AL)			X
Ms. WILSON (FL)		X		Mr. GROTHMAN (WI)	X		
Ms. BONAMICI (OR)		X		Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)		X		Mr. ALLEN (GA)	X		
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)	X		
Mr. DESAULNIER (CA)		X		Mr. BANKS (IN)		X	
Mr. NORCROSS (NJ)		X		Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)		X		Mr. COMER (KY)		X	
Mr. MORELLE (NY)	X			Mr. CLINE (VA)		X	
Ms. WILD (PA)		X		Mr. FULCHER (ID)	X		
Mr. HARDER (CA)		X		Mr. WATKINS (KS)	X		
Mrs. MCBATH (GA)		X		Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)		X	
Ms. UNDERWOOD (IL)		X		Mr. JOHNSON (SD)	X		
Mrs. HAYES (CT)		X		Mr. KELLER (PA)		X	
Ms. SHALALA (FL)	X			Mr. MURPHY (NC)	X		
Mr. LEVIN (MI)		X		Mr. VAN DREW (NJ)	X		
Ms. OMAR (MN)		X					
Mr. TRONE (MD)		X					
Ms. STEVENS (MI)		X					
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)		X					
Mr. CASTRO (TX)		X					

TOTALS: Ayes: 15

Nos: 30 Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

\*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

\*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

Date: 2/11/2020

## COMMITTEE ON EDUCATION AND LABOR RECORD OF COMMITTEE VOTE

Roll Call: 5

Bill: H.R. 5800

Amendment Number: Motion

Disposition: adopted by a vote of 32-13

Sponsor/Amendment: Takano/ to report to the House with an amendment and with the recommendation that the amendment be agreed to, and the bill as amended, do pass

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. SCOTT (VA) (Chairman)	X			Mrs. FOXX (NC) (Ranking)	X		
Mrs. DAVIS (CA)	X			Mr. ROE (TN)		X	
Mr. GRIJALVA (AZ)	X			Mr. THOMPSON (PA)		X	
Mr. COURNTEY (CT)	X			Mr. WALBERG (MI)	X		
Ms. FUDGE (OH)			X	Mr. GUTHRIE (KY)	X		
Mr. SABLAN (MP)	X			Mr. BYRNE (AL)			X
Ms. WILSON (FL)	X			Mr. GROTHMAN (WI)		X	
Ms. BONAMICI (OR)	X			Ms. STEFANIK (NY)	X		
Mr. TAKANO (CA)	X			Mr. ALLEN (GA)		X	
Ms. ADAMS (NC)			X	Mr. SMUCKER (PA)		X	
Mr. DESAULNIER (CA)	X			Mr. BANKS (IN)	X		
Mr. NORCROSS (NJ)	X			Mr. WALKER (NC)			X
Ms. JAYAPAL (WA)	X			Mr. COMER (KY)	X		
Mr. MORELLE (NY)		X		Mr. CLINE (VA)		X	
Ms. WILD (PA)	X			Mr. FULCHER (ID)		X	
Mr. HARDER (CA)	X			Mr. WATKINS (KS)		X	
Mrs. MCBATH (GA)	X			Mr. WRIGHT (TX)			X
Ms. SCHRIER (WA)	X			Mr. MEUSER (PA)	X		
Ms. UNDERWOOD (IL)	X			Mr. JOHNSON (SD)		X	
Mrs. HAYES (CT)	X			Mr. KELLER (PA)	X		
Ms. SHALALA (FL)		X		Mr. MURPHY (NC)		X	
Mr. LEVIN (MI)	X			Mr. VAN DREW (NJ)		X	
Ms. OMAR (MN)	X						
Mr. TRONE (MD)	X						
Ms. STEVENS (MI)	X						
Mrs. LEE (NV)	X						
Mrs. TRAHAN (MA)	X						
Mr. CASTRO (TX)	X						

TOTALS: Ayes: 32

Nos: 13

Not Voting: 5

Total: 50 / Quorum: / Report:

(28 D - 22 R)

\*Although not present for the recorded vote, Member expressed he/she would have voted AYE if present at time of vote.

\*Although not present for the recorded vote, Member expressed he/she would have voted NO if present at time of vote.

## STATEMENT OF PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause (3)(c) of rule XIII of the Rules of the House of Representatives, the goals of H.R. 5800 are to end surprise medical billing and increase transparency in health coverage.

## DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of H.R. 5800 establishes or reauthorizes a program of the Federal Government known to be duplicative of another federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Pub. L. No. 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

## HEARINGS

Pursuant to section 103(i) of H. Res. 6 for the 116th Congress, on April 2, 2019, the Committee on Education and Labor’s Subcommittee on Health, Employment, Labor, and Pensions held a hearing entitled “Examining Surprise Billing: Protecting Patients from Financial Pain,” which was used to develop H.R. 5800. The hearing explored the causes of surprise billing, the impact of surprise medical bills on patients, and policies to both protect consumers and improve transparency in health coverage. The Committee heard testimony from: Ms. Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy, Washington, DC; Ms. Ilyse Schuman Senior Vice President, Health Policy, American Benefits Council Washington, DC; Mr. Frederick Isasi, Executive Director, Families USA, Washington, DC; and Dr. Jack Hoadley, Research Professor Emeritus, Georgetown University Health Policy Institute, McCourt School of Public Policy, McLean, VA.

## STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee’s oversight findings and recommendations are reflected in the descriptive portions of this report.

## NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

Pursuant to clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the *Congressional Budget Act of 1974*, and pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the *Congressional Budget Act of 1974*, the Committee has received the following estimate for H.R. 5800 from the Director of the Congressional Budget Office:

H.R. 5800, THE BAN SURPRISE BILLING ACT, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON EDUCATION AND LABOR ON FEBRUARY 11, 2020 ESTIMATED BUDGETARY EFFECTS

	By fiscal year, millions of dollars—												
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2020–2025	2020–2030
Increases or Decreases (–) in Direct Spending													
Protections Against Surprise Medical Bills:													
Estimated Budget Authority .....	0	0	*	–44	–89	–103	–111	–119	–123	–128	–134	–236	–851
Estimated Outlays .....	0	0	*	–44	–89	–103	–111	–119	–123	–128	–134	–236	–851
Increases in Revenues													
Protections Against Surprise Medical Bills:													
On-budget revenues .....	0	0	872	1,809	2,170	2,335	2,689	2,944	3,153	3,387	3,642	7,186	23,002
Off-budget revenues .....	0	0	619	1,284	1,544	1,664	1,970	2,176	2,335	2,511	2,701	5,112	16,804
Total .....	0	0	253	525	625	671	720	768	819	877	940	2,074	6,198
Increases or Decreases (–) in the Deficit from Direct Spending and Revenues													
Estimated Effect on the Deficit:													
Estimated Changes in On-Budget Deficits .....	0	0	–872	–1,853	–2,259	–2,438	–2,801	–3,063	–3,276	–3,515	–3,776	–7,423	–23,853
Estimated Changes in Off-Budget Deficits .....	0	0	–619	–1,328	–1,633	–1,767	–2,081	–2,295	–2,458	–2,638	–2,835	–5,348	–17,656
Total .....	0	0	–253	–525	–625	–671	–720	–768	–819	–877	–940	–2,074	–6,198

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation. Components may not sum to totals because of rounding; \* = between zero and \$500,000. H.R. 5800 would establish patient protections from surprise medical billing, and in certain circumstances would require insurers to reimburse out-of-network providers on the basis of the median payment rate for in-network care. The bill also would establish a process for health care providers and insurers to settle disputes over out-of-network bills greater than \$750. CBO and JCT expect that under the bill, in facilities where surprise bills are likely, the average of payment rates for both in- and out-of-network care would move toward the median in-network rate, which tends to be lower than average rates. CBO and JCT estimate that in most affected markets in most years, lower payments to some providers would reduce premiums by roughly 1 percent. Lower costs for health insurance would reduce federal deficits because the federal government subsidizes most private insurance through tax preferences for employment-based coverage and through the health insurance marketplaces established under the Affordable Care Act.

## COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 5800. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when the committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the *Congressional Budget Act of 1974*. Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the *Congressional Budget Act of 1974*.

## CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, H.R. 5800, as reported, are shown as follows:

## CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

**PUBLIC HEALTH SERVICE ACT**

\* \* \* \* \*

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH  
INSURANCE COVERAGE**PART A—INDIVIDUAL AND GROUP MARKET  
REFORMS**

\* \* \* \* \*

**Subpart II—Improving Coverage**

\* \* \* \* \*

**SEC. 2719A. PATIENT PROTECTIONS.**

(a) **CHOICE OF HEALTH CARE PROFESSIONAL.**—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee 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 or individual health insurance issuer, provides or covers any benefits with respect to services

in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

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

[(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

[(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

[(i) by a nonparticipating health care provider with or without prior authorization; or

[(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

[(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

[(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 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

[(2) DEFINITIONS.—In this subsection:

[(A) 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.

[(B) EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—

[(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, 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, such further medical exam-

ination and treatment as are required under section 1867 of such Act to stabilize the patient.

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

(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 co-payment 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, 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, 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 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 rou-

*tinely 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 non-medical 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, 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 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 plan 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 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 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 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 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 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 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 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 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 Retirement 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)).

(c) ACCESS TO PEDIATRIC CARE.—

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

graph (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 offering 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 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, 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.

(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).

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**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.

**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.

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**PART B—INDIVIDUAL MARKET RULES**

**Subpart 1—Portability, Access, and Renewability Requirements**

\* \* \* \* \*

**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.

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**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 freestanding 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 NONPARTICIPATING 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 nonparticipating 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 non-physician 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 covered 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 pro-

vider 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 enrollee 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, bene-

fiary, 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 Secretary 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 insurance 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 furnishing 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. 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 services 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 Revenue 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. 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 coverage 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.

**SEC. 2799A-7. 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 rule-making 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 participant, 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.

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**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
1974**

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the “Employee Retirement Income Security Act of 1974”.

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

\* \* \* \* \*

PART 5—ADMINISTRATION AND ENFORCEMENT

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

PART 7—GROUP HEALTH PLAN REQUIREMENTS

Subpart B—Other Requirements

\* \* \* \* \*  
*Sec. 715. Additional market reforms.*  
*Sec. 716. Consumer protections.*  
*Sec. 717. Protecting patients and improving the accuracy of provider directory information.*  
*Sec. 718. Provision of cost-sharing information.*  
*Sec. 719. Continuity of care.*

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE B—REGULATORY PROVISIONS

PART 4—FIDUCIARY RESPONSIBILITY

EXEMPTIONS FROM PROHIBITED TRANSACTIONS

SEC. 408. (a) The Secretary shall establish an exemption procedure for purposes of this subsection. Pursuant to such procedure, he may grant a conditional or unconditional exemption of any fiduciary or transaction, or class of fiduciaries or transactions, from all or part of the restrictions imposed by sections 406 and 407(a). Action under this subsection may be taken only after consultation and coordination with the Secretary of the Treasury. An exemption granted under this section shall not relieve a fiduciary from any other applicable provision of this Act. The Secretary may not grant an exemption under this subsection unless he finds that such exemption is—

- (1) administratively feasible,
- (2) in the interests of the plan and of its participants and beneficiaries, and
- (3) protective of the rights of participants and beneficiaries of such plan.

Before granting an exemption under this subsection from section 406(a) or 407(a), the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this subsection from section 406(b) unless he affords an opportunity for a hearing and makes a determination on the record with respect to the findings required by paragraphs (1), (2), and (3) of this subsection.

(b) The prohibitions provided in section 406 shall not apply to any of the following transactions:

(1) Any loans made by the plan to parties in interest who are participants or beneficiaries of the plan if such loans (A) are available to all such participants and beneficiaries on a reasonably equivalent basis, (B) are not made available to highly compensated employees (within the meaning of section 414(q) of the Internal Revenue Code of 1986) in an amount greater than the amount made available to other employees, (C) are made in accordance with specific provisions regarding such loans set forth in the plan, (D) bear a reasonable rate of interest, and (E) are adequately secured. A loan made by a plan shall not fail to meet the requirements of the preceding sentence by reason of a loan repayment suspension described under section 414(u)(4) of the Internal Revenue Code of 1986.

【(2) Contracting or making】 (2) (A) *Contracting or making* reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

(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 administration 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 aggregate, 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 affiliate 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 com-

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 circumstances 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 relates 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.*

(3) A loan to an employee stock ownership plan (as defined in section 407(d)(6)), if—

(A) such loan is primarily for the benefit of participants and beneficiaries of the plan, and

(B) such loan is at an interest rate which is not in excess of a reasonable rate.

If the plan gives collateral to a party in interest for such loan, such collateral may consist only of qualifying employer securities (as defined in section 407(d)(5)).

(4) The investment of all or part of a plan's assets in deposits which bear a reasonable interest rate in a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan and if—

(A) the plan covers only employees of such bank or other institution and employees of affiliates of such bank or other institution, or

(B) such investment is expressly authorized by a provision of the plan or by a fiduciary (other than such bank or institution or affiliate thereof) who is expressly empowered by the plan to so instruct the trustee with respect to such investment.

(5) Any contract for life insurance, health insurance, or annuities with one or more insurers which are qualified to do business in a State, if the plan pays no more than adequate consideration, and if each such insurer or insurers is—

(A) the employer maintaining the plan, or

(B) a party in interest which is wholly owned (directly or indirectly) by the employer maintaining the plan, or by any person which is a party in interest with respect to the plan, but only if the total premiums and annuity considerations written by such insurers for life insurance, health insurance, or annuities for all plans (and their employers) with respect to which such insurers are parties in interest (not including premiums or annuity considerations written by the employer maintaining the plan) do not exceed 5 percent of the total premiums and annuity considerations written for all lines of insurance in that year by such insurers (not including premiums or annuity considerations written by the employer maintaining the plan).

(6) The providing of any ancillary service by a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan, and if—

(A) such bank or similar financial institution has adopted adequate internal safeguards which assure that the providing of such ancillary service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority, and

(B) the extent to which such ancillary service is provided is subject to specific guidelines issued by such bank or similar financial institution (as determined by the Secretary after consultation with Federal and State supervisory authority), and adherence to such guidelines would reasonably preclude such bank or similar financial institu-

tion from providing such ancillary service (i) in an excessive or unreasonable manner, and (ii) in a manner that would be inconsistent with the best interests of participants and beneficiaries of employee benefit plans. Such ancillary services shall not be provided at more than reasonable compensation.

(7) The exercise of a privilege to convert securities, to the extent provided in regulations of the Secretary, but only if the plan receives no less than adequate consideration pursuant to such conversion.

(8) Any transaction between a plan and (i) a common or collective trust fund or pooled investment fund maintained by a party in interest which is a bank or trust company supervised by a State or Federal agency or (ii) a pooled investment fund of an insurance company qualified to do business in a State, if—

(A) the transaction is a sale or purchase of an interest in the fund,

(B) the bank, trust company, or insurance company receives not more than reasonable compensation, and

(C) such transaction is expressly permitted by the instrument under which the plan is maintained, or by a fiduciary (other than the bank, trust company, or insurance company, or an affiliate thereof) who has authority to manage and control the assets of the plan.

(9) The making by a fiduciary of a distribution of the assets of the plan in accordance with the terms of the plan if such assets are distributed in the same manner as provided under section 4044 of this Act (relating to allocation of assets).

(10) Any transaction required or permitted under part 1 of subtitle E of title IV.

(11) A merger of multiemployer plans, or the transfer of assets or liabilities between multiemployer plans, determined by the Pension Benefit Guaranty Corporation to meet the requirements of section 4231.

(12) The sale by a plan to a party in interest on or after December 18, 1987, of any stock, if—

(A) the requirements of paragraphs (1) and (2) of subsection (e) are met with respect to such stock,

(B) on the later of the date on which the stock was acquired by the plan, or January 1, 1975, such stock constituted a qualifying employer security (as defined in section 407(d)(5) as then in effect), and

(C) such stock does not constitute a qualifying employer security (as defined in section 407(d)(5) as in effect at the time of the sale).

(13) Any transfer made before January 1, 2026, of excess pension assets from a defined benefit plan to a retiree health account in a qualified transfer permitted under section 420 of the Internal Revenue Code of 1986 (as in effect on the date of the enactment of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015).

(14) Any transaction in connection with the provision of investment advice described in section 3(21)(A)(ii) to a participant or beneficiary of an individual account plan that permits

such participant or beneficiary to direct the investment of assets in their individual account, if—

(A) the transaction is—

(i) the provision of the investment advice to the participant or beneficiary of the plan with respect to a security or other property available as an investment under the plan,

(ii) the acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice, or

(iii) the direct or indirect receipt of fees or other compensation by the fiduciary adviser or an affiliate thereof (or any employee, agent, or registered representative of the fiduciary adviser or affiliate) in connection with the provision of the advice or in connection with an acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice; and

(B) the requirements of subsection (g) are met.

(15)(A) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest (other than a fiduciary described in section 3(21)(A)) with respect to a plan if—

(i) the transaction involves a block trade,

(ii) at the time of the transaction, the interest of the plan (together with the interests of any other plans maintained by the same plan sponsor), does not exceed 10 percent of the aggregate size of the block trade,

(iii) the terms of the transaction, including the price, are at least as favorable to the plan as an arm's length transaction, and

(iv) the compensation associated with the purchase and sale is not greater than the compensation associated with an arm's length transaction with an unrelated party.

(B) For purposes of this paragraph, the term "block trade" means any trade of at least 10,000 shares or with a market value of at least \$200,000 which will be allocated across two or more unrelated client accounts of a fiduciary.

(16) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest if—

(A) the transaction is executed through an electronic communication network, alternative trading system, or similar execution system or trading venue subject to regulation and oversight by—

(i) the applicable Federal regulating entity, or

(ii) such foreign regulatory entity as the Secretary may determine by regulation,

(B) either—

(i) the transaction is effected pursuant to rules designed to match purchases and sales at the best price available through the execution system in accordance with applicable rules of the Securities and Exchange Commission or other relevant governmental authority, or

(ii) neither the execution system nor the parties to the transaction take into account the identity of the parties in the execution of trades,

(C) the price and compensation associated with the purchase and sale are not greater than the price and compensation associated with an arm's length transaction with an unrelated party,

(D) if the party in interest has an ownership interest in the system or venue described in subparagraph (A), the system or venue has been authorized by the plan sponsor or other independent fiduciary for transactions described in this paragraph, and

(E) not less than 30 days prior to the initial transaction described in this paragraph executed through any system or venue described in subparagraph (A), a plan fiduciary is provided written or electronic notice of the execution of such transaction through such system or venue.

(17)(A) Transactions described in subparagraphs (A), (B), and (D) of section 406(a)(1) between a plan and a person that is a party in interest other than a fiduciary (or an affiliate) who has or exercises any discretionary authority or control with respect to the investment of the plan assets involved in the transaction or renders investment advice (within the meaning of section 3(21)(A)(ii)) with respect to those assets, solely by reason of providing services to the plan or solely by reason of a relationship to such a service provider described in subparagraph (F), (G), (H), or (I) of section 3(14), or both, but only if in connection with such transaction the plan receives no less, nor pays no more, than adequate consideration.

(B) For purposes of this paragraph, the term "adequate consideration" means—

(i) in the case of a security for which there is a generally recognized market—

(I) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934, taking into account factors such as the size of the transaction and marketability of the security, or

(II) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of the party in interest, taking into account factors such as the size of the transaction and marketability of the security, and

(ii) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by a fiduciary or fiduciaries in accordance with regulations prescribed by the Secretary.

(18) FOREIGN EXCHANGE TRANSACTIONS.—Any foreign exchange transactions, between a bank or broker-dealer (or any affiliate of either), and a plan (as defined in section 3(3)) with respect to which such bank or broker-dealer (or affiliate) is a trustee, custodian, fiduciary, or other party in interest, if—

(A) the transaction is in connection with the purchase, holding, or sale of securities or other investment assets (other than a foreign exchange transaction unrelated to any other investment in securities or other investment assets),

(B) at the time the foreign exchange transaction is entered into, the terms of the transaction are not less favorable to the plan than the terms generally available in comparable arm's length foreign exchange transactions between unrelated parties, or the terms afforded by the bank or broker-dealer (or any affiliate of either) in comparable arm's-length foreign exchange transactions involving unrelated parties,

(C) the exchange rate used by such bank or broker-dealer (or affiliate) for a particular foreign exchange transaction does not deviate by more than 3 percent from the interbank bid and asked rates for transactions of comparable size and maturity at the time of the transaction as displayed on an independent service that reports rates of exchange in the foreign currency market for such currency, and

(D) the bank or broker-dealer (or any affiliate of either) does not have investment discretion, or provide investment advice, with respect to the transaction.

(19) CROSS TRADING.—Any transaction described in sections 406(a)(1)(A) and 406(b)(2) involving the purchase and sale of a security between a plan and any other account managed by the same investment manager, if—

(A) the transaction is a purchase or sale, for no consideration other than cash payment against prompt delivery of a security for which market quotations are readily available,

(B) the transaction is effected at the independent current market price of the security (within the meaning of section 270.17a-7(b) of title 17, Code of Federal Regulations),

(C) no brokerage commission, fee (except for customary transfer fees, the fact of which is disclosed pursuant to subparagraph (D)), or other remuneration is paid in connection with the transaction,

(D) a fiduciary (other than the investment manager engaging in the cross-trades or any affiliate) for each plan participating in the transaction authorizes in advance of any cross-trades (in a document that is separate from any other written agreement of the parties) the investment manager to engage in cross trades at the investment manager's discretion, after such fiduciary has received disclosure regarding the conditions under which cross trades may take place (but only if such disclosure is separate from any other agreement or disclosure involving the asset management relationship), including the written policies and procedures of the investment manager described in subparagraph (H),

(E) each plan participating in the transaction has assets of at least \$100,000,000, except that if the assets of a plan are invested in a master trust containing the assets of

plans maintained by employers in the same controlled group (as defined in section 407(d)(7)), the master trust has assets of at least \$100,000,000,

(F) the investment manager provides to the plan fiduciary who authorized cross trading under subparagraph (D) a quarterly report detailing all cross trades executed by the investment manager in which the plan participated during such quarter, including the following information, as applicable: (i) the identity of each security bought or sold; (ii) the number of shares or units traded; (iii) the parties involved in the cross-trade; and (iv) trade price and the method used to establish the trade price,

(G) the investment manager does not base its fee schedule on the plan's consent to cross trading, and no other service (other than the investment opportunities and cost savings available through a cross trade) is conditioned on the plan's consent to cross trading,

(H) the investment manager has adopted, and cross-trades are effected in accordance with, written cross-trading policies and procedures that are fair and equitable to all accounts participating in the cross-trading program, and that include a description of the manager's pricing policies and procedures, and the manager's policies and procedures for allocating cross trades in an objective manner among accounts participating in the cross-trading program, and

(I) the investment manager has designated an individual responsible for periodically reviewing such purchases and sales to ensure compliance with the written policies and procedures described in subparagraph (H), and following such review, the individual shall issue an annual written report no later than 90 days following the period to which it relates signed under penalty of perjury to the plan fiduciary who authorized cross trading under subparagraph (D) describing the steps performed during the course of the review, the level of compliance, and any specific instances of non-compliance.

The written report under subparagraph (I) shall also notify the plan fiduciary of the plan's right to terminate participation in the investment manager's cross-trading program at any time.

(20)(A) Except as provided in subparagraphs (B) and (C), a transaction described in section 406(a) in connection with the acquisition, holding, or disposition of any security or commodity, if the transaction is corrected before the end of the correction period.

(B) Subparagraph (A) does not apply to any transaction between a plan and a plan sponsor or its affiliates that involves the acquisition or sale of an employer security (as defined in section 407(d)(1)) or the acquisition, sale, or lease of employer real property (as defined in section 407(d)(2)).

(C) In the case of any fiduciary or other party in interest (or any other person knowingly participating in such transaction), subparagraph (A) does not apply to any transaction if, at the time the transaction occurs, such fiduciary or party in interest (or other person) knew (or reasonably should have known) that

the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(D) For purposes of this paragraph, the term “correction period” means, in connection with a fiduciary or party in interest (or other person knowingly participating in the transaction), the 14-day period beginning on the date on which such fiduciary or party in interest (or other person) discovers, or reasonably should have discovered, that the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(E) For purposes of this paragraph—

(i) The term “security” has the meaning given such term by section 475(c)(2) of the Internal Revenue Code of 1986 (without regard to subparagraph (F)(iii) and the last sentence thereof).

(ii) The term “commodity” has the meaning given such term by section 475(e)(2) of such Code (without regard to subparagraph (D)(iii) thereof).

(iii) The term “correct” means, with respect to a transaction—

(I) to undo the transaction to the extent possible and in any case to make good to the plan or affected account any losses resulting from the transaction, and

(II) to restore to the plan or affected account any profits made through the use of assets of the plan.

(c) Nothing in section 406 shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

(d)(1) Section 407(b) and subsections (b), (c), and (e) of this section shall not apply to a transaction in which a plan directly or indirectly—

(A) lends any part of the corpus or income of the plan to,

(B) pays any compensation for personal services rendered to the plan to, or

(C) acquires for the plan any property from, or sells any property to,

any person who is with respect to the plan an owner-employee (as defined in section 401(c)(3) of the Internal Revenue Code of 1986), a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or any corporation in which any

such owner-employee owns, directly or indirectly, 50 percent or more of the total combined voting power of all classes of stock entitled to vote or 50 percent or more of the total value of shares of all classes of stock of the corporation.

(2)(A) For purposes of paragraph (1), the following shall be treated as owner-employees:

(i) A shareholder-employee.

(ii) A participant or beneficiary of an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986).

(iii) An employer or association of employees which establishes such an individual retirement plan under section 408(c) of such Code.

(B) Paragraph (1)(C) shall not apply to a transaction which consists of a sale of employer securities to an employee stock ownership plan (as defined in section 407(d)(6)) by a shareholder-employee, a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or a corporation in which such a shareholder-employee owns stock representing a 50 percent or greater interest described in paragraph (1).

(C) For purposes of paragraph (1)(A), the term "owner-employee" shall only include a person described in clause (ii) or (iii) of subparagraph (A).

(3) For purposes of paragraph (2), the term "shareholder-employee" means an employee or officer of an S corporation (as defined in section 1361(a)(1) of such Code) who owns (or is considered as owning within the meaning of section 318(a)(1) of such Code) more than 5 percent of the outstanding stock of the corporation on any day during the taxable year of such corporation.

(e) Sections 406 and 407 shall not apply to the acquisition or sale by a plan of qualifying employer securities (as defined in section 407(d)(5)) or acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 407(d)(4))—

(1) if such acquisition, sale, or lease is for adequate consideration (or in the case of a marketable obligation, at a price not less favorable to the plan than the price determined under section 407(e)(1)),

(2) if no commission is charged with respect thereto, and

(3) if—

(A) the plan is an eligible individual account plan (as defined in section 407(d)(3)), or

(B) in the case of an acquisition or lease of qualifying employer real property by a plan which is not an eligible individual account plan, or of an acquisition of qualifying employer securities by such a plan, the lease or acquisition is not prohibited by section 407(a).

(f) Section 406(b)(2) shall not apply to any merger or transfer described in subsection (b)(11).

(g) PROVISION OF INVESTMENT ADVICE TO PARTICIPANT AND BENEFICIARIES.—

(1) IN GENERAL.—The prohibitions provided in section 406 shall not apply to transactions described in subsection (b)(14) if the investment advice provided by a fiduciary adviser is provided under an eligible investment advice arrangement.

(2) ELIGIBLE INVESTMENT ADVICE ARRANGEMENT.—For purposes of this subsection, the term “eligible investment advice arrangement” means an arrangement—

(A) which either—

(i) provides that any fees (including any commission or other compensation) received by the fiduciary adviser for investment advice or with respect to the sale, holding, or acquisition of any security or other property for purposes of investment of plan assets do not vary depending on the basis of any investment option selected, or

(ii) uses a computer model under an investment advice program meeting the requirements of paragraph (3) in connection with the provision of investment advice by a fiduciary adviser to a participant or beneficiary, and

(B) with respect to which the requirements of paragraph (4), (5), (6), (7), (8), and (9) are met.

(3) INVESTMENT ADVICE PROGRAM USING COMPUTER MODEL.—

(A) IN GENERAL.—An investment advice program meets the requirements of this paragraph if the requirements of subparagraphs (B), (C), and (D) are met.

(B) COMPUTER MODEL.—The requirements of this subparagraph are met if the investment advice provided under the investment advice program is provided pursuant to a computer model that—

(i) applies generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time,

(ii) utilizes relevant information about the participant, which may include age, life expectancy, retirement age, risk tolerance, other assets or sources of income, and preferences as to certain types of investments,

(iii) utilizes prescribed objective criteria to provide asset allocation portfolios comprised of investment options available under the plan,

(iv) operates in a manner that is not biased in favor of investments offered by the fiduciary adviser or a person with a material affiliation or contractual relationship with the fiduciary adviser, and

(v) takes into account all investment options under the plan in specifying how a participant’s account balance should be invested and is not inappropriately weighted with respect to any investment option.

(C) CERTIFICATION.—

(i) IN GENERAL.—The requirements of this subparagraph are met with respect to any investment advice program if an eligible investment expert certifies, prior to the utilization of the computer model and in accordance with rules prescribed by the Secretary, that the computer model meets the requirements of subparagraph (B).

(ii) RENEWAL OF CERTIFICATIONS.—If, as determined under regulations prescribed by the Secretary, there

are material modifications to a computer model, the requirements of this subparagraph are met only if a certification described in clause (i) is obtained with respect to the computer model as so modified.

(iii) ELIGIBLE INVESTMENT EXPERT.—The term “eligible investment expert” means any person—

(I) which meets such requirements as the Secretary may provide, and

(II) does not bear any material affiliation or contractual relationship with any investment adviser or a related person thereof (or any employee, agent, or registered representative of the investment adviser or related person).

(D) EXCLUSIVITY OF RECOMMENDATION.—The requirements of this subparagraph are met with respect to any investment advice program if—

(i) the only investment advice provided under the program is the advice generated by the computer model described in subparagraph (B), and

(ii) any transaction described in subsection (b)(14)(A)(ii) occurs solely at the direction of the participant or beneficiary.

Nothing in the preceding sentence shall preclude the participant or beneficiary from requesting investment advice other than that described in subparagraph (A), but only if such request has not been solicited by any person connected with carrying out the arrangement.

(4) EXPRESS AUTHORIZATION BY SEPARATE FIDUCIARY.—The requirements of this paragraph are met with respect to an arrangement if the arrangement is expressly authorized by a plan fiduciary other than the person offering the investment advice program, any person providing investment options under the plan, or any affiliate of either.

(5) ANNUAL AUDIT.—The requirements of this paragraph are met if an independent auditor, who has appropriate technical training or experience and proficiency and so represents in writing—

(A) conducts an annual audit of the arrangement for compliance with the requirements of this subsection, and

(B) following completion of the annual audit, issues a written report to the fiduciary who authorized use of the arrangement which presents its specific findings regarding compliance of the arrangement with the requirements of this subsection.

For purposes of this paragraph, an auditor is considered independent if it is not related to the person offering the arrangement to the plan and is not related to any person providing investment options under the plan.

(6) DISCLOSURE.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides to a participant or a beneficiary before the initial provision of the investment advice with regard to any security or other property offered as an investment option, a written notification

(which may consist of notification by means of electronic communication)—

(i) of the role of any party that has a material affiliation or contractual relationship with the fiduciary adviser in the development of the investment advice program and in the selection of investment options available under the plan,

(ii) of the past performance and historical rates of return of the investment options available under the plan,

(iii) of all fees or other compensation relating to the advice that the fiduciary adviser or any affiliate thereof is to receive (including compensation provided by any third party) in connection with the provision of the advice or in connection with the sale, acquisition, or holding of the security or other property,

(iv) of any material affiliation or contractual relationship of the fiduciary adviser or affiliates thereof in the security or other property,

(v) the manner, and under what circumstances, any participant or beneficiary information provided under the arrangement will be used or disclosed,

(vi) of the types of services provided by the fiduciary adviser in connection with the provision of investment advice by the fiduciary adviser,

(vii) that the adviser is acting as a fiduciary of the plan in connection with the provision of the advice, and

(viii) that a recipient of the advice may separately arrange for the provision of advice by another adviser, that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property, and

(B) at all times during the provision of advisory services to the participant or beneficiary, the fiduciary adviser—

(i) maintains the information described in subparagraph (A) in accurate form and in the manner described in paragraph (8),

(ii) provides, without charge, accurate information to the recipient of the advice no less frequently than annually,

(iii) provides, without charge, accurate information to the recipient of the advice upon request of the recipient, and

(iv) provides, without charge, accurate information to the recipient of the advice concerning any material change to the information required to be provided to the recipient of the advice at a time reasonably contemporaneous to the change in information.

(7) OTHER CONDITIONS.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides appropriate disclosure, in connection with the sale, acquisition, or holding of the security or other property, in accordance with all applicable securities laws,

(B) the sale, acquisition, or holding occurs solely at the direction of the recipient of the advice,

(C) the compensation received by the fiduciary adviser and affiliates thereof in connection with the sale, acquisition, or holding of the security or other property is reasonable, and

(D) the terms of the sale, acquisition, or holding of the security or other property are at least as favorable to the plan as an arm's length transaction would be.

(8) STANDARDS FOR PRESENTATION OF INFORMATION.—

(A) IN GENERAL.—The requirements of this paragraph are met if the notification required to be provided to participants and beneficiaries under paragraph (6)(A) is written in a clear and conspicuous manner and in a manner calculated to be understood by the average plan participant and is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of the information required to be provided in the notification.

(B) MODEL FORM FOR DISCLOSURE OF FEES AND OTHER COMPENSATION.—The Secretary shall issue a model form for the disclosure of fees and other compensation required in paragraph (6)(A)(iii) which meets the requirements of subparagraph (A).

(9) MAINTENANCE FOR 6 YEARS OF EVIDENCE OF COMPLIANCE.—The requirements of this paragraph are met if a fiduciary adviser who has provided advice referred to in paragraph (1) maintains, for a period of not less than 6 years after the provision of the advice, any records necessary for determining whether the requirements of the preceding provisions of this subsection and of subsection (b)(14) have been met. A transaction prohibited under section 406 shall not be considered to have occurred solely because the records are lost or destroyed prior to the end of the 6-year period due to circumstances beyond the control of the fiduciary adviser.

(10) EXEMPTION FOR PLAN SPONSOR AND CERTAIN OTHER FIDUCIARIES.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan sponsor or other person who is a fiduciary (other than a fiduciary adviser) shall not be treated as failing to meet the requirements of this part solely by reason of the provision of investment advice referred to in section 3(21)(A)(ii) (or solely by reason of contracting for or otherwise arranging for the provision of the advice), if—

(i) the advice is provided by a fiduciary adviser pursuant to an eligible investment advice arrangement between the plan sponsor or other fiduciary and the fiduciary adviser for the provision by the fiduciary adviser of investment advice referred to in such section,

(ii) the terms of the eligible investment advice arrangement require compliance by the fiduciary adviser with the requirements of this subsection, and

(iii) the terms of the eligible investment advice arrangement include a written acknowledgment by the fiduciary adviser that the fiduciary adviser is a fidu-

ciary of the plan with respect to the provision of the advice.

(B) CONTINUED DUTY OF PRUDENT SELECTION OF ADVISER AND PERIODIC REVIEW.—Nothing in subparagraph (A) shall be construed to exempt a plan sponsor or other person who is a fiduciary from any requirement of this part for the prudent selection and periodic review of a fiduciary adviser with whom the plan sponsor or other person enters into an eligible investment advice arrangement for the provision of investment advice referred to in section 3(21)(A)(ii). The plan sponsor or other person who is a fiduciary has no duty under this part to monitor the specific investment advice given by the fiduciary adviser to any particular recipient of the advice.

(C) AVAILABILITY OF PLAN ASSETS FOR PAYMENT FOR ADVICE.—Nothing in this part shall be construed to preclude the use of plan assets to pay for reasonable expenses in providing investment advice referred to in section 3(21)(A)(ii).

(11) DEFINITIONS.—For purposes of this subsection and subsection (b)(14)—

(A) FIDUCIARY ADVISER.—The term “fiduciary adviser” means, with respect to a plan, a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 3(21)(A)(ii) by the person to a participant or beneficiary of the plan and who is—

(i) registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1 et seq.) or under the laws of the State in which the fiduciary maintains its principal office and place of business,

(ii) a bank or similar financial institution referred to in subsection (b)(4) or a savings association (as defined in section 3(b)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b)(1)), but only if the advice is provided through a trust department of the bank or similar financial institution or savings association which is subject to periodic examination and review by Federal or State banking authorities,

(iii) an insurance company qualified to do business under the laws of a State,

(iv) a person registered as a broker or dealer under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.),

(v) an affiliate of a person described in any of clauses (i) through (iv), or

(vi) an employee, agent, or registered representative of a person described in clauses (i) through (v) who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of the advice.

For purposes of this part, a person who develops the computer model described in paragraph (3)(B) or markets the investment advice program or computer model shall be treated as a person who is a fiduciary of the plan by rea-

son of the provision of investment advice referred to in section 3(21)(A)(ii) to a participant or beneficiary and shall be treated as a fiduciary adviser for purposes of this subsection and subsection (b)(14), except that the Secretary may prescribe rules under which only 1 fiduciary adviser may elect to be treated as a fiduciary with respect to the plan.

(B) **AFFILIATE.**—The term “affiliate” of another entity means an affiliated person of the entity (as defined in section 2(a)(3) of the Investment Company Act of 1940 (15 U.S.C. 80a–2(a)(3))).

(C) **REGISTERED REPRESENTATIVE.**—The term “registered representative” of another entity means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(18)) (substituting the entity for the broker or dealer referred to in such section) or a person described in section 202(a)(17) of the Investment Advisers Act of 1940 (15 U.S.C. 80b-2(a)(17)) (substituting the entity for the investment adviser referred to in such section).

(h) **PROVISION OF PHARMACY BENEFIT SERVICES.**—

(1) **IN GENERAL.**—Provided that all of the conditions described in paragraph (2) are met, the restrictions imposed by subsections (a), (b)(1), and (b)(2) of section 406 shall not apply to—

(A) the offering of pharmacy benefit services to a group health plan that is sponsored by an entity described in section 3(37)(G)(vi) or to any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity;

(B) the purchase of pharmacy benefit services by plan participants and beneficiaries of a group health plan that is sponsored by an entity described in section 3(37)(G)(vi) or of any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity; or

(C) the operation or implementation of pharmacy benefit services by an entity described in section 3(37)(G)(vi) or by any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity,

in any arrangement where such entity described in section 3(37)(G)(vi) or any related organization or subsidiary of such entity provides pharmacy benefit services that include prior authorization and appeals, a retail pharmacy network, pharmacy benefit administration, mail order fulfillment, formulary support, manufacturer payments, audits, and specialty pharmacy and goods, to any such group health plan.

(2) **CONDITIONS.**—The conditions described in this paragraph are the following:

(A) The terms of the arrangement are at least as favorable to the group health plan as such group health plan could obtain in a similar arm’s length arrangement with an unrelated third party.

(B) At least 50 percent of the providers participating in the pharmacy benefit services offered by the arrangement

are unrelated to the contributing employers or any other party in interest with respect to the group health plan.

(C) The group health plan retains an independent fiduciary who will be responsible for monitoring the group health plan's consultants, contractors, subcontractors, and other service providers for purposes of pharmacy benefit services described in paragraph (1) offered by such entity or any of its related organizations or subsidiaries and monitors the transactions of such entity and any of its related organizations or subsidiaries to ensure that all conditions of this exemption are satisfied during each plan year.

(D) Any decisions regarding the provision of pharmacy benefit services described in paragraph (1) are made by the group health plan's independent fiduciary, based on objective standards developed by the independent fiduciary in reliance on information provided by the arrangement.

(E) The independent fiduciary of the group health plan provides an annual report to the Secretary and the congressional committees of jurisdiction attesting that the conditions described in subparagraphs (C) and (D) have been met for the applicable plan year, together with a statement that use of the arrangement's services are in the best interest of the participants and beneficiaries in the aggregate for that plan year compared to other similar arrangements the group health plan could have obtained in transactions with an unrelated third party.

(F) The arrangement is not designed to benefit any party in interest with respect to the group health plan.

(3) VIOLATIONS.—In the event an entity described in section 3(37)(G)(vi) or any affiliate of such entity violates any of the conditions of such exemption, such exemption shall not apply with respect to such entity or affiliate and all enforcement and claims available under this Act shall apply with respect to such entity or affiliate.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to modify any obligation of a group health plan otherwise set forth in this Act.

(5) GROUP HEALTH PLAN.—In this subsection, the term "group health plan" has the meaning given such term in section 733(a).

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PART 5—ADMINISTRATION AND ENFORCEMENT

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**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.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

\* \* \* \* \*

SUBPART B—OTHER REQUIREMENTS

\* \* \* \* \*

**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 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 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 ge-

ographic 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 fur-

nished 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 non-medical 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 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 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 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 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 provides 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 specializes 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 respect 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 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 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.

(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 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.

(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.*

(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).*

**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 5 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 prospec-*

*tive 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.*

**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 participant 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. For purposes of the previous sentence, the Secretary shall develop and make available in multiple languages (as specified by the Secretary) a model form that is in easily understandable language and format.

**SEC. 719. CONTINUITY OF CARE.**

(a) **ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.**—

(1) **IN GENERAL.**—*In the case of an individual with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—*

(A) *such contractual relationship is terminated (as defined in paragraph (b));*

(B) *benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or*

(C) *a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;*  
*the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.*

(2) **REQUIREMENTS.**—*The requirements of this paragraph are that the plan or issuer—*

(A) *notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;*

(B) *provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and*

(C) *permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on*

the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

- (i) the 90-day period beginning on such date; or
- (ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) DEFINITIONS.—In this section:

(1) CONTINUING CARE PATIENT.—The term “continuing care patient” means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

(2) SERIOUS AND COMPLEX CONDITION.—The term “serious and complex condition” means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) TERMINATED.—The term “terminated” includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

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**INTERNAL REVENUE CODE OF 1986**

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**Subtitle K—Group Health Plan Requirements**

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**CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS**

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**Subchapter B—OTHER REQUIREMENTS**

Sec. 9811. Standards relating to benefits for mothers and newborns.

\* \* \* \* \*

Sec. 9815. Additional market reforms.

Sec. 9816. Consumer protections.

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

Sec. 9818. Provision of cost-sharing information.

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**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 au-

*dits 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 non-medical 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—*

*(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 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 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 free-

*standing 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 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; 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 rule-making 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, 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 non-participating 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 participant 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 determined 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.

(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).

**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.

**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.

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**TITLE 5, UNITED STATES CODE**

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## PART III—EMPLOYEES

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### SUBPART G—INSURANCE AND ANNUITIES

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#### CHAPTER 89—HEALTH INSURANCE

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#### § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a

of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(1) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, “qualified health maintenance carrier” means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

(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.*

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**PATIENT PROTECTION AND AFFORDABLE CARE ACT**

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**TITLE I—QUALITY, AFFORDABLE  
HEALTH CARE FOR ALL AMERICANS**

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**Subtitle C—Quality Health Insurance  
Coverage for All Americans**

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**PART 2—OTHER PROVISIONS**

**SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.**

(a) **NO CHANGES TO EXISTING COVERAGE.—**

(1) **IN GENERAL.—**Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) **CONTINUATION OF COVERAGE.—**Except as provided in paragraph (3), with respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(3) **APPLICATION OF CERTAIN PROVISIONS.—**The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.

(4) **APPLICATION OF CERTAIN PROVISIONS.—**

(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

(i) Section 2708 (relating to excessive waiting periods).

(ii) Those provisions of section 2711 relating to lifetime limits.

(iii) Section 2712 (relating to rescissions).

(iv) Section 2714 (relating to extension of dependent coverage).

(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

(i) PROVISIONS DESCRIBED.—Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

(ii) ADULT CHILD COVERAGE.—For plan years beginning before January 1, 2014, the provisions of section 2714 of the Public Health Service Act (as added by this subtitle) shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan.

(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.*

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not

apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

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