

116TH CONGRESS
2D SESSION

H. R. 5826

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title XI of the Social Security Act to prevent certain cases of out-of-network surprise medical bills, strengthen health care consumer protections, and improve health care information transparency, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 10, 2020

Mr. NEAL (for himself, Mr. BRADY, Mr. SUOZZI, Mr. LAHOOD, Mr. HOLDING, Mr. KELLY of Pennsylvania, Mr. ESTES, Mr. THOMPSON of California, Mr. BEYER, Ms. SHALALA, Mr. MORELLE, Mr. LARSON of Connecticut, Ms. SCHRIER, Mr. SCHNEIDER, Mr. DANNY K. DAVIS of Illinois, Mr. EVANS, Mr. LEWIS, Mr. HIGGINS of New York, Mr. NUNES, Mr. SMITH of Nebraska, Mr. FERGUSON, Mr. WENSTRUP, Mr. RICE of South Carolina, Mrs. WALORSKI, Mr. SCHWEIKERT, Mr. REED, Mr. ARRINGTON, Mr. MARCHANT, Mr. BUCHANAN, Mr. THOMPSON of Pennsylvania, Mr. KILDEE, and Mr. SMITH of Missouri) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title XI of the Social Security Act to prevent certain cases of out-of-network surprise medical bills, strengthen health care

consumer protections, and improve health care information transparency, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
 5 “Consumer Protections Against Surprise Medical Bills
 6 Act of 2020”.

7 (b) TABLE OF CONTENTS.—The table of contents of
 8 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Consumer protections through requirements on health plans to prevent surprise medical bills for emergency services.
- Sec. 3. Consumer protections through requirements on health plans to prevent surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.
- Sec. 4. Consumer protections through application of health plan external review in cases of certain surprise medical bills.
- Sec. 5. Consumer protections through health plan transparency requirements.
- Sec. 6. Consumer protections through health plan requirement for fair and honest advance cost estimate.
- Sec. 7. Determination through open negotiation and mediation of out-of-network rates to be paid by health plans.
- Sec. 8. Prohibiting balance billing practices by providers for emergency services, for services furnished by nonparticipating provider at participating facility, and in certain cases of misinformation.
- Sec. 9. Additional consumer protections.
- Sec. 10. Reporting requirements regarding air ambulance services.
- Sec. 11. GAO report on effects of legislation.
- Sec. 12. Transitional rule allowing deduction for surprise billing expenses below AGI floor.

9 **SEC. 2. CONSUMER PROTECTIONS THROUGH REQUIRE-**
 10 **MENTS ON HEALTH PLANS TO PREVENT SUR-**
 11 **PRISE MEDICAL BILLS FOR EMERGENCY**
 12 **SERVICES.**

13 (a) PHSA AMENDMENTS.—

1 (1) IN GENERAL.—Section 2719A of the Public
2 Health Service Act (42 U.S.C. 300gg–19a) is
3 amended—

4 (A) in subsection (b)—

5 (i) in the heading, by striking “COV-
6 ERAGE” and inserting “COST-SHARING
7 AND PAYMENT”;

8 (ii) in paragraph (1)—

9 (I) in the matter preceding sub-
10 paragraph (A)—

11 (aa) by striking “a group
12 health plan, or a health insurance
13 issuer offering group or indi-
14 vidual health insurance issuer,”
15 and inserting “a health plan”;

16 (bb) by inserting “and, for
17 plan year 2022 or a subsequent
18 plan year, with respect to emer-
19 gency services in an independent
20 freestanding emergency depart-
21 ment” after “emergency depart-
22 ment of a hospital”;

23 (cc) by striking “the plan or
24 issuer” and inserting “the plan”;
25 and

1 (dd) by striking “(as defined
2 in paragraph (2)(B))”;

3 (II) in subparagraph (B), by in-
4 serting “or a participating facility
5 that is an emergency department of a
6 hospital or an independent free-
7 standing emergency department (in
8 this subsection referred to as a ‘par-
9 ticipating emergency facility’)” after
10 “participating provider”; and

11 (III) in subparagraph (C)—

12 (aa) in the matter preceding
13 clause (i), by inserting “by a
14 nonparticipating provider or a
15 nonparticipating facility that is
16 an emergency department of a
17 hospital or an independent free-
18 standing emergency department”
19 after “enrollee”;

20 (bb) by striking clause (i);

21 (cc) by striking “(ii)(I) such
22 services” and inserting “(i) such
23 services”;

24 (dd) by striking “where the
25 provider of services does not have

1 a contractual relationship with
2 the plan for the providing of
3 services”;

4 (ee) by striking “emergency
5 department services received
6 from providers who do have such
7 a contractual relationship with
8 the plan; and” and inserting
9 “emergency services received
10 from participating providers and
11 participating emergency facilities
12 with respect to such plan;”;

13 (ff) by striking “(II) if such
14 services” and all that follows
15 through “were provided in-net-
16 work” and inserting the fol-
17 lowing:

18 “(ii) the cost-sharing requirement is
19 not greater than the requirement that
20 would apply if such services were furnished
21 by a participating provider or a partici-
22 pating emergency facility, as applicable;”;
23 and

24 (gg) by adding at the end
25 the following new clauses:

1 “(iii) such cost-sharing requirement is
 2 calculated as if the contracted rate for
 3 such services if furnished by a partici-
 4 pating provider or a participating emer-
 5 gency facility were equal to the recognized
 6 amount for such services;

7 “(iv) the health plan pays to such pro-
 8 vider or facility, respectively, the amount
 9 by which the out-of-network rate for such
 10 services exceeds the cost-sharing amount
 11 for such services (as determined in accord-
 12 ance with clauses (ii) and (iii)); and

13 “(v) any deductible or out-of-pocket
 14 maximum that would apply if such services
 15 were furnished by a participating provider
 16 or a participating emergency facility shall
 17 be the deductible or out-of-pocket max-
 18 imum that applies; and”;

19 (iii) by striking paragraph (2) and in-
 20 serting the following new paragraph:

21 “(2) AUDIT PROCESS AND RULEMAKING PROC-
 22 ESS FOR MEDIAN CONTRACTED RATES.—

23 “(A) AUDIT PROCESS.—

24 “(i) IN GENERAL.—Not later than
 25 July 1, 2021, the Secretary, in coordina-

tion with the Secretary of the Treasury and the Secretary of Labor and in consultation with the National Association of Insurance Commissioners, shall establish through rulemaking a process, in accordance with clause (ii), under which health plans are audited by the Secretary to ensure that—

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

“(II) that such median contracted rate so applied satisfies the definition under subsection (k)(8) with respect to the year involved.

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

“(I) shall conduct audits described in such clause of a sample of health plans; and

“(II) may audit any health plan if the Secretary has received any complaint about such plan that involves

1 the compliance of the plan with the
2 requirement described in such clause.

3 “(B) RULEMAKING.—Not later than July
4 1, 2021, the Secretary, in coordination with the
5 Secretary of Labor and the Secretary of the
6 Treasury, shall establish through rulemaking—

7 “(i) the methodology the sponsor or
8 issuer of a health plan shall use to deter-
9 mine the median contracted rate, which
10 shall account for relevant payment adjust-
11 ments that take into account facility type
12 that are otherwise taken into account for
13 purposes of determining payment amounts
14 with respect to participating facilities; and

15 “(ii) the information such sponsor or
16 issuer shall share with the nonparticipating
17 provider involved when making such a de-
18 termination.”; and

19 (B) by adding at the end the following new
20 subsection:

21 “(k) DEFINITIONS.—For purposes of this section:

22 “(1) CONTRACTED RATE.—The term ‘con-
23 tracted rate’ means, with respect to a health plan
24 and a health care provider or health care facility fur-
25 nishing an item or service to a beneficiary, partici-

1 pant, or enrollee of such plan, the agreed upon total
2 payment amount (inclusive of any cost-sharing) to
3 such provider or facility for such item or service.

4 “(2) DURING A VISIT.—The term ‘during a
5 visit’ shall, with respect to an individual who is fur-
6 nished items and services at a participating facility,
7 include equipment and devices, telemedicine services,
8 imaging services, laboratory services, preoperative
9 and postoperative services, and such other items and
10 services as the Secretary may specify furnished to
11 such individual, regardless of whether or not the
12 provider furnishing such items or services is at the
13 facility.

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

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

1 (iii) of section 1867(e)(1)(A) of the Social Security
2 Act.

3 “(5) EMERGENCY SERVICES.—

4 “(A) IN GENERAL.—The term ‘emergency
5 services’, with respect to an emergency medical
6 condition, means—

7 “(i) a medical screening examination
8 (as required under section 1867 of the So-
9 cial Security Act, or as would be required
10 under such section if such section applied
11 to an independent freestanding emergency
12 department) that is within the capability of
13 the emergency department of a hospital or
14 of an independent freestanding emergency
15 department, as applicable, including ancil-
16 lary services routinely available to the
17 emergency department to evaluate such
18 emergency medical condition; and

19 “(ii) within the capabilities of the
20 staff and facilities available at the hospital
21 or the independent freestanding emergency
22 department, as applicable, such further
23 medical examination and treatment as are
24 required under section 1867 of such Act,
25 or as would be required under such section

1 if such section applied to an independent
2 freestanding emergency department, to
3 stabilize the patient (regardless of the de-
4 partment of the hospital in which such fur-
5 ther examination or treatment is fur-
6 nished).

7 “(B) INCLUSION OF ADDITIONAL SERV-
8 ICES.—In the case of an individual enrolled in
9 a health plan who is furnished services de-
10 scribed in subparagraph (A) by a provider or
11 hospital or independent freestanding emergency
12 department to stabilize such individual with re-
13 spect to an emergency medical condition, the
14 term ‘emergency services’ shall include, in addi-
15 tion to those described in subparagraph (A),
16 items and services furnished as part of out-
17 patient observation or an inpatient or out-
18 patient stay during a visit in which such indi-
19 vidual is so stabilized with respect to such
20 emergency condition if—

21 “(i) such items and services would
22 otherwise be covered under such plan if
23 furnished by a participating provider or
24 participating facility; and

1 “(ii) such items and services are fur-
2 nished—

3 “(I) to maintain, improve, or re-
4 solve the individual’s stabilization with
5 respect to such condition, unless any
6 circumstance described in subpara-
7 graph (C) has occurred with respect
8 to such individual before such items
9 and services are furnished; or

10 “(II) for any purpose not de-
11 scribed in subclause (I), unless each
12 of the criteria described in subpara-
13 graph (D) have been met with respect
14 to such individual and such item or
15 service.

16 “(C) CIRCUMSTANCES.—For purposes of
17 subparagraph (B)(ii)(I), a circumstance de-
18 scribed in this subparagraph is any of the fol-
19 lowing, with respect to an individual who is a
20 beneficiary, participant, or enrollee of a health
21 plan who is furnished services described in sub-
22 paragraph (A) by a hospital or independent
23 freestanding emergency department with re-
24 spect to an emergency medical condition:

1 “(i) A participating provider, with re-
2 spect to such plan, with privileges at the
3 hospital or independent freestanding emer-
4 gency department assumes responsibility
5 for the care of the individual.

6 “(ii) A participating provider, with re-
7 spect to such plan, assumes responsibility
8 for the care of the individual through
9 transfer of the individual.

10 “(iii) The health plan and the pro-
11 vider treating such individual at the hos-
12 pital or independent freestanding emer-
13 gency department for such condition reach
14 an agreement concerning the care for the
15 individual.

16 “(iv) The individual is discharged.

17 “(D) SIGNED NOTICE CRITERIA.—For pur-
18 poses of subparagraph (B)(ii)(II), the criteria
19 described in this subparagraph, with respect to
20 an individual and an item or service furnished
21 by a nonparticipating provider or nonpartici-
22 pating facility that is a hospital or an inde-
23 pendent freestanding emergency department,
24 are the following:

1 “(i) A written notice (as specified by
2 the Secretary and in a clear and under-
3 standable manner) is provided by such pro-
4 vider or facility to such individual, before
5 such item or service is furnished, that in-
6 cludes the following information:

7 “(I) That such provider or facil-
8 ity is a nonparticipating provider or
9 nonparticipating facility (as applica-
10 ble).

11 “(II) To the extent practicable,
12 the estimated amount that such non-
13 participating facility or nonpartici-
14 pating provider may charge the indi-
15 vidual for such item or service.

16 “(III) A statement that the indi-
17 vidual may seek such item or service
18 from a provider that is a participating
19 provider or a hospital or independent
20 freestanding emergency department
21 that is a participating facility and a
22 list, if feasible, of participating facili-
23 ties or participating providers, as ap-
24 plicable, who are able to furnish such
25 item or service.

1 “(ii) Such individual is in a condition
2 to receive (as determined in accordance
3 with guidance issued by the Secretary) the
4 information described in clause (i) and to
5 confirm notice of receipt of such notice, in
6 accordance with applicable State law.

7 “(iii) The individual signs and dates
8 such notice confirming receipt of the notice
9 before such item or service is furnished.

10 “(6) HEALTH PLAN.—The term ‘health plan’
11 means a group health plan and health insurance cov-
12 erage offered by a health insurance issuer in the
13 group or individual market and includes a grand-
14 fathered health plan (as defined in section 1251(e)
15 of the Patient Protection and Affordable Care Act).

16 “(7) INDEPENDENT FREESTANDING EMER-
17 GENCY DEPARTMENT.—The term ‘independent free-
18 standing emergency department’ means a health
19 care facility that—

20 “(A) is geographically separate and dis-
21 tinct and licensed separately from a hospital
22 under applicable State law; and

23 “(B) provides emergency services.

24 “(8) MEDIAN CONTRACTED RATE.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the term ‘median contracted rate’
3 means, with respect to a health plan—

4 “(i) for an item or service furnished
5 during 2022, the median of the contracted
6 rates recognized by the sponsor or issuer
7 of such plan (determined with respect to
8 all such plans of such sponsor or such
9 issuer that are within the same line of
10 business (as specified in subparagraph (C))
11 as the plan involved) as the total maximum
12 payment under such plans in 2019 for the
13 same or a similar item or service that is
14 provided by a provider or facility in the
15 same or similar specialty and provided in
16 the geographic region (established (and up-
17 dated, as appropriate) by the Secretary, in
18 consultation with the National Association
19 of Insurance Commissioners) in which the
20 item or service is furnished, consistent with
21 the methodology established by the Sec-
22 retary under subsection (b)(2)(B), in-
23 creased by the percentage increase in the
24 consumer price index for all urban con-

1 consumers (United States city average) over
2 2019, 2020, and 2021;

3 “(ii) for an item or service furnished
4 during 2023 or a subsequent year through
5 2026, the median contracted rate for the
6 previous year, increased by the percentage
7 increase in the consumer price index for all
8 urban consumers (United States city aver-
9 age) over such previous year;

10 “(iii) for an item or service furnished
11 during a rebasing year (as defined in sub-
12 paragraph (D)), the median of the con-
13 tracted rates recognized by the sponsor or
14 issuer of such plan (determined with re-
15 spect to all such plans of such sponsor or
16 such issuer that are within the same line
17 of business (as specified in subparagraph
18 (C)) as the plan involved) as the total max-
19 imum payment under such plans in such
20 year for the same or a similar item or serv-
21 ice that is provided by a provider or facility
22 in the same or similar specialty and pro-
23 vided in the geographic region (as estab-
24 lished pursuant to clause (i)) in which the
25 item or service is furnished, consistent with

1 the methodology established by the Sec-
2 retary under subsection (b)(2)(B); and

3 “(iv) for an item or service furnished
4 during any of the 4 years following a re-
5 basing year, the median contracted rate for
6 the previous year, increased by the per-
7 centage increase in the consumer price
8 index for all urban consumers (United
9 States city average) over such previous
10 year.

11 “(B) USE OF SUBSTITUTE RATE IN CASE
12 OF INSUFFICIENT DATA.—

13 “(i) IN GENERAL.—In the case the
14 sponsor or issuer of a health plan has in-
15 sufficient information (as specified by the
16 Secretary) to calculate the median of the
17 contracted rates in accordance with sub-
18 paragraph (A) for a year for an item or
19 service furnished in a particular geographic
20 region (as established pursuant to subpara-
21 graph (A)(i)) by a type of provider or facil-
22 ity, the substitute rate (as defined in
23 clause (ii)) for such item or service shall be
24 deemed to be the median contracted rate
25 for such item or service furnished in such

1 region during such year by such a provider
2 or facility for such year under such sub-
3 paragraph (A) for such plan.

4 “(ii) SUBSTITUTE RATE.—For pur-
5 poses of clause (i), the term ‘substitute
6 rate’ means, with respect to an item or
7 service furnished by a provider or facility
8 in a geographic region (established pursu-
9 ant to subparagraph (A)(i)) during a year
10 for which a health plan is required to make
11 payment pursuant to subsection (b)(1),
12 (e)(1), or (i)(1)—

13 “(I) if sufficient information (as
14 specified by the Secretary) exists to
15 determine the median of the con-
16 tracted rates recognized by all health
17 plans offered in the same line of busi-
18 ness (as specified in subparagraph
19 (C)) by any group health plan or
20 health insurance issuer for such an
21 item or service furnished in such re-
22 gion by such a provider or facility
23 during such year using a database or
24 other source of information deter-

1 mined appropriate by the Secretary,
2 such median; and

3 “(II) if such sufficient informa-
4 tion does not exist, the median of the
5 contracted rates recognized by all
6 health plans offered in the same line
7 of business (as specified in subpara-
8 graph (C)) by any group health plan
9 or health insurance issuer for such an
10 item or service furnished in a simi-
11 larly situated geographic region (as
12 determined by the Secretary) with
13 such sufficient information by such a
14 provider or facility during such year
15 using such a database or such other
16 source of information.

17 The Secretary shall develop a methodology
18 for determining a substitute rate based on
19 a similarly situated health plan that is not
20 a Federal health care program (as defined
21 in section 1128B(f) of the Social Security
22 Act) in the case a substitute rate is not
23 calculable under the previous sentence with
24 respect to an item or service.

1 “(C) LINE OF BUSINESS.—A line of busi-
 2 ness specified in this subparagraph is one of the
 3 following:

4 “(i) The individual market.

5 “(ii) The small group market.

6 “(iii) The large group market.

7 “(iv) In the case of a self-insured
 8 group health plan, other self-insured group
 9 health plans.

10 “(D) REBASING YEAR DEFINED.—For pur-
 11 poses of subparagraph (A), the term ‘rebasing
 12 year’ means 2027 and every 5 years thereafter.

13 “(9) NONPARTICIPATING FACILITY; PARTICI-
 14 PATING FACILITY.—

15 “(A) NONPARTICIPATING FACILITY.—The
 16 term ‘nonparticipating facility’ means, with re-
 17 spect to an item or service and a health plan,
 18 a health care facility described in subparagraph
 19 (B)(ii) that does not have a contractual rela-
 20 tionship with the plan for furnishing such item
 21 or service.

22 “(B) PARTICIPATING FACILITY.—

23 “(i) IN GENERAL.—The term ‘partici-
 24 pating facility’ means, with respect to an
 25 item or service and a health plan, a health

1 care facility described in clause (ii) that
2 has a contractual relationship with the
3 plan for furnishing such item or service.

4 “(ii) HEALTH CARE FACILITY DE-
5 SCRIBED.—A health care facility described
6 in this clause is each of the following:

7 “(I) A hospital (as defined in
8 1861(e) of the Social Security Act),
9 including an emergency department of
10 a hospital.

11 “(II) A critical access hospital
12 (as defined in section 1861(mm)(1) of
13 such Act).

14 “(III) An ambulatory surgical
15 center (as described in section
16 1833(i)(1)(A) of such Act).

17 “(IV) A laboratory.

18 “(V) A radiology facility or imag-
19 ing center.

20 “(VI) An independent free-
21 standing emergency department.

22 “(VII) Any other facility speci-
23 fied by the Secretary.

24 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
25 PATING PROVIDERS.—

1 “(A) NONPARTICIPATING PROVIDER.—The
2 term ‘nonparticipating provider’ means, with re-
3 spect to an item or service and a health plan,
4 a physician or other health care provider who
5 does not have a contractual relationship with
6 the plan for furnishing such item or service
7 under the plan.

8 “(B) PARTICIPATING PROVIDER.—The
9 term ‘participating provider’ means, with re-
10 spect to an item or service and a health plan,
11 a physician or other health care provider who
12 has a contractual relationship with the plan for
13 furnishing such item or service under the plan.

14 “(11) OUT-OF-NETWORK RATE.—The term
15 ‘out-of-network rate’ means, with respect to an item
16 or service furnished in a State during a year to a
17 participant, beneficiary, or enrollee of a health plan
18 receiving such item or service from a nonpartici-
19 pating provider or facility—

20 “(A) subject to subparagraphs (C) and
21 (D), in the case such State has in effect a State
22 law that provides for a method for determining
23 the total amount payable under such health
24 plan regulated by such State with respect to
25 such item or service furnished by such provider

1 or facility, such amount determined in accord-
2 ance with such law;

3 “(B) subject to subparagraphs (C) and
4 (D), in the case such State does not have in ef-
5 fect such a law with respect to such item or
6 service, plan, and provider or facility—

7 “(i) subject to clause (ii), if the pro-
8 vider or facility (as applicable) and such
9 plan agree on an amount of payment (in-
10 cluding if agreed on through open negotia-
11 tions under subsection (j)(1)) with respect
12 to such item or service, such agreed on
13 amount; or

14 “(ii) if such provider or facility (as
15 applicable) and such plan enter the medi-
16 ated dispute process under subsection (j)
17 and do not so agree before the date on
18 which a selected independent entity (as de-
19 fined in paragraph (3) of such subsection)
20 makes a determination with respect to
21 such item or service under such subsection,
22 the amount of such determination;

23 “(C) in the case such State has an All-
24 Payer Model Agreement under section 1115A of
25 the Social Security Act, the amount that the

1 State approves under such system for such item
2 or service so furnished; or

3 “(D) in the case such health plan is a self-
4 insured group health plan and in the case of a
5 State with an agreement with such plan in ef-
6 fect as of the date of the enactment of the Con-
7 sumer Protections Against Surprise Medical
8 Bills Act of 2020, that provides for a method
9 for determining the total amount payable under
10 such health plan with respect to such item or
11 service furnished by such provider or facility,
12 such amount determined in accordance with
13 such method.

14 “(12) RECOGNIZED AMOUNT.—The term ‘recog-
15 nized amount’ means, with respect to an item or
16 service furnished in a State during a year to a par-
17 ticipant, beneficiary, or enrollee of a health plan by
18 a nonparticipating provider or nonparticipating facil-
19 ity—

20 “(A) subject to subparagraphs (C) and
21 (D), in the case such State has in effect a law
22 described in paragraph (11)(A) with respect to
23 such item or service, provider or facility, and
24 plan, the amount determined in accordance with
25 such law;

1 “(B) subject to subparagraphs (C) and
2 (D), in the case such State does not have in ef-
3 fect such a law, an amount that is the median
4 contracted rate for such item or service for such
5 year;

6 “(C) subject to subparagraph (D), in the
7 case such State is described in paragraph
8 (11)(C) with respect to such item or service so
9 furnished, the amount that the State approves
10 under such system for such item or service so
11 furnished; or

12 “(D) in the case such health plan is a self-
13 insured group health plan and in the case of a
14 State with an agreement with such plan in ef-
15 fect as of the date of the enactment of the Con-
16 sumer Protections Against Surprise Medical
17 Bills Act of 2020, that provides for a method
18 for determining the total amount payable under
19 such health plan with respect to such item or
20 service furnished by such provider or facility,
21 such amount determined in accordance with
22 such method.

23 “(13) STABILIZE.—The term ‘to stabilize’, with
24 respect to an emergency medical condition, has the

1 meaning give in section 1867(e)(3)(A) of the Social
2 Security Act).

3 “(14) COST-SHARING.—The term ‘cost-sharing’
4 includes copayments, coinsurance, and deductibles.

5 “(1) PAYMENT TO PROVIDER OR FACILITY.—In the
6 case of any payment required to be made by a health plan
7 pursuant to subsection (b)(1), (e)(1), or (i)(1) to a
8 nonparticipating provider or nonparticipating facility for
9 an item or service, such payment shall be made to such
10 provider or facility and not to the individual receiving such
11 item or service.”.

12 (2) EFFECTIVE DATE.—The amendments made
13 by paragraph (1) shall apply with respect to plan
14 years beginning on or after January 1, 2022.

15 (b) IRC AMENDMENTS.—

16 (1) IN GENERAL.—Subchapter B of chapter
17 100 of the Internal Revenue Code of 1986 is amend-
18 ed by adding at the end the following new section:

19 **“SEC. 9816. PATIENT PROTECTIONS.**

20 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
21 a health plan requires or provides for designation by a par-
22 ticipant or beneficiary of a participating primary care pro-
23 vider, then the plan shall permit each participant or bene-
24 ficiary to designate any participating primary care pro-
25 vider who is available to accept such individual.

1 “(b) COST-SHARING AND PAYMENT OF EMERGENCY
2 SERVICES.—

3 “(1) IN GENERAL.—If a health plan provides or
4 covers any benefits with respect to services in an
5 emergency department of a hospital and, for plan
6 year 2022 or a subsequent plan year, with respect
7 to emergency services in an independent free-
8 standing emergency department, the plan shall cover
9 emergency services—

10 “(A) without the need for any prior au-
11 thorization determination;

12 “(B) whether the health care provider fur-
13 nishing such services is a participating provider
14 or a participating facility that is an emergency
15 department of a hospital or an independent
16 freestanding emergency department (in this
17 subsection referred to as a ‘participating emer-
18 gency facility’) with respect to such services;

19 “(C) in a manner so that, if such services
20 are provided to a participant or beneficiary by
21 a nonparticipating provider or a nonparti-
22 cating facility that is an emergency department
23 of a hospital or an independent freestanding
24 emergency department—

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

10 “(ii) the cost-sharing requirement is
11 not greater than the requirement that
12 would apply if such services were furnished
13 by a participating provider or a partici-
14 pating emergency facility, as applicable;

15 “(iii) such cost-sharing requirement is
16 calculated as if the contracted rate for
17 such services if furnished by a partici-
18 pating provider or a participating emer-
19 gency facility were equal to the recognized
20 amount for such services;

21 “(iv) the health plan pays to such pro-
22 vider or facility, respectively, the amount
23 by which the out-of-network rate for such
24 services exceeds the cost-sharing amount

for such services (as determined in accordance with clauses (ii) and (iii)); and

“(v) any deductible or out-of-pocket maximum that would apply if such services were furnished by a participating provider or a participating emergency facility shall be the deductible or out-of-pocket maximum that applies; 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 the Employee Retirement Income Security Act of 1974 and section 9815, and other than applicable cost-sharing).

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

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of Labor and in consultation with the Na-

1 tional Association of Insurance Commis-
2 sioners, shall establish through rulemaking
3 a process, in accordance with clause (ii),
4 under which health plans are audited by
5 the Secretary to ensure that—

6 “(I) such plans are in compliance
7 with the requirement of applying a
8 median contracted rate under this sec-
9 tion; and

10 “(II) that such median con-
11 tracted rate so applied satisfies the
12 definition under subsection (k)(8)
13 with respect to the year involved.

14 “(ii) AUDIT SAMPLES.—Under the
15 process established pursuant to clause (i),
16 the Secretary—

17 “(I) shall conduct audits de-
18 scribed in such clause of a sample of
19 health plans; and

20 “(II) may audit any health plan
21 if the Secretary has received any com-
22 plaint about such plan that involves
23 the compliance of the plan with the
24 requirement described in such clause.

1 “(B) RULEMAKING.—Not later than July
2 1, 2021, the Secretary, in coordination with the
3 Secretary of Labor and the Secretary of Health
4 and Human Services, shall establish through
5 rulemaking—

6 “(i) the methodology the sponsor of a
7 health plan shall use to determine the me-
8 dian contracted rate, which shall account
9 for relevant payment adjustments that
10 take into account facility type that are oth-
11 erwise taken into account for purposes of
12 determining payment amounts with respect
13 to participating facilities; and

14 “(ii) the information such sponsor
15 shall share with the nonparticipating pro-
16 vider involved when making such a deter-
17 mination.

18 “(c) ACCESS TO PEDIATRIC CARE.—

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

1 primary care provider if such provider participates
2 in the network of the plan.

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

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

9 “(1) GENERAL RIGHTS.—

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

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

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

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

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

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

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

1 “(B) preclude the health plan involved
2 from requiring that the obstetrical or gynecological provider notify the primary care health
3 care professional or the plan of treatment decisions.
4 care professional or the plan of treatment decisions.
5 sions.

6 “(k) DEFINITIONS.—For purposes of this section:

7 “(1) CONTRACTED RATE.—The term ‘contracted rate’ means, with respect to a health plan
8 and a health care provider or health care facility furnishing an item or service to a beneficiary or participant of such plan, the agreed upon total payment
9 amount (inclusive of any cost-sharing) to such provider or facility for such item or service.
10 amount (inclusive of any cost-sharing) to such provider or facility for such item or service.
11 amount (inclusive of any cost-sharing) to such provider or facility for such item or service.
12 amount (inclusive of any cost-sharing) to such provider or facility for such item or service.
13 amount (inclusive of any cost-sharing) to such provider or facility for such item or service.

14 “(2) DURING A VISIT.—The term ‘during a visit’ shall, with respect to an individual who is furnished items and services at a participating facility,
15 include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and
16 services as the Secretary may specify furnished to such individual, regardless of whether or not the provider furnishing such items or services is at the
17 facility.
18 facility.
19 facility.
20 facility.
21 facility.
22 facility.
23 facility.

24 “(3) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term ‘emergency department of a hospital’ means the department of a hospital that is designated as the emergency department of a hospital.
25 PITAL.—The term ‘emergency department of a hospital’ means the department of a hospital that is designated as the emergency department of a hospital.

1 pital’ includes a hospital outpatient department that
2 provides emergency services.

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

13 “(5) EMERGENCY SERVICES.—

14 “(A) IN GENERAL.—The term ‘emergency
15 services’, with respect to an emergency medical
16 condition, means—

17 “(i) a medical screening examination
18 (as required under section 1867 of the So-
19 cial Security Act, or as would be required
20 under such section if such section applied
21 to an independent freestanding emergency
22 department) that is within the capability of
23 the emergency department of a hospital or
24 of an independent freestanding emergency
25 department, as applicable, including ancil-

lary 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 (regardless of the department of the hospital in which such further examination or treatment is furnished).

“(B) INCLUSION OF ADDITIONAL SERVICES.—In the case of an individual enrolled in a health plan who is furnished services described in subparagraph (A) by a provider or hospital or independent freestanding emergency department to stabilize such individual with respect to an emergency medical condition, the term ‘emergency services’ shall include, in addition to those described in subparagraph (A),

1 items and services furnished as part of out-
2 patient observation or an inpatient or out-
3 patient stay during a visit in which such indi-
4 vidual is so stabilized with respect to such
5 emergency condition if—

6 “(i) such items and services would
7 otherwise be covered under such plan if
8 furnished by a participating provider or
9 participating facility; and

10 “(ii) such items and services are fur-
11 nished—

12 “(I) to maintain, improve, or re-
13 solve the individual’s stabilization with
14 respect to such condition, unless any
15 circumstance described in subpara-
16 graph (C) has occurred with respect
17 to such individual before such items
18 and services are furnished; or

19 “(II) for any purpose not de-
20 scribed in subclause (I), unless each
21 of the criteria described in subpara-
22 graph (D) have been met with respect
23 to such individual and such item or
24 service.

1 “(C) CIRCUMSTANCES.—For purposes of
2 subparagraph (B)(ii)(I), a circumstance de-
3 scribed in this subparagraph is any of the fol-
4 lowing, with respect to an individual who is a
5 beneficiary, participant, or enrollee of a health
6 plan who is furnished services described in sub-
7 paragraph (A) by a hospital or independent
8 freestanding emergency department with re-
9 spect to an emergency medical condition:

10 “(i) A participating provider, with re-
11 spect to such plan, with privileges at the
12 hospital or independent freestanding emer-
13 gency department assumes responsibility
14 for the care of the individual.

15 “(ii) A participating provider, with re-
16 spect to such plan, assumes responsibility
17 for the care of the individual through
18 transfer of the individual.

19 “(iii) The health plan and the pro-
20 vider treating such individual at the hos-
21 pital or independent freestanding emer-
22 gency department for such condition reach
23 an agreement concerning the care for the
24 individual.

25 “(iv) The individual is discharged.

1 “(D) SIGNED NOTICE CRITERIA.—For pur-
2 poses of subparagraph (B)(ii)(II), the criteria
3 described in this subparagraph, with respect to
4 an individual and an item or service furnished
5 by a nonparticipating provider or nonparti-
6 cipating facility that is a hospital or an inde-
7 pendent freestanding emergency department,
8 are the following:

9 “(i) A written notice (as specified by
10 the Secretary and in a clear and under-
11 standable manner) is provided by such pro-
12 vider or facility to such individual, before
13 such item or service is furnished, that in-
14 cludes the following information:

15 “(I) That such provider or facil-
16 ity is a nonparticipating provider or
17 nonparticipating facility (as applica-
18 ble).

19 “(II) To the extent practicable,
20 the estimated amount that such non-
21 participating facility or nonparti-
22 cipating provider may charge the indi-
23 vidual for such item or service.

24 “(III) A statement that the indi-
25 vidual may seek such item or service

1 from a provider that is a participating
2 provider or a hospital or independent
3 freestanding emergency department
4 that is a participating facility and a
5 list, if feasible, of participating facili-
6 ties or participating providers, as ap-
7 plicable, who are able to furnish such
8 item or service.

9 “(ii) Such individual is in a condition
10 to receive (as determined in accordance
11 with guidance issued by the Secretary) the
12 information described in clause (i) and to
13 confirm notice of receipt of such notice, in
14 accordance with applicable State law.

15 “(iii) The individual signs and dates
16 such notice confirming receipt of the notice
17 before such item or service is furnished.

18 “(6) HEALTH PLAN.—The term ‘health plan’
19 means a group health plan, including any group
20 health plan that is a grandfathered health plan (as
21 defined in section 1251(e) of the Patient Protection
22 and Affordable Care Act).

23 “(7) INDEPENDENT FREESTANDING EMER-
24 GENCY DEPARTMENT.—The term ‘independent free-

1 standing emergency department’ means a health
2 care facility that—

3 “(A) is geographically separate and dis-
4 tinct and licensed separately from a hospital
5 under applicable State law; and

6 “(B) provides emergency services.

7 “(8) MEDIAN CONTRACTED RATE.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the term ‘median contracted rate’
10 means, with respect to a health plan—

11 “(i) for an item or service furnished
12 during 2022, the median of the contracted
13 rates recognized by the sponsor of such
14 plan (determined with respect to all such
15 plans of such sponsor that are within the
16 same line of business (as specified in sub-
17 paragraph (C)) as the plan involved) as the
18 total maximum payment under such plans
19 in 2019 for the same or a similar item or
20 service that is provided by a provider or fa-
21 cility in the same or similar specialty and
22 provided in the geographic region (estab-
23 lished (and updated, as appropriate) by the
24 Secretary, in consultation with the Na-
25 tional Association of Insurance Commis-

1 sioners) in which the item or service is fur-
2 nished, consistent with the methodology es-
3 tablished by the Secretary under sub-
4 section (b)(2)(B), increased by the percent-
5 age increase in the consumer price index
6 for all urban consumers (United States
7 city average) over 2019, 2020, and 2021;

8 “(ii) for an item or service furnished
9 during 2023 or a subsequent year through
10 2026, the median contracted rate for the
11 previous year, increased by the percentage
12 increase in the consumer price index for all
13 urban consumers (United States city aver-
14 age) over such previous year;

15 “(iii) for an item or service furnished
16 during a rebasing year (as defined in sub-
17 paragraph (D)), the median of the con-
18 tracted rates recognized by the sponsor of
19 such plan (determined with respect to all
20 such plans of such sponsor that are within
21 the same line of business (as specified in
22 subparagraph (C)) as the plan involved) as
23 the total maximum payment under such
24 plans in such year for the same or a simi-
25 lar item or service that is provided by a

1 provider or facility in the same or similar
2 specialty and provided in the geographic
3 region (as established pursuant to clause
4 (i)) in which the item or service is fur-
5 nished, consistent with the methodology es-
6 tablished by the Secretary under sub-
7 section (b)(2)(B); and

8 “(iv) for an item or service furnished
9 during any of the 4 years following a re-
10 basing year, the median contracted rate for
11 the previous year, increased by the per-
12 centage increase in the consumer price
13 index for all urban consumers (United
14 States city average) over such previous
15 year.

16 “(B) USE OF SUBSTITUTE RATE IN CASE
17 OF INSUFFICIENT DATA.—

18 “(i) IN GENERAL.—In the case the
19 sponsor of a health plan has insufficient
20 information (as specified by the Secretary)
21 to calculate the median of the contracted
22 rates in accordance with subparagraph (A)
23 for a year for an item or service furnished
24 in a particular geographic region (as estab-
25 lished pursuant to subparagraph (A)(i)) by

1 a type of provider or facility, the substitute
2 rate (as defined in clause (ii)) for such
3 item or service shall be deemed to be the
4 median contracted rate for such item or
5 service furnished in such region during
6 such year by such a provider or facility for
7 such year under such subparagraph (A) for
8 such plan.

9 “(ii) SUBSTITUTE RATE.—For pur-
10 poses of clause (i), the term ‘substitute
11 rate’ means, with respect to an item or
12 service furnished by a provider or facility
13 in a geographic region (established pursu-
14 ant to subparagraph (A)(i)) during a year
15 for which a health plan is required to make
16 payment pursuant to subsection (b)(1),
17 (e)(1), or (i)(1)—

18 “(I) if sufficient information (as
19 specified by the Secretary) exists to
20 determine the median of the con-
21 tracted rates recognized by all health
22 plans offered in the same line of busi-
23 ness (as specified in subparagraph
24 (C)) by any group health plan for
25 such an item or service furnished in

1 such region by such a provider or fa-
2 cility during such year using a data-
3 base or other source of information
4 determined appropriate by the Sec-
5 retary, such median; and

6 “(II) if such sufficient informa-
7 tion does not exist, the median of the
8 contracted rates recognized by all
9 health plans offered in the same line
10 of business (as specified in subpara-
11 graph (C)) by any group health plan
12 for such an item or service furnished
13 in a similarly situated geographic re-
14 gion (as determined by the Secretary)
15 with such sufficient information by
16 such a provider or facility during such
17 year using such a database or such
18 other source of information.

19 The Secretary shall develop a methodology
20 for determining a substitute rate based on
21 a similarly situated health plan that is not
22 a Federal health care program (as defined
23 in section 1128B(f) of the Social Security
24 Act) in the case a substitute rate is not

1 calculable under the previous sentence with
2 respect to an item or service.

3 “(C) LINE OF BUSINESS.—A line of busi-
4 ness specified in this subparagraph is one of the
5 following:

6 “(i) The small group market.

7 “(ii) The large group market.

8 “(iii) In the case of a self-insured
9 group health plan, other self-insured group
10 health plans.

11 “(D) REBASING YEAR DEFINED.—For pur-
12 poses of subparagraph (A), the term ‘rebasing
13 year’ means 2027 and every 5 years thereafter.

14 “(9) NONPARTICIPATING FACILITY; PARTICI-
15 PATING FACILITY.—

16 “(A) NONPARTICIPATING FACILITY.—The
17 term ‘nonparticipating facility’ means, with re-
18 spect to an item or service and a health plan,
19 a health care facility described in subparagraph
20 (B)(ii) that does not have a contractual rela-
21 tionship with the plan for furnishing such item
22 or service.

23 “(B) PARTICIPATING FACILITY.—

24 “(i) IN GENERAL.—The term ‘partici-
25 pating facility’ means, with respect to an

1 item or service and a health plan, a health
2 care facility described in clause (ii) that
3 has a contractual relationship with the
4 plan for furnishing such item or service.

5 “(ii) HEALTH CARE FACILITY DE-
6 SCRIBED.—A health care facility described
7 in this clause is each of the following:

8 “(I) A hospital (as defined in
9 1861(e) of the Social Security Act),
10 including an emergency department of
11 a hospital.

12 “(II) A critical access hospital
13 (as defined in section 1861(mm)(1) of
14 such Act).

15 “(III) An ambulatory surgical
16 center (as described in section
17 1833(i)(1)(A) of such Act).

18 “(IV) A laboratory.

19 “(V) A radiology facility or imag-
20 ing center.

21 “(VI) An independent free-
22 standing emergency department.

23 “(VII) Any other facility speci-
24 fied by the Secretary.

1 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
2 PATING PROVIDERS.—

3 “(A) NONPARTICIPATING PROVIDER.—The
4 term ‘nonparticipating provider’ means, with re-
5 spect to an item or service and a health plan,
6 a physician or other health care provider who
7 does not have a contractual relationship with
8 the plan for furnishing such item or service
9 under the plan.

10 “(B) PARTICIPATING PROVIDER.—The
11 term ‘participating provider’ means, with re-
12 spect to an item or service and a health plan,
13 a physician or other health care provider who
14 has a contractual relationship with the plan for
15 furnishing such item or service under the plan.

16 “(11) OUT-OF-NETWORK RATE.—The term
17 ‘out-of-network rate’ means, with respect to an item
18 or service furnished in a State during a year to a
19 participant or beneficiary of a health plan receiving
20 such item or service from a nonparticipating pro-
21 vider or facility—

22 “(A) subject to subparagraphs (C) and
23 (D), in the case such State has in effect a State
24 law that provides for a method for determining
25 the total amount payable under such health

1 plan regulated by such State with respect to
2 such item or service furnished by such provider
3 or facility, such amount determined in accord-
4 ance with such law;

5 “(B) subject to subparagraphs (C) and
6 (D), in the case such State does not have in ef-
7 fect such a law with respect to such item or
8 service, plan, and provider or facility—

9 “(i) subject to clause (ii), if the pro-
10 vider or facility (as applicable) and such
11 plan agree on an amount of payment (in-
12 cluding if agreed on through open negotia-
13 tions under subsection (j)(1)) with respect
14 to such item or service, such agreed on
15 amount; or

16 “(ii) if such provider or facility (as
17 applicable) and such plan enter the medi-
18 ated dispute process under subsection (j)
19 and do not so agree before the date on
20 which a selected independent entity (as de-
21 fined in paragraph (3) of such subsection)
22 makes a determination with respect to
23 such item or service under such subsection,
24 the amount of such determination;

1 “(C) in the case such State has an All-
2 Payer Model Agreement under section 1115A of
3 the Social Security Act, the amount that the
4 State approves under such system for such item
5 or service so furnished; or

6 “(D) in the case such health plan is a self-
7 insured group health plan and in the case of a
8 State with an agreement with such plan in ef-
9 fect as of the date of the enactment of the Con-
10 sumer Protections Against Surprise Medical
11 Bills Act of 2020, that provides for a method
12 for determining the total amount payable under
13 such health plan with respect to such item or
14 service furnished by such provider or facility,
15 such amount determined in accordance with
16 such method.

17 “(12) RECOGNIZED AMOUNT.—The term ‘recog-
18 nized amount’ means, with respect to an item or
19 service furnished in a State during a year to a par-
20 ticipant or beneficiary of a health plan by a non-
21 participating provider or nonparticipating facility—

22 “(A) subject to subparagraphs (C) and
23 (D), in the case such State has in effect a law
24 described in paragraph (11)(A) with respect to
25 such item or service, provider or facility, and

1 plan, the amount determined in accordance with
2 such law;

3 “(B) subject to subparagraphs (C) and
4 (D), in the case such State does not have in ef-
5 fect such a law, an amount that is the median
6 contracted rate for such item or service for such
7 year;

8 “(C) in the case such State is described in
9 paragraph (11)(C) with respect to such item or
10 service so furnished, the amount that the State
11 approves under such system for such item or
12 service so furnished; or

13 “(D) in the case such health plan is a self-
14 insured group health plan and in the case of a
15 State with an agreement with such plan in ef-
16 fect as of the date of the enactment of the Con-
17 sumer Protections Against Surprise Medical
18 Bills Act of 2020, that provides for a method
19 for determining the total amount payable under
20 such health plan with respect to such item or
21 service furnished by such provider or facility,
22 such amount determined in accordance with
23 such method.

24 “(13) STABILIZE.—The term ‘to stabilize’, with
25 respect to an emergency medical condition, has the

1 meaning give in section 1867(e)(3)(A) of the Social
2 Security Act.

3 “(14) COST-SHARING.—The term ‘cost-sharing’
4 includes copayments, coinsurance, and deductibles.

5 “(1) PAYMENT TO PROVIDER OR FACILITY.—In the
6 case of any payment required to be made by a health plan
7 pursuant to subsection (b)(1), (e)(1), or (i)(1) to a
8 nonparticipating provider or nonparticipating facility for
9 an item or service, such payment shall be made to such
10 provider or facility and not to the individual receiving such
11 item or service.”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) APPLICATION PROVISIONS.—Section
14 9815(a) of the Internal Revenue Code of 1986
15 is amended—

16 (i) in paragraph (1), by striking “(as
17 amended by the Patient Protection and Af-
18 fordable Care Act)” and inserting “(other
19 than, with respect to a plan year beginning
20 on or after January 1, 2022, the provisions
21 of section 2719A of such Act)”; and

22 (ii) in paragraph (2), by inserting
23 “(other than, with respect to a plan year
24 beginning on or after January 1, 2022, the

1 provisions of section 2719A of such Act)”
 2 after the first occurrence of “such part A”.

3 (B) APPLICATION TO RETIREE-ONLY
 4 PLANS.—Section 9831(a) of the Internal Rev-
 5 enue Code of 1986 is amended by inserting
 6 “(other than, with respect to a group health
 7 plan described in paragraph (2), the require-
 8 ments of section 9816)” before “shall not
 9 apply”.

10 (3) CLERICAL AMENDMENT.—The table of sec-
 11 tions for such subchapter is amended by adding at
 12 the end the following new items:

“Sec. 9815. Additional market reforms.
 “Sec. 9816. Patient protections.”.

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

16 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT
 17 OF 1974 AMENDMENTS.—

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

1 **“SEC. 716. PATIENT PROTECTIONS.**

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

8 “(b) COST-SHARING AND PAYMENT OF EMERGENCY
9 SERVICES.—

10 “(1) IN GENERAL.—If a health plan provides or
11 covers any benefits with respect to services in an
12 emergency department of a hospital and, for plan
13 year 2022 or a subsequent plan year, with respect
14 to emergency services in an independent free-
15 standing emergency department, the plan shall cover
16 emergency services—

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

19 “(B) whether the health care provider fur-
20 nishing such services is a participating provider
21 or a participating facility that is an emergency
22 department of a hospital or an independent
23 freestanding emergency department (in this
24 subsection referred to as a ‘participating emer-
25 gency facility’) with respect to such services;

1 “(C) in a manner so that, if such services
2 are provided to a participant or beneficiary by
3 a nonparticipating provider or a nonpartici-
4 pating facility that is an emergency department
5 of a hospital or an independent freestanding
6 emergency department—

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

16 “(ii) the cost-sharing requirement is
17 not greater than the requirement that
18 would apply if such services were furnished
19 by a participating provider or a partici-
20 pating emergency facility, as applicable;

21 “(iii) such cost-sharing requirement is
22 calculated as if the contracted rate for
23 such services if furnished by a partici-
24 pating provider or a participating emer-

1 gency facility were equal to the recognized
2 amount for such services;

3 “(iv) the health plan pays to such pro-
4 vider or facility, respectively, the amount
5 by which the out-of-network rate for such
6 services exceeds the cost-sharing amount
7 for such services (as determined in accord-
8 ance with clauses (ii) and (iii)); and

9 “(v) any deductible or out-of-pocket
10 maximum that would apply if such services
11 were furnished by a participating provider
12 or a participating emergency facility shall
13 be the deductible or out-of-pocket max-
14 imum that applies; and

15 “(D) without regard to any other term or
16 condition of such coverage (other than exclusion
17 or coordination of benefits, or an affiliation or
18 waiting period, permitted under section 2704 of
19 the Public Health Service Act, including as in-
20 corporated pursuant to section 715 and section
21 9815 of the Internal Revenue Code of 1986,
22 and other than applicable cost-sharing).

23 “(2) AUDIT PROCESS AND RULEMAKING PROC-
24 ESS FOR MEDIAN CONTRACTED RATES.—

25 “(A) AUDIT PROCESS.—

1 “(i) IN GENERAL.—Not later than
2 July 1, 2021, the Secretary, in coordina-
3 tion with the Secretary of Health and
4 Human Services and the Secretary of the
5 Treasury and in consultation with the Na-
6 tional Association of Insurance Commis-
7 sioners, shall establish through rulemaking
8 a process, in accordance with clause (ii),
9 under which health plans are audited by
10 the Secretary to ensure that—

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

15 “(II) that such median con-
16 tracted rate so applied satisfies the
17 definition under subsection (k)(8)
18 with respect to the year involved.

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

22 “(I) shall conduct audits de-
23 scribed in such clause of a sample of
24 health plans; and

1 “(II) may audit any health plan
2 if the Secretary has received any com-
3 plaint about such plan that involves
4 the compliance of the plan with the
5 requirement described in such clause.

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

11 “(i) the methodology the sponsor or
12 issuer of a health plan shall use to deter-
13 mine the median contracted rate, which
14 shall account for relevant payment adjust-
15 ments that take into account facility type
16 that are otherwise taken into account for
17 purposes of determining payment amounts
18 with respect to participating facilities; and

19 “(ii) the information such sponsor or
20 issuer shall share with the nonparticipating
21 provider involved when making such a de-
22 termination.

23 “(c) ACCESS TO PEDIATRIC CARE.—

24 “(1) PEDIATRIC CARE.—In the case of a person
25 who has a child who is a participant or beneficiary

1 under a health plan, if the plan requires or provides
2 for the designation of a participating primary care
3 provider for the child, the plan shall permit such
4 person to designate a physician (allopathic or osteo-
5 pathic) who specializes in pediatrics as the child's
6 primary care provider if such provider participates
7 in the network of the plan.

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

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

14 “(1) GENERAL RIGHTS.—

15 “(A) DIRECT ACCESS.—A health plan de-
16 scribed in paragraph (2) may not require au-
17 thorization or referral by the plan or any per-
18 son (including a primary care provider de-
19 scribed in paragraph (2)(B)) in the case of a fe-
20 male participant or beneficiary who seeks cov-
21 erage for obstetrical or gynecological care pro-
22 vided by a participating health care professional
23 who specializes in obstetrics or gynecology.
24 Such professional shall agree to otherwise ad-
25 here to such plan's policies and procedures, in-

cluding 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 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 health plan described in this paragraph is a 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—

1 “(A) waive any exclusions of coverage
2 under the terms and conditions of the plan with
3 respect to coverage of obstetrical or gynecological
4 care; or

5 “(B) preclude the health plan involved
6 from requiring that the obstetrical or gynecological
7 provider notify the primary care health
8 care professional or the plan of treatment decisions.
9 sions.

10 “(k) DEFINITIONS.—For purposes of this section:

11 “(1) CONTRACTED RATE.—The term ‘contracted
12 rate’ means, with respect to a health plan
13 and a health care provider or health care facility furnishing
14 an item or service to a beneficiary or participant
15 of such plan, the agreed upon total payment
16 amount (inclusive of any cost-sharing) to such provider
17 or facility for such item or service.

18 “(2) DURING A VISIT.—The term ‘during a
19 visit’ shall, with respect to an individual who is furnished
20 items and services at a participating facility, include
21 equipment and devices, telemedicine services, imaging
22 services, laboratory services, preoperative and postoperative
23 services, and such other items and services as the Secretary
24 may specify furnished to such individual, regardless of
25 whether or not the

1 provider furnishing such items or services is at the
2 facility.

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

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

17 “(5) EMERGENCY SERVICES.—

18 “(A) IN GENERAL.—The term ‘emergency
19 services’, with respect to an emergency medical
20 condition, means—

21 “(i) a medical screening examination
22 (as required under section 1867 of the So-
23 cial Security Act, or as would be required
24 under such section if such section applied
25 to an independent freestanding emergency

1 department) that is within the capability of
2 the emergency department of a hospital or
3 of an independent freestanding emergency
4 department, as applicable, including ancil-
5 lary services routinely available to the
6 emergency department to evaluate such
7 emergency medical condition; and

8 “(ii) within the capabilities of the
9 staff and facilities available at the hospital
10 or the independent freestanding emergency
11 department, as applicable, such further
12 medical examination and treatment as are
13 required under section 1867 of such Act,
14 or as would be required under such section
15 if such section applied to an independent
16 freestanding emergency department, to
17 stabilize the patient (regardless of the de-
18 partment of the hospital in which such fur-
19 ther examination or treatment is fur-
20 nished).

21 “(B) INCLUSION OF ADDITIONAL SERV-
22 ICES.—In the case of an individual enrolled in
23 a health plan who is furnished services de-
24 scribed in subparagraph (A) by a provider or
25 hospital or independent freestanding emergency

1 department to stabilize such individual with re-
2 spect to an emergency medical condition, the
3 term ‘emergency services’ shall include, in addi-
4 tion to those described in subparagraph (A),
5 items and services furnished as part of out-
6 patient observation or an inpatient or out-
7 patient stay during a visit in which such indi-
8 vidual is so stabilized with respect to such
9 emergency condition if—

10 “(i) such items and services would
11 otherwise be covered under such plan if
12 furnished by a participating provider or
13 participating facility; and

14 “(ii) such items and services are fur-
15 nished—

16 “(I) to maintain, improve, or re-
17 solve the individual’s stabilization with
18 respect to such condition, unless any
19 circumstance described in subpara-
20 graph (C) has occurred with respect
21 to such individual before such items
22 and services are furnished; or

23 “(II) for any purpose not de-
24 scribed in subclause (I), unless each
25 of the criteria described in subpara-

1 graph (D) have been met with respect
2 to such individual and such item or
3 service.

4 “(C) CIRCUMSTANCES.—For purposes of
5 subparagraph (B)(ii)(I), a circumstance de-
6 scribed in this subparagraph is any of the fol-
7 lowing, with respect to an individual who is a
8 beneficiary, participant, or enrollee of a health
9 plan who is furnished services described in sub-
10 paragraph (A) by a hospital or independent
11 freestanding emergency department with re-
12 spect to an emergency medical condition:

13 “(i) A participating provider, with re-
14 spect to such plan, with privileges at the
15 hospital or independent freestanding emer-
16 gency department assumes responsibility
17 for the care of the individual.

18 “(ii) A participating provider, with re-
19 spect to such plan, assumes responsibility
20 for the care of the individual through
21 transfer of the individual.

22 “(iii) The health plan and the pro-
23 vider treating such individual at the hos-
24 pital or independent freestanding emer-
25 gency department for such condition reach

1 an agreement concerning the care for the
2 individual.

3 “(iv) The individual is discharged.

4 “(D) SIGNED NOTICE CRITERIA.—For pur-
5 poses of subparagraph (B)(ii)(II), the criteria
6 described in this subparagraph, with respect to
7 an individual and an item or service furnished
8 by a nonparticipating provider or nonpartici-
9 pating facility that is a hospital or an inde-
10 pendent freestanding emergency department,
11 are the following:

12 “(i) A written notice (as specified by
13 the Secretary and in a clear and under-
14 standable manner) is provided by such pro-
15 vider or facility to such individual, before
16 such item or service is furnished, that in-
17 cludes the following information:

18 “(I) That such provider or facil-
19 ity is a nonparticipating provider or
20 nonparticipating facility (as applica-
21 ble).

22 “(II) To the extent practicable,
23 the estimated amount that such non-
24 participating facility or nonpartici-

1 pating provider may charge the indi-
2 vidual for such item or service.

3 “(III) A statement that the indi-
4 vidual may seek such item or service
5 from a provider that is a participating
6 provider or a hospital or independent
7 freestanding emergency department
8 that is a participating facility and a
9 list, if feasible, of participating facili-
10 ties or participating providers, as ap-
11 plicable, who are able to furnish such
12 item or service.

13 “(ii) Such individual is in a condition
14 to receive (as determined in accordance
15 with guidance issued by the Secretary) the
16 information described in clause (i) and to
17 confirm notice of receipt of such notice, in
18 accordance with applicable State law.

19 “(iii) The individual signs and dates
20 such notice confirming receipt of the notice
21 before such item or service is furnished.

22 “(6) HEALTH PLAN.—The term ‘health plan’
23 means a group health plan and health insurance cov-
24 erage offered by a health insurance issuer in the
25 group market and includes a grandfathered health

1 plan (as defined in section 1251(e) of the Patient
2 Protection and Affordable Care Act) that is such a
3 plan or coverage.

4 “(7) INDEPENDENT FREESTANDING EMER-
5 GENCY DEPARTMENT.—The term ‘independent free-
6 standing emergency department’ means a health
7 care facility that—

8 “(A) is geographically separate and dis-
9 tinct and licensed separately from a hospital
10 under applicable State law; and

11 “(B) provides emergency services.

12 “(8) MEDIAN CONTRACTED RATE.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the term ‘median contracted rate’
15 means, with respect to a health plan—

16 “(i) for an item or service furnished
17 during 2022, the median of the contracted
18 rates recognized by the sponsor or issuer
19 of such plan (determined with respect to
20 all such plans of such sponsor or such
21 issuer that are within the same line of
22 business (as specified in subparagraph (C))
23 as the plan involved) as the total maximum
24 payment under such plans in 2019 for the
25 same or a similar item or service that is

1 provided by a provider or facility in the
2 same or similar specialty and provided in
3 the geographic region (established (and up-
4 dated, as appropriate) by the Secretary, in
5 consultation with the National Association
6 of Insurance Commissioners) in which the
7 item or service is furnished, consistent with
8 the methodology established by the Sec-
9 retary under subsection (b)(2)(B), in-
10 creased by the percentage increase in the
11 consumer price index for all urban con-
12 sumers (United States city average) over
13 2019, 2020, and 2021;

14 “(ii) for an item or service furnished
15 during 2023 or a subsequent year through
16 2026, the median contracted rate for the
17 previous year, increased by the percentage
18 increase in the consumer price index for all
19 urban consumers (United States city aver-
20 age) over such previous year;

21 “(iii) for an item or service furnished
22 during a rebasing year (as defined in sub-
23 paragraph (D)), the median of the con-
24 tracted rates recognized by the sponsor or
25 issuer of such plan (determined with re-

1 spect to all such plans of such sponsor or
2 issuer that are within the same line of
3 business (as specified in subparagraph (C))
4 as the plan involved) as the total maximum
5 payment under such plans in such year for
6 the same or a similar item or service that
7 is provided by a provider or facility in the
8 same or similar specialty and provided in
9 the geographic region (as established pur-
10 suant to clause (i)) in which the item or
11 service is furnished, consistent with the
12 methodology established by the Secretary
13 under subsection (b)(2)(B); and

14 “(iv) for an item or service furnished
15 during any of the 4 years following a re-
16 basing year, the median contracted rate for
17 the previous year, increased by the per-
18 centage increase in the consumer price
19 index for all urban consumers (United
20 States city average) over such previous
21 year.

22 “(B) USE OF SUBSTITUTE RATE IN CASE
23 OF INSUFFICIENT DATA.—

24 “(i) IN GENERAL.—In the case the
25 sponsor or issuer of a health plan has in-

1 sufficient information (as specified by the
2 Secretary) to calculate the median of the
3 contracted rates in accordance with sub-
4 paragraph (A) for a year for an item or
5 service furnished in a particular geographic
6 region (as established pursuant to subpara-
7 graph (A)(i)) by a type of provider or facil-
8 ity, the substitute rate (as defined in
9 clause (ii)) for such item or service shall be
10 deemed to be the median contracted rate
11 for such item or service furnished in such
12 region during such year by such a provider
13 or facility for such year under such sub-
14 paragraph (A) for such plan.

15 “(ii) SUBSTITUTE RATE.—For pur-
16 poses of clause (i), the term ‘substitute
17 rate’ means, with respect to an item or
18 service furnished by a provider or facility
19 in a geographic region (established pursu-
20 ant to subparagraph (A)(i)) during a year
21 for which a health plan is required to make
22 payment pursuant to subsection (b)(1),
23 (e)(1), or (i)(1)—

24 “(I) if sufficient information (as
25 specified by the Secretary) exists to

1 determine the median of the con-
2 tracted rates recognized by all health
3 plans offered in the same line of busi-
4 ness (as specified in subparagraph
5 (C)) by any group health plan for
6 such an item or service furnished in
7 such region by such a provider or fa-
8 cility during such year using a data-
9 base or other source of information
10 determined appropriate by the Sec-
11 retary, such median; and

12 “(II) if such sufficient informa-
13 tion does not exist, the median of the
14 contracted rates recognized by all
15 health plans offered in the same line
16 of business (as specified in subpara-
17 graph (C)) by any group health plan
18 for such an item or service furnished
19 in a similarly situated geographic re-
20 gion (as determined by the Secretary)
21 with such sufficient information by
22 such a provider or facility during such
23 year using such a database or such
24 other source of information.

1 The Secretary shall develop a methodology
2 for determining a substitute rate based on
3 a similarly situated health plan that is not
4 a Federal health care program (as defined
5 in section 1128B(f) of the Social Security
6 Act) in the case a substitute rate is not
7 calculable under the previous sentence with
8 respect to an item or service.

9 “(C) LINE OF BUSINESS.—A line of busi-
10 ness specified in this subparagraph is one of the
11 following:

12 “(i) The small group market.

13 “(ii) The large group market.

14 “(iii) In the case of a self-insured
15 group health plan, other self-insured group
16 health plans.

17 “(D) REBASING YEAR DEFINED.—For pur-
18 poses of subparagraph (A), the term ‘rebasing
19 year’ means 2027 and every 5 years thereafter.

20 “(9) NONPARTICIPATING FACILITY; PARTICI-
21 PATING FACILITY.—

22 “(A) NONPARTICIPATING FACILITY.—The
23 term ‘nonparticipating facility’ means, with re-
24 spect to an item or service and a health plan,
25 a health care facility described in subparagraph

1 (B)(ii) that does not have a contractual rela-
2 tionship with the plan for furnishing such item
3 or service.

4 “(B) PARTICIPATING FACILITY.—

5 “(i) IN GENERAL.—The term ‘partici-
6 pating facility’ means, with respect to an
7 item or service and a health plan, a health
8 care facility described in clause (ii) that
9 has a contractual relationship with the
10 plan for furnishing such item or service.

11 “(ii) HEALTH CARE FACILITY DE-
12 SCRIBED.—A health care facility described
13 in this clause is each of the following:

14 “(I) A hospital (as defined in
15 1861(e) of the Social Security Act),
16 including an emergency department of
17 a hospital.

18 “(II) A critical access hospital
19 (as defined in section 1861(mm)(1) of
20 such Act).

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

24 “(IV) A laboratory.

1 “(V) A radiology facility or imag-
2 ing center.

3 “(VI) An independent free-
4 standing emergency department.

5 “(VII) Any other facility speci-
6 fied by the Secretary.

7 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
8 PATING PROVIDERS.—

9 “(A) NONPARTICIPATING PROVIDER.—The
10 term ‘nonparticipating provider’ means, with re-
11 spect to an item or service and a health plan,
12 a physician or other health care provider who
13 does not have a contractual relationship with
14 the plan for furnishing such item or service
15 under the plan.

16 “(B) PARTICIPATING PROVIDER.—The
17 term ‘participating provider’ means, with re-
18 spect to an item or service and a health plan,
19 a physician or other health care provider who
20 has a contractual relationship with the plan for
21 furnishing such item or service under the plan.

22 “(11) OUT-OF-NETWORK RATE.—The term
23 ‘out-of-network rate’ means, with respect to an item
24 or service furnished in a State during a year to a
25 participant or beneficiary of a health plan receiving

1 such item or service from a nonparticipating pro-
2 vider or facility—

3 “(A) subject to subparagraphs (C) and
4 (D), in the case such State has in effect a State
5 law that provides for a method for determining
6 the total amount payable under such health
7 plan regulated by such State with respect to
8 such item or service furnished by such provider
9 or facility, such amount determined in accord-
10 ance with such law;

11 “(B) subject to subparagraphs (C) and
12 (D), in the case such State does not have in ef-
13 fect such a law with respect to such item or
14 service, plan, and provider or facility—

15 “(i) subject to clause (ii), if the pro-
16 vider or facility (as applicable) and such
17 plan agree on an amount of payment (in-
18 cluding if agreed on through open negotia-
19 tions under subsection (j)(1)) with respect
20 to such item or service, such agreed on
21 amount; or

22 “(ii) if such provider or facility (as
23 applicable) and such plan enter the medi-
24 ated dispute process under subsection (j)
25 and do not so agree before the date on

1 which a selected independent entity (as de-
2 fined in paragraph (3) of such subsection)
3 makes a determination with respect to
4 such item or service under such subsection,
5 the amount of such determination;

6 “(C) in the case such State has an All-
7 Payer Model Agreement under section 1115A of
8 the Social Security Act, the amount that the
9 State approves under such system for such item
10 or service so furnished; or

11 “(D) in the case such health plan is a self-
12 insured group health plan and in the case of a
13 State with an agreement with such plan in ef-
14 fect as of the date of the enactment of the Con-
15 sumer Protections Against Surprise Medical
16 Bills Act of 2020, that provides for a method
17 for determining the total amount payable under
18 such health plan with respect to such item or
19 service furnished by such provider or facility,
20 such amount determined in accordance with
21 such method.

22 “(12) RECOGNIZED AMOUNT.—The term ‘recog-
23 nized amount’ means, with respect to an item or
24 service furnished in a State during a year to a par-

1 ticipant or beneficiary of a health plan by a non-
2 participating provider or nonparticipating facility—

3 “(A) subject to subparagraphs (C) and
4 (D), in the case such State has in effect a law
5 described in paragraph (11)(A) with respect to
6 such item or service, provider or facility, and
7 plan, the amount determined in accordance with
8 such law;

9 “(B) subject to subparagraphs (C) and
10 (D), in the case such State does not have in ef-
11 fect such a law, an amount that is the median
12 contracted rate for such item or service for such
13 year;

14 “(C) in the case such State is described in
15 paragraph (11)(C) with respect to such item or
16 service so furnished, the amount that the State
17 approves under such system for such item or
18 service so furnished; or

19 “(D) in the case such health plan is a self-
20 insured group health plan and in the case of a
21 State with an agreement with such plan in ef-
22 fect as of the date of the enactment of the Con-
23 sumer Protections Against Surprise Medical
24 Bills Act of 2020, that provides for a method
25 for determining the total amount payable under

1 such health plan with respect to such item or
 2 service furnished by such provider or facility,
 3 such amount determined in accordance with
 4 such method.

5 “(13) STABILIZE.—The term ‘to stabilize’, with
 6 respect to an emergency medical condition, has the
 7 meaning give in section 1867(e)(3)(A) of the Social
 8 Security Act).

9 “(14) COST-SHARING.—The term ‘cost-sharing’
 10 includes copayments, coinsurance, and deductibles.

11 “(1) PAYMENT TO PROVIDER OR FACILITY.—In the
 12 case of any payment required to be made by a health plan
 13 pursuant to subsection (b)(1), (e)(1), or (i)(1) to a
 14 nonparticiapting provider or nonparticipating facility for
 15 an item or service, such payment shall be made to such
 16 provider or facility and not to the individual receiving such
 17 item or service.”.

18 (2) CONFORMING AMENDMENT.—

19 (A) APPLICATION PROVISIONS.—Section
 20 715(a) of the Employee Retirement Income Se-
 21 curity Act of 1974 (29 U.S.C. 1185d(a)) is
 22 amended—

23 (i) in paragraph (1), by striking “(as
 24 amended by the Patient Protection and Af-
 25 fordable Care Act)” and inserting “(other

1 than, with respect to a plan year beginning
 2 on or after January 1, 2022, the provisions
 3 of section 2719A of such Act)”; and

4 (ii) in paragraph (2), by inserting
 5 “(other than, with respect to a plan year
 6 beginning on or after January 1, 2022, the
 7 provisions of section 2719A of such Act)”
 8 after the first occurrence of “such part A”.

9 (B) APPLICATION TO RETIREE-ONLY
 10 PLANS.—Section 732(a) of the Employee Re-
 11 tirement Income Security Act of 1974 (29
 12 U.S.C. 1191a(a)) is amended by striking “sec-
 13 tion 711” and inserting “sections 711 and
 14 716”.

15 (3) CLERICAL AMENDMENT.—The table of con-
 16 tents in section 1 of the Employee Retirement In-
 17 come Security Act of 1974 is amended by inserting
 18 after the item relating to section 714 the following
 19 new items:

“Sec. 715. Additional market reforms.
 “Sec. 716. Patient protections.”.

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

1 **SEC. 3. CONSUMER PROTECTIONS THROUGH REQUIRE-**
2 **MENTS ON HEALTH PLANS TO PREVENT SUR-**
3 **PRISE MEDICAL BILLS FOR NON-EMERGENCY**
4 **SERVICES PERFORMED BY NONPARTICI-**
5 **PATING PROVIDERS AT CERTAIN PARTICI-**
6 **PATING FACILITIES.**

7 (a) PHSA AMENDMENTS.—

8 (1) IN GENERAL.—Section 2719A of the Public
9 Health Service Act (42 U.S.C. 300gg–19a), as
10 amended by section 2(a), is further amended by in-
11 serting before subsection (k) the following new sub-
12 section:

13 “(e) COST-SHARING AND PAYMENT OF NON-EMER-
14 GENCY SERVICES PERFORMED BY NONPARTICIPATING
15 PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 in the case of items or services (other than emer-
18 gency services to which subsection (b) applies or
19 items and services to which subsection (i) applies)
20 furnished to a participant, beneficiary, or enrollee of
21 a health plan by a nonparticipating provider during
22 a visit (as defined by the Secretary in accordance
23 with subsection (k)(2)) at a participating facility, if
24 such items and services would otherwise be covered
25 under such plan if furnished by a participating pro-
26 vider, the plan—

1 “(A) shall not impose on such participant,
2 beneficiary, or enrollee a cost-sharing amount
3 for such items and services so furnished that is
4 greater than the cost-sharing amount that
5 would apply under such plan had such items or
6 services been furnished by a participating pro-
7 vider;

8 “(B) shall calculate such cost-sharing
9 amount as if the contracted rate for such serv-
10 ices if furnished by a participating provider
11 were equal to the recognized amount for such
12 items and services;

13 “(C) shall pay to such provider furnishing
14 such items and services to such participant,
15 beneficiary, or enrollee the amount by which the
16 out-of-network rate for such items and services
17 exceeds the cost-sharing amount imposed under
18 the plan for such items and services (as deter-
19 mined in accordance with subparagraphs (A)
20 and (B)); and

21 “(D) shall apply the deductible or out-of-
22 pocket maximum, if any, that would apply if
23 such services were furnished by a participating
24 provider.

1 “(2) EXCEPTION.—Paragraph (1) shall not
 2 apply to a health plan in the case of items or serv-
 3 ices furnished to a participant, beneficiary, or en-
 4 rollee of a health plan by a nonparticipating provider
 5 during a visit (as so defined by the Secretary in ac-
 6 cordance with subsection (k)(2)) at a participating
 7 facility if the requirement described in paragraph (1)
 8 of section 1150C(b) of the Social Security Act does
 9 not apply with respect to such provider and such
 10 items and services due to the application of para-
 11 graph (2) of such section.”.

12 (2) EFFECTIVE DATE.—The amendment made
 13 by paragraph (1) shall apply with respect to plan
 14 years beginning on or after January 1, 2022.

15 (b) IRC AMENDMENTS.—

16 (1) IN GENERAL.—Section 9816 of the Internal
 17 Revenue Code of 1986, as added by section 2(b), is
 18 amended by inserting before subsection (k) the fol-
 19 lowing new subsection:

20 “(e) COST-SHARING AND PAYMENT OF NON-EMER-
 21 GENCY SERVICES PERFORMED BY NONPARTICIPATING
 22 PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

23 “(1) IN GENERAL.—Subject to paragraph (2),
 24 in the case of items or services (other than emer-
 25 gency services to which subsection (b) applies or

1 items and services to which subsection (i) applies)
2 furnished to a participant or beneficiary of a health
3 plan by a nonparticipating provider during a visit
4 (as defined by the Secretary in accordance with sub-
5 section (k)(2)) at a participating facility, if such
6 items and services would otherwise be covered under
7 such plan if furnished by a participating provider,
8 the plan—

9 “(A) shall not impose on such participant
10 or beneficiary a cost-sharing amount for such
11 items and services so furnished that is greater
12 than the cost-sharing amount that would apply
13 under such plan had such items or services been
14 furnished by a participating provider;

15 “(B) shall calculate such cost-sharing
16 amount as if the contracted rate for such serv-
17 ices if furnished by a participating provider
18 were equal to the recognized amount for such
19 items and services;

20 “(C) shall pay to such provider furnishing
21 such items and services to such participant or
22 beneficiary the amount by which the out-of-net-
23 work rate for such items and services exceeds
24 the cost-sharing amount imposed under the
25 plan for such items and services (as determined

1 in accordance with subparagraphs (A) and (B));
2 and

3 “(D) shall apply the deductible or out-of-
4 pocket maximum, if any, that would apply if
5 such services were furnished by a participating
6 provider.

7 “(2) EXCEPTION.—Paragraph (1) shall not
8 apply to a health plan in the case of items or serv-
9 ices furnished to a participant or beneficiary of a
10 health plan by a nonparticipating provider during a
11 visit (as so defined by the Secretary in accordance
12 with subsection (k)(2)) at a participating facility if
13 the requirement described in paragraph (1) of sec-
14 tion 1150C(b) of the Social Security Act does not
15 apply with respect to such provider and such items
16 and services due to the application of paragraph (2)
17 of such section.”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply with respect to plan
20 years beginning on or after January 1, 2022.

21 (c) ERISA AMENDMENTS.—

22 (1) IN GENERAL.—Section 716 of the Employee
23 Retirement Income Security Act of 1974, as added
24 by section 2(c), is amended by inserting before sub-
25 section (k) the following new subsection:

1 “(e) COST-SHARING AND PAYMENT OF NON-EMER-
2 GENCY SERVICES PERFORMED BY NONPARTICIPATING
3 PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

4 “(1) IN GENERAL.—Subject to paragraph (2),
5 in the case of items or services (other than emer-
6 gency services to which subsection (b) applies or
7 items and services to which subsection (i) applies)
8 furnished to a participant or beneficiary of a health
9 plan by a nonparticipating provider during a visit
10 (as defined by the Secretary in accordance with sub-
11 section (k)(2)) at a participating facility, if such
12 items and services would otherwise be covered under
13 such plan if furnished by a participating provider,
14 the plan—

15 “(A) shall not impose on such participant
16 or beneficiary a cost-sharing amount for such
17 items and services so furnished that is greater
18 than the cost-sharing amount that would apply
19 under such plan had such items or services been
20 furnished by a participating provider;

21 “(B) shall calculate such cost-sharing
22 amount as if the contracted rate for such serv-
23 ices if furnished by a participating provider
24 were equal to the recognized amount for such
25 items and services;

1 “(C) shall pay to such provider furnishing
2 such items and services to such participant or
3 beneficiary the amount by which the out-of-net-
4 work rate for such items and services exceeds
5 the cost-sharing amount imposed under the
6 plan for such items and services (as determined
7 in accordance with subparagraphs (A) and (B));
8 and

9 “(D) shall apply the deductible or out-of-
10 pocket maximum, if any, that would apply if
11 such services were furnished by a participating
12 provider.

13 “(2) EXCEPTION.—Paragraph (1) shall not
14 apply to a health plan in the case of items or serv-
15 ices furnished to a participant or beneficiary of a
16 health plan by a nonparticipating provider during a
17 visit (as so defined by the Secretary in accordance
18 with subsection (k)(2)) at a participating facility if
19 the requirement described in paragraph (1) of sec-
20 tion 1150C(b) of the Social Security Act does not
21 apply with respect to such provider and such items
22 and services due to the application of paragraph (2)
23 of such section.”.

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

4 **SEC. 4. CONSUMER PROTECTIONS THROUGH APPLICATION**
5 **OF HEALTH PLAN EXTERNAL REVIEW IN**
6 **CASES OF CERTAIN SURPRISE MEDICAL**
7 **BILLS.**

8 Section 2719(b)(1) of the Public Health Service Act
9 (42 U.S.C. 300gg–19(b)(1)) is amended—

10 (1) by striking “at a minimum, includes” and
11 inserting “at a minimum—

12 “(A) includes”;

13 (2) by striking at the end “or” and inserting
14 “and”; and

15 (3) by adding at the end the following new sub-
16 paragraph:

17 “(B) beginning not later than January 1,
18 2022, applies such external review process with
19 respect to any adverse determination by such
20 plan or issuer under subsection (b) of section
21 2719A, subsection (e) of such section, or sub-
22 section (i) of such section, including with re-
23 spect to whether an item or service that is the
24 subject to such a determination is an item or

1 service to which such subsection (b), (e), or (i)
2 applies; or”.

3 **SEC. 5. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
4 **TRANSPARENCY REQUIREMENTS.**

5 (a) PHSA AMENDMENTS.—Section 2719A of the
6 Public Health Service Act (42 U.S.C. 300gg–19a), as
7 amended by sections 2(a) and 3(a), is further amended
8 by inserting before subsection (k) the following new sub-
9 sections:

10 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

11 “(1) IN GENERAL.—Beginning not later than
12 January 1, 2022, each health plan shall—

13 “(A) establish the verification process de-
14 scribed in paragraph (2);

15 “(B) establish the response protocol de-
16 scribed in paragraph (3);

17 “(C) establish the database described in
18 paragraph (4); and

19 “(D) include in any directory (other than
20 the database described in subparagraph (C))
21 containing provider directory information with
22 respect to such plan the information described
23 in paragraph (5).

1 “(2) VERIFICATION PROCESS.—The verification
2 process described in this paragraph is, with respect
3 to a health plan, a process—

4 “(A) under which such plan verifies and
5 updates the provider directory information in-
6 cluded on the database described in paragraph
7 (4) of such plan of—

8 “(i) not less frequently than once
9 every 90 days, a random sample of at least
10 10 percent of health care providers and
11 health care facilities included in such data-
12 base; and

13 “(ii) any such provider or such facility
14 included in such database that has not
15 submitted any claim to such plan during a
16 12-month period;

17 “(B) that establishes a procedure for the
18 removal from such database of such a provider
19 or facility with respect to which such plan has
20 been unable to verify such information during a
21 period specified by the plan; and

22 “(C) that provides for the update of such
23 database within 2 business days of such plan
24 receiving from such a provider or facility infor-

1 mation pursuant to section 1150D of the Social
2 Security Act.

3 “(3) RESPONSE PROTOCOL.—The response pro-
4 tocol described in this paragraph is, in the case of
5 an individual enrolled in a health plan who requests
6 information through a telephone call or email on
7 whether a health care provider or health care facility
8 has a contractual relationship to furnish items and
9 services under such plan, a protocol under which
10 such plan—

11 “(A) responds to such individual as soon
12 as practicable, and in no case later than 1 busi-
13 ness day after such call or email is received,
14 through a written electronic or paper (as re-
15 quested by such individual) communication; and

16 “(B) retains such communication in such
17 individual’s file for at least 2 years following
18 such response.

19 “(4) DATABASE.—The database described in
20 this paragraph is, with respect to a health plan, a
21 database on the public website of such plan or issuer
22 that contains—

23 “(A) a list of each health care provider and
24 health care facility with which such plan has a

1 contractual relationship for furnishing items
2 and services under such plan; and

3 “(B) provider directory information with
4 respect to each such provider and facility.

5 “(5) INFORMATION.—The information de-
6 scribed in this paragraph is, with respect to a direc-
7 tory containing provider directory information with
8 respect to a health plan, a notification that such in-
9 formation contained in such directory was accurate
10 as of the date of publication of such directory and
11 that an individual enrolled under such plan should
12 consult the database described in paragraph (4) with
13 respect to such plan or contact such plan to obtain
14 the most current provider directory information with
15 respect to such plan.

16 “(6) DEFINITION.—For purposes of this sec-
17 tion, the term ‘provider directory information’ in-
18 cludes, with respect to a health plan, the name, ad-
19 dress, specialty, and telephone number of each
20 health care provider or health care facility with
21 which such plan has a contractual relationship for
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS
24 AGAINST BALANCE BILLING.—Beginning not later than
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-
2 viduals enrolled under such plan, and include on each ex-
3 planation of benefits for an item or service with respect
4 to which the requirements under subsection (b), (e), or
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-
8 plied under section 1150C of the Social Secu-
9 rity Act (relating to prohibitions on balance bill-
10 ing in certain circumstances);

11 “(B) if provided for under applicable State
12 law, any other requirements on providers and
13 facilities regarding the amounts such providers
14 and facilities may, with respect to an item or
15 service, charge a participant, beneficiary, or en-
16 rollee of such plan with respect to which such
17 a provider is a nonparticipating provider or fa-
18 cility is a nonparticipating facility, with respect
19 to such plan, for furnishing such item or service
20 after receiving payment from the plan for such
21 item or service and any applicable cost-sharing
22 payment from such participant, beneficiary, or
23 enrollee; and

24 “(C) the requirements applied under sub-
25 sections (b), (e), and (i); and

1 “(2) information in plain language on con-
2 tacting appropriate State and Federal agencies in
3 the case that an individual believes that such a
4 health plan, provider, or facility has violated any re-
5 quirement described in paragraph (1) with respect to
6 such individual.”.

7 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
8 nal Revenue Code of 1986, as added by section 2(b) and
9 amended by section 3(b), is further amended by inserting
10 before subsection (k) the following new subsections:

11 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

12 “(1) IN GENERAL.—Beginning not later than
13 January 1, 2022, each health plan shall—

14 “(A) establish the verification process de-
15 scribed in paragraph (2);

16 “(B) establish the response protocol de-
17 scribed in paragraph (3);

18 “(C) establish the database described in
19 paragraph (4); and

20 “(D) include in any directory (other than
21 the database described in subparagraph (C))
22 containing provider directory information with
23 respect to such plan the information described
24 in paragraph (5).

1 “(2) VERIFICATION PROCESS.—The verification
2 process described in this paragraph is, with respect
3 to a health plan, a process—

4 “(A) under which such plan verifies and
5 updates the provider directory information in-
6 cluded on the database described in paragraph
7 (4) of such plan of—

8 “(i) not less frequently than once
9 every 90 days, a random sample of at least
10 10 percent of health care providers and
11 health care facilities included in such data-
12 base; and

13 “(ii) any such provider or such facility
14 included in such database that has not
15 submitted any claim to such plan during a
16 12-month period;

17 “(B) that establishes a procedure for the
18 removal from such database of such a provider
19 or facility with respect to which such plan has
20 been unable to verify such information during a
21 period specified by the plan; and

22 “(C) that provides for the update of such
23 database within 2 business days of such plan
24 receiving from such a provider or facility infor-

1 mation pursuant to section 1150D of the Social
2 Security Act.

3 “(3) RESPONSE PROTOCOL.—The response pro-
4 tocol described in this paragraph is, in the case of
5 an individual enrolled in a health plan who requests
6 information through a telephone call or email on
7 whether a health care provider or health care facility
8 has a contractual relationship to furnish items and
9 services under such plan, a protocol under which
10 such plan—

11 “(A) responds to such individual as soon
12 as practicable, and in no case later than 1 busi-
13 ness day after such call or email is received,
14 through a written electronic or paper (as re-
15 quested by such individual) communication; and

16 “(B) retains such communication in such
17 individual’s file for at least 2 years following
18 such response.

19 “(4) DATABASE.—The database described in
20 this paragraph is, with respect to a health plan, a
21 database on the public website of such plan or issuer
22 that contains—

23 “(A) a list of each health care provider and
24 health care facility with which such plan has a

1 contractual relationship for furnishing items
2 and services under such plan; and

3 “(B) provider directory information with
4 respect to each such provider and facility.

5 “(5) INFORMATION.—The information de-
6 scribed in this paragraph is, with respect to a direc-
7 tory containing provider directory information with
8 respect to a health plan, a notification that such in-
9 formation contained in such directory was accurate
10 as of the date of publication of such directory and
11 that an individual enrolled under such plan should
12 consult the database described in paragraph (4) with
13 respect to such plan or contact such plan to obtain
14 the most current provider directory information with
15 respect to such plan.

16 “(6) DEFINITION.—For purposes of this sec-
17 tion, the term ‘provider directory information’ in-
18 cludes, with respect to a health plan, the name, ad-
19 dress, specialty, and telephone number of each
20 health care provider or health care facility with
21 which such plan has a contractual relationship for
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS
24 AGAINST BALANCE BILLING.—Beginning not later than
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-
2 viduals enrolled under such plan, and include on each ex-
3 planation of benefits for an item or service with respect
4 to which the requirements under subsection (b), (e), or
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-
8 plied under section 1150C of the Social Secu-
9 rity Act (relating to prohibitions on balance bill-
10 ing in certain circumstances);

11 “(B) if provided for under applicable State
12 law, any other requirements on providers and
13 facilities regarding the amounts such providers
14 and facilities may, with respect to an item or
15 service, charge a participant or beneficiary of
16 such plan with respect to which such a provider
17 is a nonparticipating provider or facility is a
18 nonparticipating facility, with respect to such
19 plan, for furnishing such item or service after
20 receiving payment from the plan for such item
21 or service and any applicable cost-sharing pay-
22 ment from such participant or beneficiary; and
23 “(C) the requirements applied under sub-
24 sections (b), (e), and (i); and

1 “(2) information in plain language on con-
2 tacting appropriate State and Federal agencies in
3 the case that an individual believes that such a
4 health plan, provider, or facility has violated any re-
5 quirement described in paragraph (1) with respect to
6 such individual.”.

7 (c) ERISA AMENDMENTS.—Section 716 of the Em-
8 ployee Retirement Income Security Act of 1974, as added
9 by section 2(c) and amended by section 3(c), is further
10 amended by inserting before subsection (k) the following
11 new subsections:

12 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

13 “(1) IN GENERAL.—Beginning not later than
14 January 1, 2022, each health plan shall—

15 “(A) establish the verification process de-
16 scribed in paragraph (2);

17 “(B) establish the response protocol de-
18 scribed in paragraph (3);

19 “(C) establish the database described in
20 paragraph (4); and

21 “(D) include in any directory (other than
22 the database described in subparagraph (C))
23 containing provider directory information with
24 respect to such plan the information described
25 in paragraph (5).

1 “(2) VERIFICATION PROCESS.—The verification
2 process described in this paragraph is, with respect
3 to a health plan, a process—

4 “(A) under which such plan verifies and
5 updates the provider directory information in-
6 cluded on the database described in paragraph
7 (4) of such plan of—

8 “(i) not less frequently than once
9 every 90 days, a random sample of at least
10 10 percent of health care providers and
11 health care facilities included in such data-
12 base; and

13 “(ii) any such provider or such facility
14 included in such database that has not
15 submitted any claim to such plan during a
16 12-month period;

17 “(B) that establishes a procedure for the
18 removal from such database of such a provider
19 or facility with respect to which such plan has
20 been unable to verify such information during a
21 period specified by the plan; and

22 “(C) that provides for the update of such
23 database within 2 business days of such plan
24 receiving from such a provider or facility infor-

1 mation pursuant to section 1150D of the Social
2 Security Act.

3 “(3) RESPONSE PROTOCOL.—The response pro-
4 tocol described in this paragraph is, in the case of
5 an individual enrolled in a health plan who requests
6 information through a telephone call or email on
7 whether a health care provider or health care facility
8 has a contractual relationship to furnish items and
9 services under such plan, a protocol under which
10 such plan—

11 “(A) responds to such individual as soon
12 as practicable, and in no case later than 1 busi-
13 ness day after such call or email is received,
14 through a written electronic or paper (as re-
15 quested by such individual) communication; and

16 “(B) retains such communication in such
17 individual’s file for at least 2 years following
18 such response.

19 “(4) DATABASE.—The database described in
20 this paragraph is, with respect to a health plan, a
21 database on the public website of such plan or issuer
22 that contains—

23 “(A) a list of each health care provider and
24 health care facility with which such plan has a

1 contractual relationship for furnishing items
2 and services under such plan; and

3 “(B) provider directory information with
4 respect to each such provider and facility.

5 “(5) INFORMATION.—The information de-
6 scribed in this paragraph is, with respect to a direc-
7 tory containing provider directory information with
8 respect to a health plan, a notification that such in-
9 formation contained in such directory was accurate
10 as of the date of publication of such directory and
11 that an individual enrolled under such plan should
12 consult the database described in paragraph (4) with
13 respect to such plan or contact such plan to obtain
14 the most current provider directory information with
15 respect to such plan.

16 “(6) DEFINITION.—For purposes of this sec-
17 tion, the term ‘provider directory information’ in-
18 cludes, with respect to a health plan, the name, ad-
19 dress, specialty, and telephone number of each
20 health care provider or health care facility with
21 which such plan has a contractual relationship for
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS
24 AGAINST BALANCE BILLING.—Beginning not later than
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-
2 viduals enrolled under such plan, and include on each ex-
3 planation of benefits for an item or service with respect
4 to which the requirements under subsection (b), (e), or
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-
8 plied under section 1150C of the Social Secu-
9 rity Act (relating to prohibitions on balance bill-
10 ing in certain circumstances);

11 “(B) if provided for under applicable State
12 law, any other requirements on providers and
13 facilities regarding the amounts such providers
14 and facilities may, with respect to an item or
15 service, charge a participant or beneficiary of
16 such plan with respect to which such a provider
17 is a nonparticipating provider or facility is a
18 nonparticipating facility, with respect to such
19 plan, for furnishing such item or service after
20 receiving payment from the plan for such item
21 or service and any applicable cost-sharing pay-
22 ment from such participant or beneficiary; and
23 “(C) the requirements applied under sub-
24 sections (b), (e), and (i); and

1 “(2) information in plain language on con-
2 tacting appropriate State and Federal agencies in
3 the case that an individual believes that such a
4 health plan, provider, or facility has violated any re-
5 quirement described in paragraph (1) with respect to
6 such individual.”.

7 **SEC. 6. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
8 **REQUIREMENT FOR FAIR AND HONEST AD-**
9 **VANCE COST ESTIMATE.**

10 (a) PHSA AMENDMENT.—Section 2719A of the Pub-
11 lic Health Service Act (42 U.S.C. 300gg–19a), as amend-
12 ed by sections 2(a), 3(a), and 5(a), is further amended
13 by inserting before subsection (k) the following new sub-
14 sections:

15 “(h) ADVANCED EXPLANATION OF BENEFITS.—Be-
16 ginning on January 1, 2022, each health plan shall, with
17 respect to a notification submitted under section
18 1150D(b)(2)(A) of the Social Security Act by a health
19 care provider or health care facility, respectively, to the
20 health plan for a participant, beneficiary, or enrollee under
21 such health plan scheduled to receive an item or service
22 from the provider or facility, not later than 1 business day
23 (or, in the case such item or service was so scheduled at
24 least 10 business days before such item or service is to
25 be furnished (or in the case such notification was made

1 pursuant to a request by such participant, beneficiary, or
2 enrollee), 3 business days) after the date on which the
3 health plan receives such notification, provide to the par-
4 ticipant, beneficiary, or enrollee (through mail or elec-
5 tronic means, as requested by the participant, beneficiary,
6 or enrollee) a notification (in clear and understandable
7 language) including the following:

8 “(1) Whether or not the provider or facility is
9 a participating provider or a participating facility
10 with respect to the health plan with respect to the
11 furnishing of such item or service and—

12 “(A) in the case the provider or facility is
13 a participating provider or facility with respect
14 to the health plan with respect to the furnishing
15 of such item or service, the contracted rate
16 under such plan for such item or service; and

17 “(B) in the case the provider or facility is
18 a nonparticipating provider or facility with re-
19 spect to such plan, a description of how such
20 individual may obtain information on providers
21 and facilities that, with respect to such health
22 plan, are participating providers and facilities.

23 “(2) The good faith estimate included in the
24 notification received from the provider or facility.

1 “(3) A good faith estimate of the amount the
2 health plan is responsible for paying for items and
3 services included in the estimate described in para-
4 graph (2).

5 “(4) A good faith estimate of the amount of
6 any cost-sharing (including with respect to the de-
7 ductible and any copayment or coinsurance obliga-
8 tion) for which the participant, beneficiary, or en-
9 rollee would be responsible for such item or service
10 (as of the date of such notification).

11 “(5) A good faith estimate of the amount that
12 the participant, beneficiary, or enrollee has incurred
13 toward meeting the limit of the financial responsi-
14 bility (including with respect to deductibles and out-
15 of-pocket maximums) under the health plan (as of
16 the date of such notification).

17 “(6) In the case such item or service is subject
18 to a medical management technique (including con-
19 current review, prior authorization, and step-therapy
20 or fail-first protocols) for coverage under the health
21 plan, a disclaimer that coverage for such item or
22 service is subject to such medical management tech-
23 nique.

24 “(7) A disclaimer that the information provided
25 in the notification is only an estimate based on the

1 items and services reasonably expected, at the time
2 of scheduling (or requesting) the item or service, to
3 be furnished and is subject to change.

4 “(8) A statement that the individual may seek
5 such an item or service from a provider that is a
6 participating provider or a facility that is a partici-
7 pating facility and a list of participating facilities, or
8 of participating providers, as applicable, who are
9 able to furnish such items and services involved.

10 “(9) Any other information or disclaimer the
11 health plan determines appropriate that is consistent
12 with information and disclaimers required under this
13 section.

14 “(i) COST-SHARING AND PAYMENT FOR SERVICES
15 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-
16 VIDER NETWORK INFORMATION.—

17 “(1) IN GENERAL.—For plan years beginning
18 on or after January 1, 2022, in the case of an item
19 or service furnished to a participant, beneficiary, or
20 enrollee of a health plan by a nonparticipating pro-
21 vider or a nonparticipating facility, if such item or
22 service would otherwise be covered under such plan
23 if furnished by a participating provider or partici-
24 pating facility and if either of the criteria described
25 in paragraph (2) applies with respect to such partici-

1 pant, beneficiary, or enrollee and item or service, the
2 plan—

3 “(A) shall not impose on such enrollee a
4 cost-sharing amount for such item or service so
5 furnished that is greater than the cost-sharing
6 amount that would apply under such plan had
7 such item or service been furnished by a partici-
8 pating provider;

9 “(B) shall calculate such cost-sharing
10 amount as if the contracted rate for such item
11 or service furnished by such a participating pro-
12 vider or facility were equal to—

13 “(i) the most recent (as of the date
14 such item or service was furnished) con-
15 tracted rate in effect between such pro-
16 vider or facility and such plan for such
17 item or service furnished under such plan,
18 if any; or

19 “(ii) if no contracted rate described in
20 clause (i) exists, the recognized amount for
21 such item or service;

22 “(C) shall pay to such nonparticipating
23 provider or facility furnishing such item or serv-
24 ice to such participant, beneficiary, or enrollee
25 the amount by which—

1 “(i) if a contracted rate described in
2 subparagraph (B)(i) exists, the most re-
3 cent (as of the date such item or services
4 was furnished) such rate; or

5 “(ii) if no contracted rate described in
6 such subparagraph exists, the out-of-net-
7 work rate;

8 for such items and services exceeds the cost-
9 sharing amount imposed under the plan for
10 such items and services (as determined in ac-
11 cordance with subparagraphs (A) and (B)); and

12 “(D) shall apply the deductible or out-of-
13 pocket maximum, if any, that would apply if
14 such services were furnished by a participating
15 provider or a participating facility.

16 “(2) CRITERIA DESCRIBED.—For purposes of
17 paragraph (1), the criteria described in this para-
18 graph, with respect to an item or service furnished
19 to a participant, beneficiary, or enrollee of a health
20 plan by a nonparticipating provider or a nonparti-
21 cating facility, are the following:

22 “(A) The participant, beneficiary, or en-
23 rollee received a notification under subsection
24 (h) with respect to such item and service to be
25 furnished and such notification provided infor-

1 mation that the provider was a participating
2 provider or facility was a participating facility,
3 with respect to the plan for furnishing such
4 item or service.

5 “(B) A notification was not provided, in
6 accordance with subsection (h), to the partici-
7 pant, beneficiary, or enrollee, and the partici-
8 pant, beneficiary, or enrollee requested through
9 the response protocol of the plan under sub-
10 section (f)(3) information on whether the pro-
11 vider was a participating provider or facility
12 was a participating facility with respect to the
13 plan for furnishing such item or service and
14 was informed through such protocol that the
15 provider was such a participating provider or
16 facility was such a participating facility.”.

17 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
18 nal Revenue Code of 1986, as added by section 2(b) and
19 amended by sections 3(b) and 5(b), is further amended
20 by inserting before subsection (k) the following new sub-
21 sections:

22 “(h) ADVANCED EXPLANATION OF BENEFITS.—Be-
23 ginning on January 1, 2022, each health plan shall, with
24 respect to a notification submitted under section
25 1150D(b)(2)(A) of the Social Security Act by a health

1 care provider or health care facility, respectively, to the
2 health plan for a participant or beneficiary under such
3 health plan scheduled to receive an item or service from
4 the provider or facility, not later than 1 business day (or,
5 in the case such item or service was so scheduled at least
6 10 business days before such item or service is to be fur-
7 nished (or in the case such notification was made pursuant
8 to a request by such participant or beneficiary), 3 business
9 days) after the date on which the health plan receives such
10 notification, provide to the participant or beneficiary
11 (through mail or electronic means, as requested by the
12 participant or beneficiary) a notification (in clear and
13 understandable language) including the following:

14 “(1) Whether or not the provider or facility is
15 a participating provider or a participating facility
16 with respect to the health plan with respect to the
17 furnishing of such item or service and—

18 “(A) in the case the provider or facility is
19 a participating provider or facility with respect
20 to the health plan with respect to the furnishing
21 of such item or service, the contracted rate
22 under such plan for such item or service; and

23 “(B) in the case the provider or facility is
24 a nonparticipating provider or facility with re-
25 spect to such plan, a description of how such

1 individual may obtain information on providers
2 and facilities that, with respect to such health
3 plan, are participating providers and facilities.

4 “(2) The good faith estimate included in the
5 notification received from the provider or facility.

6 “(3) A good faith estimate of the amount the
7 health plan is responsible for paying for items and
8 services included in the estimate described in para-
9 graph (2).

10 “(4) A good faith estimate of the amount of
11 any cost-sharing (including with respect to the de-
12 ductible and any copayment or coinsurance obliga-
13 tion) for which the participant or beneficiary would
14 be responsible for such item or service (as of the
15 date of such notification).

16 “(5) A good faith estimate of the amount that
17 the participant or beneficiary has incurred toward
18 meeting the limit of the financial responsibility (in-
19 cluding with respect to deductibles and out-of-pocket
20 maximums) under the health plan (as of the date of
21 such notification).

22 “(6) In the case such item or service is subject
23 to a medical management technique (including con-
24 current review, prior authorization, and step-therapy
25 or fail-first protocols) for coverage under the health

1 plan, a disclaimer that coverage for such item or
2 service is subject to such medical management tech-
3 nique.

4 “(7) A disclaimer that the information provided
5 in the notification is only an estimate based on the
6 items and services reasonably expected, at the time
7 of scheduling (or requesting) the item or service, to
8 be furnished and is subject to change.

9 “(8) A statement that the individual may seek
10 such an item or service from a provider that is a
11 participating provider or a facility that is a partici-
12 pating facility and a list of participating facilities, or
13 of participating providers, as applicable, who are
14 able to furnish such items and services involved.

15 “(9) Any other information or disclaimer the
16 health plan determines appropriate that is consistent
17 with information and disclaimers required under this
18 section.

19 “(i) COST-SHARING AND PAYMENT FOR SERVICES
20 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-
21 VIDER NETWORK INFORMATION.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after January 1, 2022, in the case of an item
24 or service furnished to a participant or beneficiary of
25 a health plan by a nonparticipating provider or a

1 nonparticipating facility, if such item or service
2 would otherwise be covered under such plan if fur-
3 nished by a participating provider or participating
4 facility and if either of the criteria described in para-
5 graph (2) applies with respect to such participant or
6 beneficiary and item or service, the plan—

7 “(A) shall not impose on such enrollee a
8 cost-sharing amount for such item or service so
9 furnished that is greater than the cost-sharing
10 amount that would apply under such plan had
11 such item or service been furnished by a partici-
12 pating provider;

13 “(B) shall calculate such cost-sharing
14 amount as if the contracted rate for such item
15 or service furnished by such a participating pro-
16 vider or facility were equal to—

17 “(i) the most recent (as of the date
18 such item or service was furnished) con-
19 tracted rate in effect between such pro-
20 vider or facility and such plan for such
21 item or service furnished under such plan,
22 if any; or

23 “(ii) if no contracted rate described in
24 clause (i) exists, the recognized amount for
25 such item or service;

“(C) shall pay to such nonparticipating provider or facility furnishing such item or service to such participant or beneficiary the amount by which—

“(i) if a contracted rate described in subparagraph (B)(i) exists, the most recent (as of the date such item or services was furnished) such rate; or

“(ii) if no contracted rate described in such subparagraph exists, the out-of-network rate;

for such items and services 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 apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

“(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant or beneficiary of a health plan by a nonparticipating provider or a nonparticipating facility, are the following:

1 “(A) The participant or beneficiary re-
2 ceived a notification under subsection (h) with
3 respect to such item and service to be furnished
4 and such notification provided information that
5 the provider was a participating provider or fa-
6 cility was a participating facility, with respect
7 to the plan for furnishing such item or service.

8 “(B) A notification was not provided, in
9 accordance with subsection (h), to the partici-
10 pant or beneficiary and the participant or bene-
11 ficiary requested through the response protocol
12 of the plan under subsection (f)(3) information
13 on whether the provider was a participating
14 provider or facility was a participating facility
15 with respect to the plan for furnishing such
16 item or service and was informed through such
17 protocol that the provider was such a partici-
18 pating provider or facility was such a partici-
19 pating facility.”.

20 (c) ERISA AMENDMENTS.—Section 716 of the Em-
21 ployee Retirement Income Security Act of 1974, as added
22 by section 2(c) and amended by sections 3(c) and 5(c),
23 is further amended by inserting before subsection (k) the
24 following new subsections:

1 “(h) ADVANCED EXPLANATION OF BENEFITS.—Be-
2 ginning on January 1, 2022, each health plan shall, with
3 respect to a notification submitted under section
4 1150D(b)(2)(A) of the Social Security Act by a health
5 care provider or health care facility, respectively, to the
6 health plan for a participant or beneficiary under such
7 health plan scheduled to receive an item or service from
8 the provider or facility, not later than 1 business day (or,
9 in the case such item or service was so scheduled at least
10 10 business days before such item or service is to be fur-
11 nished (or in the case such notification was made pursuant
12 to a request by such participant or beneficiary), 3 business
13 days) after the date on which the health plan receives such
14 notification, provide to the participant or beneficiary
15 (through mail or electronic means, as requested by the
16 participant or beneficiary) a notification (in clear and un-
17 derstandable language) including the following:

18 “(1) Whether or not the provider or facility is
19 a participating provider or a participating facility
20 with respect to the health plan with respect to the
21 furnishing of such item or service and—

22 “(A) in the case the provider or facility is
23 a participating provider or facility with respect
24 to the health plan with respect to the furnishing

1 of such item or service, the contracted rate
2 under such plan for such item or service; and

3 “(B) in the case the provider or facility is
4 a nonparticipating provider or facility with re-
5 spect to such plan, a description of how such
6 individual may obtain information on providers
7 and facilities that, with respect to such health
8 plan, are participating providers and facilities.

9 “(2) The good faith estimate included in the
10 notification received from the provider or facility.

11 “(3) A good faith estimate of the amount the
12 health plan is responsible for paying for items and
13 services included in the estimate described in para-
14 graph (2).

15 “(4) A good faith estimate of the amount of
16 any cost-sharing (including with respect to the de-
17 ductible and any copayment or coinsurance obliga-
18 tion) for which the participant or beneficiary would
19 be responsible for such item or service (as of the
20 date of such notification).

21 “(5) A good faith estimate of the amount that
22 the participant or beneficiary has incurred toward
23 meeting the limit of the financial responsibility (in-
24 cluding with respect to deductibles and out-of-pocket

1 maximums) under the health plan (as of the date of
2 such notification).

3 “(6) In the case such item or service is subject
4 to a medical management technique (including con-
5 current review, prior authorization, and step-therapy
6 or fail-first protocols) for coverage under the health
7 plan, a disclaimer that coverage for such item or
8 service is subject to such medical management tech-
9 nique.

10 “(7) A disclaimer that the information provided
11 in the notification is only an estimate based on the
12 items and services reasonably expected, at the time
13 of scheduling (or requesting) the item or service, to
14 be furnished and is subject to change.

15 “(8) A statement that the individual may seek
16 such an item or service from a provider that is a
17 participating provider or a facility that is a partici-
18 pating facility and a list of participating facilities, or
19 of participating providers, as applicable, who are
20 able to furnish such items and services involved.

21 “(9) Any other information or disclaimer the
22 health plan determines appropriate that is consistent
23 with information and disclaimers required under this
24 section.

1 “(i) COST-SHARING AND PAYMENT FOR SERVICES
2 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-
3 VIDER NETWORK INFORMATION.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2022, in the case of an item
6 or service furnished to a participant or beneficiary of
7 a health plan by a nonparticipating provider or a
8 nonparticipating facility, if such item or service
9 would otherwise be covered under such plan if fur-
10 nished by a participating provider or participating
11 facility and if either of the criteria described in para-
12 graph (2) applies with respect to such participant or
13 beneficiary and item or service, the plan—

14 “(A) shall not impose on such enrollee a
15 cost-sharing amount for such item or service so
16 furnished that is greater than the cost-sharing
17 amount that would apply under such plan had
18 such item or service been furnished by a partici-
19 pating provider;

20 “(B) shall calculate such cost-sharing
21 amount as if the contracted rate for such item
22 or service furnished by such a participating pro-
23 vider or facility were equal to—

24 “(i) the most recent (as of the date
25 such item or service was furnished) con-

1 tracted rate in effect between such pro-
2 vider or facility and such plan for such
3 item or service furnished under such plan,
4 if any; or

5 “(ii) if no contracted rate described in
6 clause (i) exists, the recognized amount for
7 such item or service;

8 “(C) shall pay to such nonparticipating
9 provider or facility furnishing such item or serv-
10 ice to such participant or beneficiary the
11 amount by which—

12 “(i) if a contracted rate described in
13 subparagraph (B)(i) exists, the most re-
14 cent (as of the date such item or services
15 was furnished) such rate; or

16 “(ii) if no contracted rate described in
17 such subparagraph exists, the out-of-net-
18 work rate;

19 for such items and services exceeds the cost-
20 sharing amount imposed under the plan for
21 such items and services (as determined in ac-
22 cordance with subparagraphs (A) and (B)); and

23 “(D) shall apply the deductible or out-of-
24 pocket maximum, if any, that would apply if

1 such services were furnished by a participating
2 provider or a participating facility.

3 “(2) CRITERIA DESCRIBED.—For purposes of
4 paragraph (1), the criteria described in this para-
5 graph, with respect to an item or service furnished
6 to a participant or beneficiary of a health plan by
7 a nonparticipating provider or a nonparticipating fa-
8 cility, are the following:

9 “(A) The participant or beneficiary re-
10 ceived a notification under subsection (h) with
11 respect to such item and service to be furnished
12 and such notification provided information that
13 the provider was a participating provider or fa-
14 cility was a participating facility, with respect
15 to the plan for furnishing such item or service.

16 “(B) A notification was not provided, in
17 accordance with subsection (h), to the partici-
18 pant or beneficiary and the participant or bene-
19 ficiary requested through the response protocol
20 of the plan under subsection (f)(3) information
21 on whether the provider was a participating
22 provider or facility was a participating facility
23 with respect to the plan for furnishing such
24 item or service and was informed through such
25 protocol that the provider was such a partici-

1 pating provider or facility was such a partici-
 2 pating facility.”.

3 **SEC. 7. DETERMINATION THROUGH OPEN NEGOTIATION**
 4 **AND MEDIATION OF OUT-OF-NETWORK RATES**
 5 **TO BE PAID BY HEALTH PLANS.**

6 (a) PHSA AMENDMENT.—Section 2719A of the Pub-
 7 lic Health Service Act (42 U.S.C. 300gg–19a), as amend-
 8 ed by sections 2(a), 3(a), 5(a), and 6(a), is further amend-
 9 ed by inserting before subsection (k) the following new
 10 subsection:

11 “(j) DETERMINATION OF OUT-OF-NETWORK RATES
 12 TO BE PAID BY HEALTH PLANS.—

13 “(1) DETERMINATION THROUGH OPEN NEO-
 14 TLATION.—

15 “(A) IN GENERAL.—With respect to an
 16 item or service furnished in a year by a non-
 17 participating provider or a nonparticipating fa-
 18 cility, with respect to a health plan, in a State
 19 described in subparagraph (B) of subsection
 20 (k)(11) with respect to such plan and provider
 21 or facility, and for which a payment is required
 22 to be made by the health plan pursuant to sub-
 23 section (b)(1), (e)(1), or (i)(1), the provider or
 24 facility (as applicable) or plan may, during the
 25 30-day period beginning on the day the provider

1 or facility receives a response from the plan re-
2 garding a claim for payment for such item or
3 service, initiate open negotiations under this
4 paragraph between such provider or facility and
5 plan for purposes of determining, during the
6 open negotiation period, an amount agreed on
7 by such provider or facility, respectively, and
8 such plan for payment (including any cost-shar-
9 ing) for such item or service. For purposes of
10 this subsection, the open negotiation period,
11 with respect to an item or service, is the 30-day
12 period beginning on the date of initiation of the
13 negotiations with respect to such item or serv-
14 ice.

15 “(B) EXCHANGE OF INFORMATION.—In
16 carrying out negotiations initiated under sub-
17 paragraph (A), with respect to an item or serv-
18 ice described in such subparagraph furnished in
19 a year, not later than the fifth business day of
20 the open negotiation period described in such
21 subparagraph with respect to such item or serv-
22 ice—

23 “(i) the health plan that is party to
24 such negotiations shall notify the provider
25 or facility that is party to such negotia-

1 tions of the median contracted rate for
2 such item or service and year; and

3 “(ii) such provider or facility shall no-
4 tify such health plan of—

5 “(I) the median of the total
6 amount of reimbursement (including
7 any cost-sharing) paid, for the most
8 recent year for which information is
9 available, to such provider or facility
10 for furnishing such item or service to
11 a participant, beneficiary, or enrollee
12 of a health plan that, at the time such
13 item or service was furnished, had a
14 contract in effect with such provider
15 or facility with respect to the fur-
16 nishing of such item or service;

17 “(II) in the case that information
18 described in subclause (I) is not avail-
19 able, such information as specified by
20 the Secretary; and

21 “(III) any additional information
22 specified by the Secretary.

23 “(C) ACCESSING MEDIATED DISPUTE
24 PROCESS IN CASE OF FAILED NEGOTIATIONS.—

25 In the case of open negotiations pursuant to

1 subparagraph (A), with respect to an item or
2 service, that do not result in a determination of
3 an amount of payment for such item or service
4 by the last day of the open negotiation period
5 described in such subparagraph with respect to
6 such item or service, the provider or facility (as
7 applicable) or health plan that was party to
8 such negotiations may, during the 2-day period
9 beginning on the day after such open negotia-
10 tion period, initiate the mediated dispute proc-
11 ess under paragraph (2) with respect to such
12 item or service. The mediated dispute process
13 shall be initiated by a party pursuant to the
14 previous sentence by submission to the other
15 party and to the Secretary of a notification
16 (containing such information as specified by the
17 Secretary) and for purposes of this subsection,
18 the date of initiation of such process shall be
19 the date of such submission or such other date
20 specified by the Secretary pursuant to regula-
21 tions that is not later than the date of receipt
22 of such notification by both the other party and
23 the Secretary.

24 “(2) MEDIATED DISPUTE PROCESS AVAILABLE

25 IN CASE OF FAILED OPEN NEGOTIATIONS.—

1 “(A) ESTABLISHMENT.—Not later than
2 July 1, 2021, the Secretary, in coordination
3 with the Secretary of the Treasury and the Sec-
4 retary of Labor, shall establish a process (in
5 this subsection referred to as the ‘mediated dis-
6 pute process’) under which, in the case of an
7 item or service with respect to which a provider
8 or facility (as applicable) or health plan submits
9 a notification under paragraph (1)(C) (in this
10 subsection referred to as a ‘qualified mediated
11 dispute item or service’), an entity selected
12 under paragraph (3) determines, subject to sub-
13 paragraph (B) and in accordance with the suc-
14 ceeding provisions of this subsection, the
15 amount of payment under the health plan for
16 such item or service furnished by such provider
17 or facility.

18 “(B) AUTHORITY TO CONTINUE NEGOTIA-
19 TIONS.—Under the mediated dispute process, in
20 the case that the parties to a determination for
21 a qualified mediated dispute item or service
22 agree on a payment amount for such item or
23 service during such process but before the date
24 on which the entity selected with respect to
25 such determination under paragraph (3) makes

1 such determination, such amount shall be treat-
2 ed for purposes of subsection (k)(11)(B) as the
3 amount agreed to by such parties for such item
4 or service. In the case of an agreement de-
5 scribed in the previous sentence, the mediated
6 dispute process shall provide for a method to
7 determine how to allocate between the parties
8 to such determination the payment of the com-
9 pensation of the entity selected with respect to
10 such determination.

11 “(3) SELECTION UNDER MEDIATED DISPUTE
12 PROCESS.—Under the mediated dispute process, the
13 Secretary shall, with respect to the determination of
14 the amount of payment under this subsection of a
15 qualified mediated dispute item or service, provide
16 for a method—

17 “(A) that allows the parties to such deter-
18 mination to jointly select, not later than the last
19 day of the 3-day period following the date of
20 the initiation of the process with respect to such
21 item or service, for purposes of making such de-
22 termination, an entity certified under paragraph
23 (7) that—

1 “(i) is not a party to such determina-
2 tion or an employee or agent of such a
3 party;

4 “(ii) does not have a material familial,
5 financial, or professional relationship with
6 such a party; and

7 “(iii) does not otherwise have a con-
8 flict of interest with such a party (as de-
9 termined by the Secretary); and

10 “(B) that requires, in the case such parties
11 do not make such selection by such last day,
12 the Secretary to, not later than 6 days after
13 such date of initiation—

14 “(i) select such an entity that satisfies
15 clauses (i) through (iii) of subparagraph
16 (A); and

17 “(ii) provide notification of such selec-
18 tion to the provider or facility (as applica-
19 ble) and the health plan party to such de-
20 termination.

21 An entity selected pursuant to the previous sentence
22 to make a determination described in such sentence
23 shall be referred to in this subsection as the ‘selected
24 independent entity’ with respect to such determina-
25 tion.

1 “(4) TREATMENT OF CONSIDERATION OF MUL-
2 TIPLE ITEMS AND SERVICES.—

3 “(A) IN GENERAL.—Under the mediated
4 dispute process, the Secretary shall specify cri-
5 teria under which multiple qualified mediated
6 dispute items and services are permitted to be
7 considered jointly as part of a single determina-
8 tion by an entity for purposes of encouraging
9 the efficiency (including minimizing costs) of
10 the mediated dispute process. Such items and
11 services may be so considered only if—

12 “(i) such items and services to be in-
13 cluded in such determination are furnished
14 by the same provider or facility;

15 “(ii) payment for such items and serv-
16 ices is required to be made by the same
17 health plan; and

18 “(iii) such items and services are re-
19 lated to the treatment of a similar condi-
20 tion.

21 “(B) TREATMENT OF BUNDLED PAY-
22 MENTS.—In carrying out subparagraph (A), the
23 Secretary shall provide that, in the case of
24 items and services which are included by a pro-
25 vider or facility as part of a bundled payment,

1 such items and services included in such bun-
2 dled payment may be part of a single deter-
3 mination under this subsection.

4 “(C) WAIVER OF DEADLINES.—For pur-
5 poses of permitting joint consideration of quali-
6 fied mediated dispute items and services as part
7 of a single determination under the criteria
8 specified pursuant to subparagraph (A), the
9 Secretary may waive any deadline specified in
10 this subsection.

11 “(5) DETERMINATION OF PAYMENT AMOUNT.—

12 “(A) IN GENERAL.—Not later than 30
13 days after the date of initiation of the mediated
14 dispute resolution, with respect to a qualified
15 mediated dispute item or service, the selected
16 independent entity with respect to a determina-
17 tion under this subsection for such item or serv-
18 ice shall—

19 “(i) taking into account only the con-
20 siderations specified in subparagraph
21 (C)(i), select one of the offers submitted
22 under subparagraph (B) to be the amount
23 of payment for such item or service deter-
24 mined under this subsection for purposes

1 of subsection (b)(1), (e)(1), or (i)(1), as
2 applicable; and

3 “(ii) notify the provider or facility and
4 the health plan party to such determina-
5 tion of the offer selected under clause (i).

6 “(B) SUBMISSION OF OFFERS.—Not later
7 than 10 days after the date of initiation of the
8 mediated dispute resolution with respect to a
9 determination for a qualified mediated dispute
10 item or service, the provider or facility and the
11 health plan party to such determination shall
12 each submit to the selected independent enti-
13 ty—

14 “(i) an offer for a payment amount
15 under for such item or service furnished by
16 such provider or facility;

17 “(ii) information relating to such
18 offer; and

19 “(iii) such other information as re-
20 quested by the selected independent entity.

21 “(C) CONSIDERATIONS.—

22 “(i) IN GENERAL.—For purposes of
23 subparagraph (A), the considerations spec-
24 ified in this subparagraph, with respect to

1 a determination for a qualified mediated
2 dispute item or service, are the following:

3 “(I) The median contracted rate
4 for such item or service.

5 “(II) Subject to clause (ii), infor-
6 mation that is submitted pursuant to
7 subparagraph (B).

8 “(ii) TREATMENT OF CERTAIN CON-
9 siderations.—In making a determination
10 with respect to a qualified mediated dis-
11 pute item or service pursuant to subpara-
12 graph (A)(i), a selected independent entity
13 may not take into account usual and cus-
14 tomary charges for the item or service nor
15 charges billed by the provider or facility for
16 the item or service.

17 “(6) SELECTED INDEPENDENT ENTITY COM-
18 PENSATION.—

19 “(A) IN GENERAL.—Not later than 5 days
20 after receiving a notification described in para-
21 graph (5)(A)(ii) from a selected independent
22 entity with respect to the determination of a
23 payment amount for a qualified mediated dis-
24 pute item or service, the party to such deter-
25 mination whose offer submitted under para-

graph (5)(B) was not selected by the entity shall pay to such entity a fee in compensation for the services of such entity in accordance with the guidelines on such compensation established by the Secretary under subparagraph (B).

“(B) GUIDELINES ON COMPENSATION.—

For purposes of subparagraph (A), the Secretary shall establish guidelines with respect to the compensation of a selected independent entity for the services of such entity with respect to determinations under the mediated dispute process. Such guidelines shall provide that such compensation reimburses the entity for at least the costs of such entity in performing the duties of the entity under the mediated dispute process.

“(7) CERTIFICATION OF ENTITIES.—

“(A) IN GENERAL.—The Secretary shall establish or recognize a process to certify (including recertification of) entities under this paragraph. Such process shall ensure that an entity so certified—

“(i) has (directly or through contracts or other arrangements) sufficient medical,

1 legal, and other expertise and sufficient
2 staffing to make determinations described
3 in paragraph (2) on a timely basis;

4 “(ii) is not—

5 “(I) a health plan, provider, or
6 facility;

7 “(II) an affiliate or a subsidiary
8 of a health plan, provider, or facility;
9 or

10 “(III) an affiliate or subsidiary of
11 a professional or trade association of
12 health plans or of providers or facili-
13 ties;

14 “(iii) carries out the responsibilities of
15 such an entity in accordance with this sub-
16 section;

17 “(iv) meets appropriate indicators of
18 fiscal integrity;

19 “(v) maintains the confidentiality (in
20 accordance with regulations promulgated
21 by the Secretary) of individually identifi-
22 able health information obtained in the
23 course of conducting such determinations;

24 “(vi) does not under the mediated dis-
25 pute process carry out any determination

1 with respect to which the entity would not
2 pursuant to clause (i), (ii), or (iii) of para-
3 graph (3)(A) be eligible for selection; and
4 “(vii) meets such other requirements
5 as determined appropriate by the Sec-
6 retary.

7 “(B) PERIOD OF CERTIFICATION.—Subject
8 to subparagraph (C), each certification (includ-
9 ing a recertification) of an entity under the
10 process described in subparagraph (A) shall be
11 for a 5-year period.

12 “(C) REVOCATION.—A certification of an
13 entity under this paragraph may be revoked
14 under the process described in subparagraph
15 (A) if the entity has a pattern or practice of
16 noncompliance with any of the requirements de-
17 scribed in such subparagraph.

18 “(D) PETITION FOR DENIAL OR WITH-
19 DRAWAL.—The process described in subpara-
20 graph (A) shall ensure that an individual, pro-
21 vider, facility, or health plan may petition for a
22 denial of a certification or a revocation of a cer-
23 tification with respect to an entity under this
24 paragraph for failure of meeting a requirement
25 of this subsection.

1 “(E) SUFFICIENT NUMBER OF ENTI-
2 TIES.—The process described in subparagraph
3 (A) shall ensure that a sufficient number of en-
4 tities are certified under this paragraph to en-
5 sure the timely and efficient provision of deter-
6 minations described in paragraph (2).

7 “(F) PROVISION OF INFORMATION.—

8 “(i) IN GENERAL.—An entity certified
9 under this paragraph shall provide to the
10 Secretary, in such manner as the Secretary
11 may require and on a quarterly basis (as
12 specified by the Secretary), such informa-
13 tion as the Secretary determines appro-
14 priate to assure compliance with the re-
15 quirements described in subparagraph (A)
16 and to monitor and assess the determina-
17 tions made by such entity and to ensure
18 the absence of bias in making such deter-
19 minations. Such information shall include
20 information described in clause (ii) but
21 shall not include individually identifiable
22 health information.

23 “(ii) INFORMATION TO BE IN-
24 CLUDED.—The information described in

1 this clause with respect to an entity is the
2 following:

3 “(I) The number of payment de-
4 terminations described in paragraph
5 (2) made by such entity,
6 disaggregated by—

7 “(aa) the line of business
8 (as specified in subsection
9 (k)(8)(C)) of the health plans
10 party to such determinations;
11 and

12 “(bb) the type of providers
13 and facilities party to such deter-
14 minations.

15 “(II) A description of each item
16 or service included in each such deter-
17 mination.

18 “(III) The amount of each offer
19 submitted to the entity for each such
20 determination.

21 “(IV) The amount of each such
22 determination.

23 “(V) The length of time in mak-
24 ing each such determination.

1 “(VI) The compensation paid to
2 such entity with respect to each such
3 determination.

4 “(VII) Any other information
5 specified by the Secretary.

6 “(8) ADMINISTRATIVE FEE.—

7 “(A) IN GENERAL.—Each party to a deter-
8 mination to which an entity is selected under
9 paragraph (3) in a year shall pay to the Sec-
10 retary, at such time and in such manner as
11 specified by the Secretary, a fee for partici-
12 pating in the mediated dispute process with re-
13 spect to such determination in an amount de-
14 scribed in subparagraph (B) for such year.

15 “(B) AMOUNT OF FEE.—The amount de-
16 scribed in this subparagraph for a year is an
17 amount established by the Secretary in a man-
18 ner such that the total amount of fees paid
19 under this paragraph for such year is estimated
20 to be equal to the amount of expenditures esti-
21 mated to be made by the Secretary for such
22 year in carrying out the mediated dispute proc-
23 ess.

24 “(9) SECRETARIAL REPORT; PUBLICATION OF
25 INFORMATION.—

1 “(A) SECRETARIAL REPORT.—Beginning
2 not later than July 1, 2023, the Secretary shall,
3 in coordination with the Secretary of the Treas-
4 ury and the Secretary of Labor, periodically
5 study and submit to Congress a report on—

6 “(i) the extent to which the payment
7 amount determined under this subsection
8 for an item or service furnished in a year
9 (or otherwise agreed to by a health plan
10 and provider or facility for purposes of de-
11 termining payment by the plan to the pro-
12 vider or facility pursuant to subsection
13 (b)(1), (e)(1), or (i)(1)) differs from the
14 median contracted rate for such item or
15 service and year, including the number of
16 times such determined (or agreed to)
17 amount exceeds such median contracted
18 rate; and

19 “(ii) the effect of such difference on
20 the cost-sharing for such item or service
21 for a participant, beneficiary, or enrollee of
22 a health plan.

23 “(B) PUBLICATION OF INFORMATION.—
24 Beginning with July 1, 2023, and for each cal-
25 endar quarter thereafter, the Secretary shall, in

1 coordination with the Secretary of the Treasury
2 and the Secretary of Labor, make publicly
3 available a summary of the following:

4 “(i) The information described in sub-
5 clauses (I) through (V) of clause (ii) of
6 paragraph (7)(F) that was submitted to
7 the Secretary under clause (i) of such
8 paragraph during such quarter.

9 “(ii) The amount of expenditures
10 made by the Secretary during such year to
11 carry out the mediated dispute process.

12 “(iii) The total amount of fees paid
13 under paragraph (8) during such quarter.

14 “(iv) The total amount of compensa-
15 tion paid to selected independent entities
16 under paragraph (6) during such quar-
17 ter.”.

18 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
19 nal Revenue Code of 1986, as added by section 2(b) and
20 amended by sections 3(b), 5(b), and 6(b), is further
21 amended by inserting before subsection (k) the following
22 new subsection:

23 “(j) DETERMINATION OF OUT-OF-NETWORK RATES
24 TO BE PAID BY HEALTH PLANS.—

1 “(1) DETERMINATION THROUGH OPEN NEGO-
2 TATION.—

3 “(A) IN GENERAL.—With respect to an
4 item or service furnished in a year by a non-
5 participating provider or a nonparticipating fa-
6 cility, with respect to a health plan, in a State
7 described in subparagraph (B) of subsection
8 (k)(11) with respect to such plan and provider
9 or facility, and for which a payment is required
10 to be made by the health plan pursuant to sub-
11 section (b)(1), (e)(1), or (i)(1), the provider or
12 facility (as applicable) or plan may, during the
13 30-day period beginning on the day the provider
14 or facility receives a response from the plan re-
15 garding a claim for payment for such item or
16 service, initiate open negotiations under this
17 paragraph between such provider or facility and
18 plan for purposes of determining, during the
19 open negotiation period, an amount agreed on
20 by such provider or facility, respectively, and
21 such plan for payment (including any cost-shar-
22 ing) for such item or service. For purposes of
23 this subsection, the open negotiation period,
24 with respect to an item or service, is the 30-day
25 period beginning on the date of initiation of the

1 negotiations with respect to such item or serv-
2 ice.

3 “(B) EXCHANGE OF INFORMATION.—In
4 carrying out negotiations initiated under sub-
5 paragraph (A), with respect to an item or serv-
6 ice described in such subparagraph furnished in
7 a year, not later than the fifth business day of
8 the open negotiation period described in such
9 subparagraph with respect to such item or serv-
10 ice—

11 “(i) the health plan that is party to
12 such negotiations shall notify the provider
13 or facility that is party to such negotia-
14 tions of the median contracted rate for
15 such item or service and year; and

16 “(ii) such provider or facility shall no-
17 tify such health plan of—

18 “(I) the median of the total
19 amount of reimbursement (including
20 any cost-sharing) paid, for the most
21 recent year for which information is
22 available, to such provider or facility
23 for furnishing such item or service to
24 a participant or beneficiary of a
25 health plan that, at the time such

1 item or service was furnished, had a
2 contract in effect with such provider
3 or facility with respect to the fur-
4 nishing of such item or service;

5 “(II) in the case that information
6 described in subclause (I) is not avail-
7 able, such information as specified by
8 the Secretary; and

9 “(III) any additional information
10 specified by the Secretary.

11 “(C) ACCESSING MEDIATED DISPUTE
12 PROCESS IN CASE OF FAILED NEGOTIATIONS.—

13 In the case of open negotiations pursuant to
14 subparagraph (A), with respect to an item or
15 service, that do not result in a determination of
16 an amount of payment for such item or service
17 by the last day of the open negotiation period
18 described in such subparagraph with respect to
19 such item or service, the provider or facility (as
20 applicable) or health plan that was party to
21 such negotiations may, during the 2-day period
22 beginning on the day after such open negotia-
23 tion period, initiate the mediated dispute proc-
24 ess under paragraph (2) with respect to such
25 item or service. The mediated dispute process

1 shall be initiated by a party pursuant to the
2 previous sentence by submission to the other
3 party and to the Secretary of a notification
4 (containing such information as specified by the
5 Secretary) and for purposes of this subsection,
6 the date of initiation of such process shall be
7 the date of such submission or such other date
8 specified by the Secretary pursuant to regula-
9 tions that is not later than the date of receipt
10 of such notification by both the other party and
11 the Secretary.

12 “(2) MEDIATED DISPUTE PROCESS AVAILABLE
13 IN CASE OF FAILED OPEN NEGOTIATIONS.—

14 “(A) ESTABLISHMENT.—Not later than
15 July 1, 2021, the Secretary, in coordination
16 with the Secretary of Health and Human Serv-
17 ices and the Secretary of Labor, shall establish
18 a process (in this subsection referred to as the
19 ‘mediated dispute process’) under which, in the
20 case of an item or service with respect to which
21 a provider or facility (as applicable) or health
22 plan submits a notification under paragraph
23 (1)(C) (in this subsection referred to as a
24 ‘qualified mediated dispute item or service’), an
25 entity selected under paragraph (3) determines,

1 subject to subparagraph (B) and in accordance
2 with the succeeding provisions of this sub-
3 section, the amount of payment under the
4 health plan for such item or service furnished
5 by such provider or facility.

6 “(B) AUTHORITY TO CONTINUE NEGOTIA-
7 TIONS.—Under the mediated dispute process, in
8 the case that the parties to a determination for
9 a qualified mediated dispute item or service
10 agree on a payment amount for such item or
11 service during such process but before the date
12 on which the entity selected with respect to
13 such determination under paragraph (3) makes
14 such determination, such amount shall be treat-
15 ed for purposes of subsection (k)(11)(B) as the
16 amount agreed to by such parties for such item
17 or service. In the case of an agreement de-
18 scribed in the previous sentence, the mediated
19 dispute process shall provide for a method to
20 determine how to allocate between the parties
21 to such determination the payment of the com-
22 pensation of the entity selected with respect to
23 such determination.

24 “(3) SELECTION UNDER MEDIATED DISPUTE
25 PROCESS.—Under the mediated dispute process, the

1 Secretary shall, with respect to the determination of
2 the amount of payment under this subsection of a
3 qualified mediated dispute item or service, provide
4 for a method—

5 “(A) that allows the parties to such deter-
6 mination to jointly select, not later than the last
7 day of the 3-day period following the date of
8 the initiation of the process with respect to such
9 item or service, for purposes of making such de-
10 termination, an entity certified under paragraph
11 (7) that—

12 “(i) is not a party to such determina-
13 tion or an employee or agent of such a
14 party;

15 “(ii) does not have a material familial,
16 financial, or professional relationship with
17 such a party; and

18 “(iii) does not otherwise have a con-
19 flict of interest with such a party (as de-
20 termined by the Secretary); and

21 “(B) that requires, in the case such parties
22 do not make such selection by such last day,
23 the Secretary to, not later than 6 days after
24 such date of initiation—

1 “(i) select such an entity that satisfies
2 clauses (i) through (iii) of subparagraph
3 (A); and

4 “(ii) provide notification of such selec-
5 tion to the provider or facility (as applica-
6 ble) and the health plan party to such de-
7 termination.

8 An entity selected pursuant to the previous sentence
9 to make a determination described in such sentence
10 shall be referred to in this subsection as the ‘selected
11 independent entity’ with respect to such determina-
12 tion.

13 “(4) TREATMENT OF CONSIDERATION OF MUL-
14 TIPLE ITEMS AND SERVICES.—

15 “(A) IN GENERAL.—Under the mediated
16 dispute process, the Secretary shall specify cri-
17 teria under which multiple qualified mediated
18 dispute items and services are permitted to be
19 considered jointly as part of a single determina-
20 tion by an entity for purposes of encouraging
21 the efficiency (including minimizing costs) of
22 the mediated dispute process. Such items and
23 services may be so considered only if—

1 “(i) such items and services to be in-
2 cluded in such determination are furnished
3 by the same provider or facility;

4 “(ii) payment for such items and serv-
5 ices is required to be made by the same
6 health plan; and

7 “(iii) such items and services are re-
8 lated to the treatment of a similar condi-
9 tion.

10 “(B) TREATMENT OF BUNDLED PAY-
11 MENTS.—In carrying out subparagraph (A), the
12 Secretary shall provide that, in the case of
13 items and services which are included by a pro-
14 vider or facility as part of a bundled payment,
15 such items and services included in such bun-
16 dled payment may be part of a single deter-
17 mination under this subsection.

18 “(C) WAIVER OF DEADLINES.—For pur-
19 poses of permitting joint consideration of quali-
20 fied mediated dispute items and services as part
21 of a single determination under the criteria
22 specified pursuant to subparagraph (A), the
23 Secretary may waive any deadline specified in
24 this subsection.

25 “(5) DETERMINATION OF PAYMENT AMOUNT.—

1 “(A) IN GENERAL.—Not later than 30
2 days after the date of initiation of the mediated
3 dispute resolution, with respect to a qualified
4 mediated dispute item or service, the selected
5 independent entity with respect to a determina-
6 tion under this subsection for such item or serv-
7 ice shall—

8 “(i) taking into account only the con-
9 siderations specified in subparagraph
10 (C)(i), select one of the offers submitted
11 under subparagraph (B) to be the amount
12 of payment for such item or service deter-
13 mined under this subsection for purposes
14 of subsection (b)(1), (e)(1), or (i)(1), as
15 applicable; and

16 “(ii) notify the provider or facility and
17 the health plan party to such determina-
18 tion of the offer selected under clause (i).

19 “(B) SUBMISSION OF OFFERS.—Not later
20 than 10 days after the date of initiation of the
21 mediated dispute resolution with respect to a
22 determination for a qualified mediated dispute
23 item or service, the provider or facility and the
24 health plan party to such determination shall

1 each submit to the selected independent enti-
2 ty—

3 “(i) an offer for a payment amount
4 under for such item or service furnished by
5 such provider or facility;

6 “(ii) information relating to such
7 offer; and

8 “(iii) such other information as re-
9 quested by the selected independent entity.

10 “(C) CONSIDERATIONS.—

11 “(i) IN GENERAL.—For purposes of
12 subparagraph (A), the considerations spec-
13 ified in this subparagraph, with respect to
14 a determination for a qualified mediated
15 dispute item or service, are the following:

16 “(I) The median contracted rate
17 for such item or service.

18 “(II) Subject to clause (ii), infor-
19 mation that is submitted pursuant to
20 subparagraph (B).

21 “(ii) TREATMENT OF CERTAIN CON-
22 siderations.—In making a determination
23 with respect to a qualified mediated dis-
24 pute item or service pursuant to subpara-
25 graph (A)(i), a selected independent entity

1 may not take into account usual and cus-
2 tomary charges for the item or service nor
3 charges billed by the provider or facility for
4 the item or service.

5 “(6) SELECTED INDEPENDENT ENTITY COM-
6 PENSATION.—

7 “(A) IN GENERAL.—Not later than 5 days
8 after receiving a notification described in para-
9 graph (5)(A)(ii) from a selected independent
10 entity with respect to the determination of a
11 payment amount for a qualified mediated dis-
12 pute item or service, the party to such deter-
13 mination whose offer submitted under para-
14 graph (5)(B) was not selected by the entity
15 shall pay to such entity a fee in compensation
16 for the services of such entity in accordance
17 with the guidelines on such compensation estab-
18 lished by the Secretary under subparagraph
19 (B).

20 “(B) GUIDELINES ON COMPENSATION.—
21 For purposes of subparagraph (A), the Sec-
22 retary shall establish guidelines with respect to
23 the compensation of a selected independent en-
24 tity for the services of such entity with respect
25 to determinations under the mediated dispute

1 process. Such guidelines shall provide that such
2 compensation reimburses the entity for at least
3 the costs of such entity in performing the duties
4 of the entity under the mediated dispute proc-
5 ess.

6 “(7) CERTIFICATION OF ENTITIES.—

7 “(A) IN GENERAL.—The Secretary shall
8 establish or recognize a process to certify (in-
9 cluding recertification of) entities under this
10 paragraph. Such process shall ensure that an
11 entity so certified—

12 “(i) has (directly or through contracts
13 or other arrangements) sufficient medical,
14 legal, and other expertise and sufficient
15 staffing to make determinations described
16 in paragraph (2) on a timely basis;

17 “(ii) is not—

18 “(I) a health plan, provider, or
19 facility;

20 “(II) an affiliate or a subsidiary
21 of a health plan, provider, or facility;
22 or

23 “(III) an affiliate or subsidiary of
24 a professional or trade association of

1 health plans or of providers or facili-
2 ties;

3 “(iii) carries out the responsibilities of
4 such an entity in accordance with this sub-
5 section;

6 “(iv) meets appropriate indicators of
7 fiscal integrity;

8 “(v) maintains the confidentiality (in
9 accordance with regulations promulgated
10 by the Secretary) of individually identifi-
11 able health information obtained in the
12 course of conducting such determinations;

13 “(vi) does not under the mediated dis-
14 pute process carry out any determination
15 with respect to which the entity would not
16 pursuant to clause (i), (ii), or (iii) of para-
17 graph (3)(A) be eligible for selection; and

18 “(vii) meets such other requirements
19 as determined appropriate by the Sec-
20 retary.

21 “(B) PERIOD OF CERTIFICATION.—Subject
22 to subparagraph (C), each certification (includ-
23 ing a recertification) of an entity under the
24 process described in subparagraph (A) shall be
25 for a 5-year period.

1 “(C) REVOCATION.—A certification of an
2 entity under this paragraph may be revoked
3 under the process described in subparagraph
4 (A) if the entity has a pattern or practice of
5 noncompliance with any of the requirements de-
6 scribed in such subparagraph.

7 “(D) PETITION FOR DENIAL OR WITH-
8 DRAWAL.—The process described in subpara-
9 graph (A) shall ensure that an individual, pro-
10 vider, facility, or health plan may petition for a
11 denial of a certification or a revocation of a cer-
12 tification with respect to an entity under this
13 paragraph for failure of meeting a requirement
14 of this subsection.

15 “(E) SUFFICIENT NUMBER OF ENTI-
16 TIES.—The process described in subparagraph
17 (A) shall ensure that a sufficient number of en-
18 tities are certified under this paragraph to en-
19 sure the timely and efficient provision of deter-
20 minations described in paragraph (2).

21 “(F) PROVISION OF INFORMATION.—

22 “(i) IN GENERAL.—An entity certified
23 under this paragraph shall provide to the
24 Secretary, in such manner as the Secretary
25 may require and on a quarterly basis (as

1 specified by the Secretary), such informa-
2 tion as the Secretary determines appro-
3 priate to assure compliance with the re-
4 quirements described in subparagraph (A)
5 and to monitor and assess the determina-
6 tions made by such entity and to ensure
7 the absence of bias in making such deter-
8 minations. Such information shall include
9 information described in clause (ii) but
10 shall not include individually identifiable
11 health information.

12 “(ii) INFORMATION TO BE IN-
13 CLUDED.—The information described in
14 this clause with respect to an entity is the
15 following:

16 “(I) The number of payment de-
17 terminations described in paragraph
18 (2) made by such entity,
19 disaggregated by—

20 “(aa) the line of business
21 (as specified in subsection
22 (k)(8)(C)) of the health plans
23 party to such determinations;
24 and

1 “(bb) the type of providers
2 and facilities party to such deter-
3 minations.

4 “(II) A description of each item
5 or service included in each such deter-
6 mination.

7 “(III) The amount of each offer
8 submitted to the entity for each such
9 determination.

10 “(IV) The amount of each such
11 determination.

12 “(V) The length of time in mak-
13 ing each such determination.

14 “(VI) The compensation paid to
15 such entity with respect to each such
16 determination.

17 “(VII) Any other information
18 specified by the Secretary.

19 “(8) ADMINISTRATIVE FEE.—

20 “(A) IN GENERAL.—Each party to a deter-
21 mination to which an entity is selected under
22 paragraph (3) in a year shall pay to the Sec-
23 retary, at such time and in such manner as
24 specified by the Secretary, a fee for partici-
25 pating in the mediated dispute process with re-

1 spect to such determination in an amount de-
2 scribed in subparagraph (B) for such year.

3 “(B) AMOUNT OF FEE.—The amount de-
4 scribed in this subparagraph for a year is an
5 amount established by the Secretary in a man-
6 ner such that the total amount of fees paid
7 under this paragraph for such year is estimated
8 to be equal to the amount of expenditures esti-
9 mated to be made by the Secretary for such
10 year in carrying out the mediated dispute proc-
11 ess.

12 “(9) SECRETARIAL REPORT; PUBLICATION OF
13 INFORMATION.—

14 “(A) SECRETARIAL REPORT.—Beginning
15 not later than July 1, 2023, the Secretary shall,
16 in coordination with the Secretary of Health
17 and Human Services and the Secretary of
18 Labor, periodically study and submit to Con-
19 gress a report on—

20 “(i) the extent to which the payment
21 amount determined under this subsection
22 for an item or service furnished in a year
23 (or otherwise agreed to by a health plan
24 and provider or facility for purposes of de-
25 termining payment by the plan to the pro-

1 vider or facility pursuant to subsection
2 (b)(1), (e)(1), or (i)(1)) differs from the
3 median contracted rate for such item or
4 service and year, including the number of
5 times such determined (or agreed to)
6 amount exceeds such median contracted
7 rate; and

8 “(ii) the effect of such difference on
9 the cost-sharing for such item or service
10 for a participant or beneficiary of a health
11 plan.

12 “(B) PUBLICATION OF INFORMATION.—
13 Beginning with July 1, 2023, and for each cal-
14 endar quarter thereafter, the Secretary shall, in
15 coordination with the Secretary of Health and
16 Human Services and the Secretary of Labor,
17 make publicly available a summary of the fol-
18 lowing:

19 “(i) The information described in sub-
20 clauses (I) through (V) of clause (ii) of
21 paragraph (7)(F) that was submitted to
22 the Secretary under clause (i) of such
23 paragraph during such quarter.

1 “(ii) The amount of expenditures
2 made by the Secretary during such year to
3 carry out the mediated dispute process.

4 “(iii) The total amount of fees paid
5 under paragraph (8) during such quarter.

6 “(iv) The total amount of compensa-
7 tion paid to selected independent entities
8 under paragraph (6) during such quar-
9 ter.”.

10 (c) ERISA AMENDMENTS.—Section 716 of the Em-
11 ployee Retirement Income Security Act of 1974, as added
12 by section 2(c) and amended by sections 3(c), 5(c), and
13 6(c), is further amended by inserting before subsection (k)
14 the following new subsection:

15 “(j) DETERMINATION OF OUT-OF-NETWORK RATES
16 TO BE PAID BY HEALTH PLANS.—

17 “(1) DETERMINATION THROUGH OPEN NEGO-
18 TIATION.—

19 “(A) IN GENERAL.—With respect to an
20 item or service furnished in a year by a non-
21 participating provider or a nonparticipating fa-
22 cility, with respect to a health plan, in a State
23 described in subparagraph (B) of subsection
24 (k)(11) with respect to such plan and provider
25 or facility, and for which a payment is required

1 to be made by the health plan pursuant to sub-
2 section (b)(1), (e)(1), or (i)(1), the provider or
3 facility (as applicable) or plan may, during the
4 30-day period beginning on the day the provider
5 or facility receives a response from the plan re-
6 garding a claim for payment for such item or
7 service, initiate open negotiations under this
8 paragraph between such provider or facility and
9 plan for purposes of determining, during the
10 open negotiation period, an amount agreed on
11 by such provider or facility, respectively, and
12 such plan for payment (including any cost-shar-
13 ing) for such item or service. For purposes of
14 this subsection, the open negotiation period,
15 with respect to an item or service, is the 30-day
16 period beginning on the date of initiation of the
17 negotiations with respect to such item or serv-
18 ice.

19 “(B) EXCHANGE OF INFORMATION.—In
20 carrying out negotiations initiated under sub-
21 paragraph (A), with respect to an item or serv-
22 ice described in such subparagraph furnished in
23 a year, not later than the fifth business day of
24 the open negotiation period described in such

1 subparagraph with respect to such item or serv-
2 ice—

3 “(i) the health plan that is party to
4 such negotiations shall notify the provider
5 or facility that is party to such negotia-
6 tions of the median contracted rate for
7 such item or service and year; and

8 “(ii) such provider or facility shall no-
9 tify such health plan of—

10 “(I) the median of the total
11 amount of reimbursement (including
12 any cost-sharing) paid, for the most
13 recent year for which information is
14 available, to such provider or facility
15 for furnishing such item or service to
16 a participant or beneficiary of a
17 health plan that, at the time such
18 item or service was furnished, had a
19 contract in effect with such provider
20 or facility with respect to the fur-
21 nishing of such item or service;

22 “(II) in the case that information
23 described in subclause (I) is not avail-
24 able, such information as specified by
25 the Secretary; and

1 “(III) any additional information
2 specified by the Secretary.

3 “(C) ACCESSING MEDIATED DISPUTE
4 PROCESS IN CASE OF FAILED NEGOTIATIONS.—
5 In the case of open negotiations pursuant to
6 subparagraph (A), with respect to an item or
7 service, that do not result in a determination of
8 an amount of payment for such item or service
9 by the last day of the open negotiation period
10 described in such subparagraph with respect to
11 such item or service, the provider or facility (as
12 applicable) or health plan that was party to
13 such negotiations may, during the 2-day period
14 beginning on the day after such open negotia-
15 tion period, initiate the mediated dispute proc-
16 ess under paragraph (2) with respect to such
17 item or service. The mediated dispute process
18 shall be initiated by a party pursuant to the
19 previous sentence by submission to the other
20 party and to the Secretary of a notification
21 (containing such information as specified by the
22 Secretary) and for purposes of this subsection,
23 the date of initiation of such process shall be
24 the date of such submission or such other date
25 specified by the Secretary pursuant to regula-

1 tions that is not later than the date of receipt
2 of such notification by both the other party and
3 the Secretary.

4 “(2) MEDIATED DISPUTE PROCESS AVAILABLE
5 IN CASE OF FAILED OPEN NEGOTIATIONS.—

6 “(A) ESTABLISHMENT.—Not later than
7 July 1, 2021, the Secretary, in coordination
8 with the Secretary of Health and Human Serv-
9 ices and the Secretary of the Treasury, shall es-
10 tablish a process (in this subsection referred to
11 as the ‘mediated dispute process’) under which,
12 in the case of an item or service with respect
13 to which a provider or facility (as applicable) or
14 health plan submits a notification under para-
15 graph (1)(C) (in this subsection referred to as
16 a ‘qualified mediated dispute item or service’),
17 an entity selected under paragraph (3) deter-
18 mines, subject to subparagraph (B) and in ac-
19 cordance with the succeeding provisions of this
20 subsection, the amount of payment under the
21 health plan for such item or service furnished
22 by such provider or facility.

23 “(B) AUTHORITY TO CONTINUE NEGOTIA-
24 TIONS.—Under the mediated dispute process, in
25 the case that the parties to a determination for

1 a qualified mediated dispute item or service
2 agree on a payment amount for such item or
3 service during such process but before the date
4 on which the entity selected with respect to
5 such determination under paragraph (3) makes
6 such determination, such amount shall be treat-
7 ed for purposes of subsection (k)(11)(B) as the
8 amount agreed to by such parties for such item
9 or service. In the case of an agreement de-
10 scribed in the previous sentence, the mediated
11 dispute process shall provide for a method to
12 determine how to allocate between the parties
13 to such determination the payment of the com-
14 pensation of the entity selected with respect to
15 such determination.

16 “(3) SELECTION UNDER MEDIATED DISPUTE
17 PROCESS.—Under the mediated dispute process, the
18 Secretary shall, with respect to the determination of
19 the amount of payment under this subsection of a
20 qualified mediated dispute item or service, provide
21 for a method—

22 “(A) that allows the parties to such deter-
23 mination to jointly select, not later than the last
24 day of the 3-day period following the date of
25 the initiation of the process with respect to such

1 item or service, for purposes of making such de-
2 termination, an entity certified under paragraph
3 (7) that—

4 “(i) is not a party to such determina-
5 tion or an employee or agent of such a
6 party;

7 “(ii) does not have a material familial,
8 financial, or professional relationship with
9 such a party; and

10 “(iii) does not otherwise have a con-
11 flict of interest with such a party (as de-
12 termined by the Secretary); and

13 “(B) that requires, in the case such parties
14 do not make such selection by such last day,
15 the Secretary to, not later than 6 days after
16 such date of initiation—

17 “(i) select such an entity that satisfies
18 clauses (i) through (iii) of subparagraph
19 (A); and

20 “(ii) provide notification of such selec-
21 tion to the provider or facility (as applica-
22 ble) and the health plan party to such de-
23 termination.

24 An entity selected pursuant to the previous sentence
25 to make a determination described in such sentence

1 shall be referred to in this subsection as the ‘selected
 2 independent entity’ with respect to such determina-
 3 tion.

4 “(4) TREATMENT OF CONSIDERATION OF MUL-
 5 TIPLE ITEMS AND SERVICES.—

6 “(A) IN GENERAL.—Under the mediated
 7 dispute process, the Secretary shall specify cri-
 8 teria under which multiple qualified mediated
 9 dispute items and services are permitted to be
 10 considered jointly as part of a single determina-
 11 tion by an entity for purposes of encouraging
 12 the efficiency (including minimizing costs) of
 13 the mediated dispute process. Such items and
 14 services may be so considered only if—

15 “(i) such items and services to be in-
 16 cluded in such determination are furnished
 17 by the same provider or facility;

18 “(ii) payment for such items and serv-
 19 ices is required to be made by the same
 20 health plan; and

21 “(iii) such items and services are re-
 22 lated to the treatment of a similar condi-
 23 tion.

24 “(B) TREATMENT OF BUNDLED PAY-
 25 MENTS.—In carrying out subparagraph (A), the

1 Secretary shall provide that, in the case of
2 items and services which are included by a pro-
3 vider or facility as part of a bundled payment,
4 such items and services included in such bun-
5 dled payment may be part of a single deter-
6 mination under this subsection.

7 “(C) WAIVER OF DEADLINES.—For pur-
8 poses of permitting joint consideration of quali-
9 fied mediated dispute items and services as part
10 of a single determination under the criteria
11 specified pursuant to subparagraph (A), the
12 Secretary may waive any deadline specified in
13 this subsection.

14 “(5) DETERMINATION OF PAYMENT AMOUNT.—

15 “(A) IN GENERAL.—Not later than 30
16 days after the date of initiation of the mediated
17 dispute resolution, with respect to a qualified
18 mediated dispute item or service, the selected
19 independent entity with respect to a determina-
20 tion under this subsection for such item or serv-
21 ice shall—

22 “(i) taking into account only the con-
23 siderations specified in subparagraph
24 (C)(i), select one of the offers submitted
25 under subparagraph (B) to be the amount

1 of payment for such item or service deter-
2 mined under this subsection for purposes
3 of subsection (b)(1), (e)(1), or (i)(1), as
4 applicable; and

5 “(ii) notify the provider or facility and
6 the health plan party to such determina-
7 tion of the offer selected under clause (i).

8 “(B) SUBMISSION OF OFFERS.—Not later
9 than 10 days after the date of initiation of the
10 mediated dispute resolution with respect to a
11 determination for a qualified mediated dispute
12 item or service, the provider or facility and the
13 health plan party to such determination shall
14 each submit to the selected independent enti-
15 ty—

16 “(i) an offer for a payment amount
17 under for such item or service furnished by
18 such provider or facility;

19 “(ii) information relating to such
20 offer; and

21 “(iii) such other information as re-
22 quested by the selected independent entity.

23 “(C) CONSIDERATIONS.—

24 “(i) IN GENERAL.—For purposes of
25 subparagraph (A), the considerations spec-

ified in this subparagraph, with respect to a determination for a qualified mediated dispute item or service, are the following:

“(I) The median contracted rate for such item or service.

“(II) Subject to clause (ii), information that is submitted pursuant to subparagraph (B).

“(ii) TREATMENT OF CERTAIN CONSIDERATIONS.—In making a determination with respect to a qualified mediated dispute item or service pursuant to subparagraph (A)(i), a selected independent entity may not take into account usual and customary charges for the item or service nor charges billed by the provider or facility for the item or service.

“(6) SELECTED INDEPENDENT ENTITY COMPENSATION.—

“(A) IN GENERAL.—Not later than 5 days after receiving a notification described in paragraph (5)(A)(ii) from a selected independent entity with respect to the determination of a payment amount for a qualified mediated dispute item or service, the party to such deter-

1 mination whose offer submitted under para-
2 graph (5)(B) was not selected by the entity
3 shall pay to such entity a fee in compensation
4 for the services of such entity in accordance
5 with the guidelines on such compensation estab-
6 lished by the Secretary under subparagraph
7 (B).

8 “(B) GUIDELINES ON COMPENSATION.—
9 For purposes of subparagraph (A), the Sec-
10 retary shall establish guidelines with respect to
11 the compensation of a selected independent en-
12 tity for the services of such entity with respect
13 to determinations under the mediated dispute
14 process. Such guidelines shall provide that such
15 compensation reimburses the entity for at least
16 the costs of such entity in performing the duties
17 of the entity under the mediated dispute proc-
18 ess.

19 “(7) CERTIFICATION OF ENTITIES.—

20 “(A) IN GENERAL.—The Secretary shall
21 establish or recognize a process to certify (in-
22 cluding recertification of) entities under this
23 paragraph. Such process shall ensure that an
24 entity so certified—

1 “(i) has (directly or through contracts
2 or other arrangements) sufficient medical,
3 legal, and other expertise and sufficient
4 staffing to make determinations described
5 in paragraph (2) on a timely basis;

6 “(ii) is not—

7 “(I) a health plan, provider, or
8 facility;

9 “(II) an affiliate or a subsidiary
10 of a health plan, provider, or facility;
11 or

12 “(III) an affiliate or subsidiary of
13 a professional or trade association of
14 health plans or of providers or facili-
15 ties;

16 “(iii) carries out the responsibilities of
17 such an entity in accordance with this sub-
18 section;

19 “(iv) meets appropriate indicators of
20 fiscal integrity;

21 “(v) maintains the confidentiality (in
22 accordance with regulations promulgated
23 by the Secretary) of individually identifi-
24 able health information obtained in the
25 course of conducting such determinations;

1 “(vi) does not under the mediated dis-
2 pute process carry out any determination
3 with respect to which the entity would not
4 pursuant to clause (i), (ii), or (iii) of para-
5 graph (3)(A) be eligible for selection; and

6 “(vii) meets such other requirements
7 as determined appropriate by the Sec-
8 retary.

9 “(B) PERIOD OF CERTIFICATION.—Subject
10 to subparagraph (C), each certification (includ-
11 ing a recertification) of an entity under the
12 process described in subparagraph (A) shall be
13 for a 5-year period.

14 “(C) REVOCATION.—A certification of an
15 entity under this paragraph may be revoked
16 under the process described in subparagraph
17 (A) if the entity has a pattern or practice of
18 noncompliance with any of the requirements de-
19 scribed in such subparagraph.

20 “(D) PETITION FOR DENIAL OR WITH-
21 DRAWAL.—The process described in subpara-
22 graph (A) shall ensure that an individual, pro-
23 vider, facility, or health plan may petition for a
24 denial of a certification or a revocation of a cer-
25 tification with respect to an entity under this

1 paragraph for failure of meeting a requirement
2 of this subsection.

3 “(E) SUFFICIENT NUMBER OF ENTI-
4 TIES.—The process described in subparagraph
5 (A) shall ensure that a sufficient number of en-
6 tities are certified under this paragraph to en-
7 sure the timely and efficient provision of deter-
8 minations described in paragraph (2).

9 “(F) PROVISION OF INFORMATION.—

10 “(i) IN GENERAL.—An entity certified
11 under this paragraph shall provide to the
12 Secretary, in such manner as the Secretary
13 may require and on a quarterly basis (as
14 specified by the Secretary), such informa-
15 tion as the Secretary determines appro-
16 priate to assure compliance with the re-
17 quirements described in subparagraph (A)
18 and to monitor and assess the determina-
19 tions made by such entity and to ensure
20 the absence of bias in making such deter-
21 minations. Such information shall include
22 information described in clause (ii) but
23 shall not include individually identifiable
24 health information.

1 “(ii) INFORMATION TO BE IN-
2 CLUDED.—The information described in
3 this clause with respect to an entity is the
4 following:

5 “(I) The number of payment de-
6 terminations described in paragraph
7 (2) made by such entity,
8 disaggregated by—

9 “(aa) the line of business
10 (as specified in subsection
11 (k)(8)(C)) of the health plans
12 party to such determinations;
13 and

14 “(bb) the type of providers
15 and facilities party to such deter-
16 minations.

17 “(II) A description of each item
18 or service included in each such deter-
19 mination.

20 “(III) The amount of each offer
21 submitted to the entity for each such
22 determination.

23 “(IV) The amount of each such
24 determination.

1 “(V) The length of time in mak-
2 ing each such determination.

3 “(VI) The compensation paid to
4 such entity with respect to each such
5 determination.

6 “(VII) Any other information
7 specified by the Secretary.

8 “(8) ADMINISTRATIVE FEE.—

9 “(A) IN GENERAL.—Each party to a deter-
10 mination to which an entity is selected under
11 paragraph (3) in a year shall pay to the Sec-
12 retary, at such time and in such manner as
13 specified by the Secretary, a fee for partici-
14 pating in the mediated dispute process with re-
15 spect to such determination in an amount de-
16 scribed in subparagraph (B) for such year.

17 “(B) AMOUNT OF FEE.—The amount de-
18 scribed in this subparagraph for a year is an
19 amount established by the Secretary in a man-
20 ner such that the total amount of fees paid
21 under this paragraph for such year is estimated
22 to be equal to the amount of expenditures esti-
23 mated to be made by the Secretary for such
24 year in carrying out the mediated dispute proc-
25 ess.

1 “(9) SECRETARIAL REPORT; PUBLICATION OF
2 INFORMATION.—

3 “(A) SECRETARIAL REPORT.—Beginning
4 not later than July 1, 2023, the Secretary shall,
5 in coordination with the Secretary of Health
6 and Human Services and the Secretary of the
7 Treasury, periodically study and submit to Con-
8 gress a report on—

9 “(i) the extent to which the payment
10 amount determined under this subsection
11 for an item or service furnished in a year
12 (or otherwise agreed to by a health plan
13 and provider or facility for purposes of de-
14 termining payment by the plan to the pro-
15 vider or facility pursuant to subsection
16 (b)(1), (e)(1), or (i)(1)) differs from the
17 median contracted rate for such item or
18 service and year, including the number of
19 times such determined (or agreed to)
20 amount exceeds such median contracted
21 rate; and

22 “(ii) the effect of such difference on
23 the cost-sharing for such item or service
24 for a participant or beneficiary of a health
25 plan.

1 “(B) PUBLICATION OF INFORMATION.—
2 Beginning with July 1, 2023, and for each cal-
3 endar quarter thereafter, the Secretary shall, in
4 coordination with the Secretary of Health and
5 Human Services and the Secretary of Labor,
6 make publicly available a summary of the fol-
7 lowing:

8 “(i) The information described in sub-
9 clauses (I) through (V) of clause (ii) of
10 paragraph (7)(F) that was submitted to
11 the Secretary under clause (i) of such
12 paragraph during such quarter.

13 “(ii) The amount of expenditures
14 made by the Secretary during such year to
15 carry out the mediated dispute process.

16 “(iii) The total amount of fees paid
17 under paragraph (8) during such quarter.

18 “(iv) The total amount of compensa-
19 tion paid to selected independent entities
20 under paragraph (6) during such quar-
21 ter.”.

22 (d) RULE OF CONSTRUCTION.—Nothing in this Act,
23 or the amendment made by this Act, shall be construed
24 as removing any obligation of a health plan (as defined
25 in subsection (k)(6) of section 2719A of the Public Health

1 Service Act (42 U.S.C. 300gg–19A), as amended by this
2 Act) to provide payment to a health care provider or
3 health care facility for items and services furnished by
4 such provider or facility to an individual enrolled in such
5 plan.

6 **SEC. 8. PROHIBITING BALANCE BILLING PRACTICES BY**
7 **PROVIDERS FOR EMERGENCY SERVICES, FOR**
8 **SERVICES FURNISHED BY NONPARTICI-**
9 **PATING PROVIDER AT PARTICIPATING FACIL-**
10 **ITY, AND IN CERTAIN CASES OF MISINFORMA-**
11 **TION.**

12 (a) NO BALANCE BILLING.—Part A of title XI of the
13 Social Security Act (42 U.S.C. 1301 et seq.) is amended
14 by adding at the end the following new section:

15 **“SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING**
16 **PRACTICES.**

17 “(a) EMERGENCY SERVICES.—In the case of an indi-
18 vidual with benefits under a group health plan or health
19 insurance coverage offered in the group or individual mar-
20 ket who is furnished in a plan year that begins on or after
21 January 1, 2022, emergency services with respect to an
22 emergency medical condition during a visit at an emer-
23 gency department of a hospital or an independent free-
24 standing emergency department—

1 “(1) if the hospital or independent freestanding
2 emergency department does not have a contractual
3 relationship with such plan or coverage for fur-
4 nishing such services, the hospital or independent
5 freestanding emergency department shall not bill,
6 and shall not hold liable, the individual for a pay-
7 ment amount for such emergency services so fur-
8 nished that is more than the cost-sharing amount
9 for such services (as determined in accordance with
10 section 2719A(b) of the Public Health Service Act,
11 section 716(b) of the Employee Retirement Income
12 Security Act of 1974, or section 9816(b) of the In-
13 ternal Revenue Code of 1986, as applicable); and

14 “(2) a health care provider without a contrac-
15 tual relationship with such plan or coverage for fur-
16 nishing such services shall not bill, and shall not
17 hold liable, such individual for a payment amount
18 for such services furnished to such individual by
19 such provider with respect to such emergency med-
20 ical condition and visit for which the individual re-
21 ceives emergency services at the emergency depart-
22 ment of the hospital or independent freestanding
23 emergency department that is more than the cost-
24 sharing amount for such services furnished by the
25 provider (as determined in accordance with section

1 2719A(b) of the Public Health Service Act, section
2 716(b) of the Employee Retirement Income Security
3 Act of 1974, or section 9816(b) of the Internal Rev-
4 enue Code of 1986, as applicable).

5 “(b) SERVICES FURNISHED BY NONPARTICIPATING
6 PROVIDER AT PARTICIPATING FACILITY.—

7 “(1) IN GENERAL.—Subject to paragraph (2),
8 in the case of an individual with benefits under a
9 health plan who is furnished items or services (other
10 than emergency services to which subsection (a) ap-
11 plies or items and services to which subsection (c)
12 applies) in a plan year that, with respect to such
13 plan or such coverage (as applicable), begins on or
14 after January 1, 2022, at a participating facility by
15 a nonparticipating provider, such provider shall not
16 bill, and shall not hold liable, such individual for a
17 payment amount for such an item or service fur-
18 nished by such provider during a visit at such facil-
19 ity that is more than the cost-sharing amount for
20 such item or service (as determined in accordance
21 with section 2719A(e) of the Public Health Service
22 Act, section 716(e) of the Employee Retirement In-
23 come Security Act of 1974, or section 9816(e) of the
24 Internal Revenue Code of 1986, as applicable).

1 “(2) EXCEPTION IN CASE NOTICE PROVIDED.—

2 Paragraph (1) shall not apply with respect to items
3 and services (other than items and services described
4 in paragraph (3)) furnished to an individual enrolled
5 in a group health plan or in health insurance cov-
6 erage offered in the group or individual market by
7 a health care provider that does not have a contrac-
8 tual relationship with such plan or coverage for fur-
9 nishing such items and services if the following cri-
10 teria are met:

11 “(A) A written notice (as specified by the
12 Secretary and in clear and understandable lan-
13 guage) is provided by the provider to such indi-
14 vidual, not later than 48 hours before such
15 items and services are to be so furnished, that
16 includes the following information:

17 “(i) A statement verifying that the
18 provider does not have such a relationship
19 with such plan or coverage.

20 “(ii) The estimated amount that such
21 provider may charge the individual for
22 such items and services.

23 “(iii) A statement that the individual
24 may seek such items or services from a
25 health care provider that does have such a

1 contractual relationship and a list, if fea-
2 sible, of providers with such a relationship
3 who are able to furnish such items and
4 services involved.

5 “(B) On the date such item or service is
6 to be furnished, before such item or service is
7 so furnished, the individual signs and dates
8 such notice confirming receipt of the notice and
9 consent of the individual to be so furnished
10 such items and services.

11 “(C) A copy of such signed and dated no-
12 tice is provided by the provider to the plan or
13 coverage.

14 “(3) ITEMS AND SERVICES DESCRIBED.—The
15 items and services described in this paragraph are
16 items and services furnished by a specified provider
17 (as defined in subsection (f)(3)).

18 “(c) RELIANCE ON INCORRECT PROVIDER INFORMA-
19 TION.—In the case of an individual who is furnished items
20 or services by a health care provider or health care facility
21 for which a group health plan or health insurance issuer
22 is required to make payment under section 2719A(i) of
23 the Public Health Service Act, section 716(i) of the Em-
24 ployee Retirement Income Security Act of 1974, or section
25 9816(i) of the Internal Revenue Code of 1986, such pro-

1 vider or facility shall not bill, and shall not hold liable,
2 such individual for a payment amount for such an item
3 or service that is more than the cost-sharing amount for
4 such item or service (as determined in accordance with
5 section 2719A(i) of the Public Health Service Act, section
6 716(i) of the Employee Retirement Income Security Act
7 of 1974, or section 9816(i) of the Internal Revenue Code
8 of 1986, as applicable).

9 “(d) COMPLIANCE WITH REQUIREMENTS UNDER
10 OPEN NEGOTIATION AND MEDIATED DISPUTE RESOLU-
11 TION PROCESSES.—A health care provider or health care
12 facility shall comply with any requirement imposed on
13 such provider or facility, respectively, under section
14 2719A(j) of the Public Health Service Act, 9816(j) of the
15 Internal Revenue Code of 1986, or 716(j) of the Employee
16 Retirement Income Security Act of 1974.

17 “(e) PENALTY.—

18 “(1) IN GENERAL.—Any health care provider or
19 health care facility that violates a provision of this
20 section shall be subject to a civil monetary penalty
21 in an amount not to exceed \$10,000 for each such
22 violation.

23 “(2) APPLICATION OF PROVISIONS.—The provi-
24 sions of section 1128A (other than subsection (a),
25 subsection (b), the first sentence of subsection

1 (c)(1), and subsection (o)) shall apply with respect
2 to a civil monetary penalty imposed under this sub-
3 section in the same manner as such provisions apply
4 with respect to a penalty or proceeding under sub-
5 section (a) of such section.

6 “(f) DEFINITIONS.—For purposes of this section and
7 sections 1150D and 1150E:

8 “(1) The terms ‘during a visit’, ‘emergency de-
9 partment of a hospital’, ‘emergency medical condi-
10 tion’, ‘emergency services’, ‘independent freestanding
11 emergency department’, ‘nonparticipating provider’,
12 ‘nonparticipating facility’, ‘participating facility’,
13 ‘participating provider’ have the meanings given
14 such terms, respectively, in section 2719A(k) of the
15 Public Health Service Act.

16 “(2) The terms ‘group health plan’, ‘group mar-
17 ket’, ‘health insurance issuer’, ‘health insurance cov-
18 erage’, and ‘individual market’ have the meanings
19 given such terms, respectively, in section 2791 of the
20 Public Health Service Act.

21 “(3) The term ‘specified provider’, with respect
22 to an individual with benefits under a group health
23 plan or health insurance coverage and a hospital
24 with a contractual relationship with such plan or
25 coverage for furnishing items and services—

“(A) means an ancillary health care provider, including emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers determined by the Secretary (including providers who furnish similar items and services as the providers specified in this paragraph); and

“(B) includes, with respect to an item or service, any health care provider furnishing such item or service at such hospital if there is no health care provider at such hospital who can furnish such item or service who has such a relationship with such plan or coverage for furnishing such item or service.”.

(b) PROVIDER DIRECTORY; PATIENT-PROVIDER DISPUTE RESOLUTION PROCESS.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by subsection (a), is further amended by adding at the end the following new sections:

“SEC. 1150D. PATIENT PROTECTIONS AGAINST SURPRISE BILLING THROUGH TRANSPARENCY.

“(a) SUBMISSION OF INFORMATION TO HEALTH PLANS OF CERTAIN PROVIDER INFORMATION.—Beginning not later than 1 year after the date of the enactment

1 of this section, each health care provider and health care
2 facility shall establish a process under which such provider
3 or facility transmits, to each health insurance issuer offer-
4 ing group or individual health insurance coverage and
5 group health plan with which such provider or supplier
6 has in effect a contractual relationship for furnishing
7 items and services under such coverage or such plan, pro-
8 vider directory information (as defined in section
9 2719A(f)(6) of the Public Health Service Act, section
10 716(f)(6) of the Employee Retirement Income Security
11 Act of 1974, or section 9816(f)(6) of the Internal Revenue
12 Code of 1986, as applicable) with respect to such provider
13 or facility, as applicable. Such provider or facility shall so
14 transmit such information to such issuer offering such
15 coverage or such group health plan—

16 “(1) when there are any material changes (in-
17 cluding a change in address, telephone number, or
18 other contact information) to such provider directory
19 information of the provider or facility with respect to
20 such coverage offered by such issuer or with respect
21 to such plan; and

22 “(2) at any other time (including upon the re-
23 quest of such issuer or plan) determined appropriate
24 by the provider, facility, or the Secretary.

1 “(b) PROVISION OF INFORMATION UPON REQUEST
2 AND FOR SCHEDULED APPOINTMENTS.—Each health care
3 provider and health care facility shall, beginning January
4 1, 2022, in the case of an individual who schedules an
5 item or service to be furnished to such individual by such
6 provider or facility at least 3 business days before the date
7 such item or service is to be so furnished, not later than
8 1 business day after the date of such scheduling (or, in
9 the case of such an item or service scheduled at least 10
10 business days before the date such item or service is to
11 be so furnished (or if requested by the individual), not
12 later than 3 business days after the date of such sched-
13 uling or such request)—

14 “(1) inquire if such individual is enrolled in a
15 group health plan, group or individual health insur-
16 ance coverage offered by a health insurance issuer,
17 or a Federal health care program (and if is so en-
18 rolled in such plan or coverage, seeking to have a
19 claim for such item or service submitted to such
20 plan or coverage); and

21 “(2) provide a notification (in clear and under-
22 standable language) of the good faith estimate of the
23 expected charges for furnishing such item or service
24 (including any item or service that is reasonably ex-

1 pected to be provided in conjunction with such
2 scheduled item or service) to—

3 “(A) in the case the individual is enrolled
4 in such a plan or such coverage (and is seeking
5 to have a claim for such item or service sub-
6 mitted to such plan or coverage), such plan or
7 issuer of such coverage; and

8 “(B) in the case the individual is not de-
9 scribed in subparagraph (A) and not enrolled in
10 a Federal health care program, the individual.

11 “(c) CONTINUITY OF CARE.—A health care provider
12 or health care facility shall, in the case of an individual
13 furnished items and services by such provider or facility
14 for which coverage is provided under a group health plan
15 or group or individual health insurance coverage pursuant
16 to section 2730 of such Act, section 9817 of the Internal
17 Revenue Code of 1986, or section 717 of the Employee
18 Retirement Income Security Act of 1974—

19 “(1) accept payment from such plan or such
20 issuer (as applicable) (and cost-sharing from such
21 individual, if applicable, in accordance with sub-
22 section (a)(2)(C) of such section 2730, 9817, or
23 717) for such items and services as payment in full
24 for such items and services; and

1 “(2) continue to adhere to all policies, proce-
2 dures, and quality standards imposed by such plan
3 or issuer with respect to such individual and such
4 items and services in the same manner as if such
5 termination had not occurred.

6 “(d) LIMITATION.—Beginning on January 1, 2022,
7 a health care provider or health care facility may not ini-
8 tiate a process to seek reimbursement of payment for
9 items and services furnished to an individual enrolled in
10 a group health plan or health insurance coverage offered
11 in the group or individual market more than 1 year after
12 the date on which such items and services were so fur-
13 nished.

14 “(e) PENALTY.—

15 “(1) GENERAL PENALTY.—

16 “(A) IN GENERAL.—Except as provided in
17 paragraph (2), any health care provider or
18 health care facility that violates a provision of
19 this section shall be subject to a civil monetary
20 penalty in an amount not to exceed \$10,000 for
21 each such violation.

22 “(B) APPLICATION OF PROVISIONS.—The
23 provisions of section 1128A (other than sub-
24 section (a), subsection (b), the first sentence of
25 subsection (c)(1), and subsection (o)) shall

1 apply with respect to a civil monetary penalty
2 imposed under this paragraph in the same man-
3 ner as such provisions apply with respect to a
4 penalty or proceeding under subsection (a) of
5 such section.

6 “(2) PROVIDER DIRECTORY INFORMATION PEN-
7 ALTY.—

8 “(A) IN GENERAL.—Each health care pro-
9 vider or health care facility that fails to trans-
10 mit information as required under subsection
11 (a) shall be subject to a civil monetary penalty
12 of \$1,000 for each day such provider or facility
13 (as applicable) fails to so transmit such infor-
14 mation.

15 “(B) APPLICATION OF PROVISIONS.—The
16 provisions of section 1128A (other than sub-
17 section (a), subsection (b), the first sentence of
18 subsection (c)(1), subsection (d), and subsection
19 (o)) shall apply with respect to a civil monetary
20 penalty imposed under this paragraph in the
21 same manner as such provisions apply with re-
22 spect to a penalty or proceeding under sub-
23 section (a) of such section.

1 **“SEC. 1150E. PATIENT-PROVIDER DISPUTE RESOLUTION.**

2 “(a) IN GENERAL.—Not later than July 1, 2021, the
3 Secretary shall establish a process (in this subsection re-
4 ferred to as the ‘patient-provider dispute resolution proc-
5 ess’) under which an uninsured individual, with respect
6 to an item or service, who received, pursuant to section
7 1150D(b), from a health care provider or health care facil-
8 ity a good-faith estimate of the expected charges for fur-
9 nishing such item or service to such individual and who
10 after being furnished such item or service by such provider
11 or facility is billed by such provider or facility for such
12 item or service for charges that are substantially in excess
13 of such estimate, may seek a determination from a se-
14 lected dispute resolution entity for the charges to be paid
15 by such individual (in lieu of such amount so billed) to
16 such provider or facility for such item or service. For pur-
17 poses of this subsection, the term ‘uninsured individual’
18 means, with respect to an item or service, an individual
19 who does not have benefits for such item or service under
20 a group health plan, health insurance coverage offered in
21 the group or individual market by a health insurance
22 issuer, Federal health care program (as defined in section
23 1128B(f)), or a health benefits plan under chapter 89 of
24 title 5, United States Code (or an individual who has bene-
25 fits for such item or service under a group health plan
26 or health insurance coverage offered in the group or indi-

1 vidual market by a health insurance issuer, but who does
2 not seek to have a claim for such item or service submitted
3 to such plan or coverage).

4 “(b) SELECTION OF ENTITIES.—Under the patient-
5 provider dispute resolution process, the Secretary shall,
6 with respect to a determination sought by an individual
7 under subsection (a), with respect to charges to be paid
8 by such individual to a health care provider or health care
9 facility described in such paragraph for an item or service
10 furnished to such individual by such provider or facility,
11 provide for—

12 “(1) a method to select to make such deter-
13 mination an entity certified under subsection (d)
14 that—

15 “(A) is not a party to such determination
16 or an employee or agent of such party;

17 “(B) does not have a material familial, fi-
18 nancial, or professional relationship with such a
19 party; and

20 “(C) does not otherwise have a conflict of
21 interest with such a party (as determined by
22 the Secretary); and

23 “(2) the provision of a notification of such se-
24 lection to the individual and the provider or facility
25 (as applicable) party to such determination.

1 An entity selected pursuant to the previous sentence to
 2 make a determination described in such sentence shall be
 3 referred to in this subsection as the ‘selected dispute reso-
 4 lution entity’ with respect to such determination.

5 “(c) ADMINISTRATIVE FEE.—The Secretary shall es-
 6 tablish a fee to participate in the patient-provider dispute
 7 resolution process in such a manner as to not create a
 8 barrier to an uninsured individual’s access to such process.

9 “(d) CERTIFICATION.—The Secretary shall establish
 10 or recognize a process to certify entities under this sub-
 11 paragraph. Such process shall ensure that an entity so cer-
 12 tified satisfies at least the criteria specified in section
 13 2719A(j)(7) of the Public Health Service Act.”.

14 **SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.**

15 (a) PUBLIC HEALTH SERVICE ACT.—Subpart II of
 16 part A of title XXVII of the Public Health Service Act
 17 (42 U.S.C. 300gg–11 et seq.) is amended by adding at
 18 the end the following new sections:

19 **“SEC. 2730. CONTINUITY OF CARE.**

20 “(a) ENSURING CONTINUITY OF CARE WITH RE-
 21 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
 22 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
 23 NETWORK STATUS.—

24 “(1) IN GENERAL.—In the case of an individual
 25 with benefits under a group health plan or group or

1 individual health insurance coverage offered by a
2 health insurance issuer and with respect to a health
3 care provider or facility that has a contractual rela-
4 tionship with such plan or such issuer (as applica-
5 ble) for furnishing items and services under such
6 plan or such coverage, if, while such individual is a
7 continuing care patient (as defined in subsection (b))
8 with respect to such provider or facility—

9 “(A) such contractual relationship is termi-
10 nated (as defined in subsection (b));

11 “(B) benefits provided under such plan or
12 such health insurance coverage with respect to
13 such provider or facility are terminated because
14 of a change in the terms of the participation of
15 such provider or facility in such plan or cov-
16 erage; or

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

23 the plan or issuer, respectively, shall meet the re-
24 quirements of paragraph (2) with respect to such in-
25 dividual.

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

3 “(A) notify each individual enrolled under
4 such plan or coverage who is a continuing care
5 patient with respect to a provider or facility at
6 the time of a termination described in para-
7 graph (1) affecting such provider or facility on
8 a timely basis of such termination and such in-
9 dividual’s right to elect continued transitional
10 care from such provider or facility under this
11 section;

12 “(B) provide such individual with an op-
13 portunity to notify the plan or issuer of the in-
14 dividual’s need for transitional care; and

15 “(C) permit the patient to elect to continue
16 to have benefits provided under such plan or
17 such coverage, under the same terms and condi-
18 tions as would have applied and with respect to
19 such items and services as would have been cov-
20 ered under such plan or coverage had such ter-
21 mination not occurred, with respect to the
22 course of treatment furnished by such provider
23 or facility relating to such individual’s status as
24 a continuing care patient during the period be-
25 ginning on the date on which the notice under

1 subparagraph (A) is provided and ending on the
2 earlier of—

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

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

8 “(b) DEFINITIONS.—In this section:

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

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

15 “(B) is undergoing a course of institu-
16 tional or inpatient care from the provider or fa-
17 cility;

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

22 “(D) is pregnant and undergoing a course
23 of treatment for the pregnancy from the pro-
24 vider or facility; or

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

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

10 “(A) in the case of an acute illness, a con-
11 dition that is serious enough to require special-
12 ized medical treatment to avoid the reasonable
13 possibility of death or permanent harm; or

14 “(B) in the case of a chronic illness or con-
15 dition, a condition that is—

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

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

20 “(3) TERMINATED.—The term ‘terminated’ in-
21 cludes, with respect to a contract, the expiration or
22 nonrenewal of the contract, but does not include a
23 termination of the contract for failure to meet appli-
24 cable quality standards or for fraud.

1 **“SEC. 2731. INFORMATION REQUIRED TO BE INCLUDED ON**
2 **HEALTH INSURANCE MEMBERSHIP CARDS.**

3 “In the case of a group health plan or health insur-
4 ance issuer offering group or individual health insurance
5 coverage that provides a physical or electronic card indi-
6 cating membership in such plan or coverage to an indi-
7 vidual enrolled under such plan or coverage, such group
8 health plan or issuer shall include on such card each of
9 the following:

10 “(1) The nearest hospital to the primary resi-
11 dence of such individual that has in effect a contrac-
12 tual relationship with such plan or coverage for fur-
13 nishing items and services under such plan or cov-
14 erage.

15 “(2) A telephone number or Internet website
16 address through which such individual may seek con-
17 sumer assistance information, such as information
18 related to hospitals and urgent care facilities that
19 have in effect a contractual relationship with such
20 plan or coverage for furnishing items and services
21 under such plan or coverage.

22 “(3) Any deductible applicable to such indi-
23 vidual.

24 “(4) Any out-of-pocket maximum applicable to
25 such individual.

1 “(5) Any cost-sharing obligation applicable to
2 such individual for a visit at an emergency depart-
3 ment, or urgent care facility, that has in effect a
4 contractual relationship with such plan or coverage
5 for furnishing items and services under such plan or
6 coverage.

7 **“SEC. 2732. MAINTENANCE OF PRICE COMPARISON TOOL.**

8 “‘In connection with the offering of a group health
9 plan or group or individual health insurance coverage in
10 a geographic region for a plan year, a plan sponsor or
11 health insurance issuer, respectively, shall employ an indi-
12 vidual to offer price comparison guidance, or make avail-
13 able on an Internet website a price comparison tool, that
14 (to the extent practicable) allows an individual enrolled
15 under such plan or coverage, with respect to such plan
16 year and such geographic region, to compare the amount
17 (determined by historic claims data of participating pro-
18 viders with respect to such plan or coverage) of cost-shar-
19 ing (including deductibles, copayments, and coinsurance)
20 that the individual would be responsible for paying under
21 such plan or coverage with respect to the furnishing of
22 a specific item or service by any such provider.”.

23 (b) INTERNAL REVENUE CODE.—

24 (1) IN GENERAL.—Subchapter B of chapter
25 100 of the Internal Revenue Code of 1986, as

1 amended by the previous sections, is further amend-
2 ed by adding at the end the following new sections:

3 **“SEC. 9817. CONTINUITY OF CARE.**

4 “(a) ENSURING CONTINUITY OF CARE WITH RE-
5 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
6 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
7 NETWORK STATUS.—

8 “(1) IN GENERAL.—In the case of an individual
9 with benefits under a group health plan and with re-
10 spect to a health care provider or facility that has
11 a contractual relationship with such plan for fur-
12 nishing items and services under such plan, if, while
13 such individual is a continuing care patient (as de-
14 fined in subsection (b)) with respect to such provider
15 or facility—

16 “(A) such contractual relationship is termi-
17 nated (as defined in paragraph (b));

18 “(B) benefits provided under such plan
19 with respect to such provider or facility are ter-
20 minated because of a change in the terms of the
21 participation of such provider or facility in such
22 plan; or

23 “(C) a contract between such group health
24 plan and a health insurance issuer offering
25 health insurance coverage in connection with

1 such plan is terminated, resulting in a loss of
2 benefits provided under such plan with respect
3 to such provider or facility;
4 the plan shall meet the requirements of paragraph
5 (2) with respect to such individual.

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

8 “(A) notify each individual enrolled under
9 such plan who is a continuing care patient with
10 respect to a provider or facility at the time of
11 a termination described in paragraph (1) affect-
12 ing such provider on a timely basis of such ter-
13 mination and such individual’s right to elect
14 continued transitional care from such provider
15 or facility under this section;

16 “(B) provide such individual with an op-
17 portunity to notify the plan of the individual’s
18 need for transitional care; and

19 “(C) permit the patient to elect to continue
20 to have benefits provided under such plan,
21 under the same terms and conditions as would
22 have applied and with respect to such items and
23 services as would have been covered under such
24 plan had such termination not occurred, with
25 respect to the course of treatment furnished by

1 such provider or facility relating to such indi-
2 vidual's status as a continuing care patient dur-
3 ing the period beginning on the date on which
4 the notice under subparagraph (A) is provided
5 and ending on the earlier of—

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

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

11 “(b) DEFINITIONS.—In this section:

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

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

18 “(B) is undergoing a course of institu-
19 tional or inpatient care from the provider or fa-
20 cility;

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

1 “(D) is pregnant and undergoing a course
2 of treatment for the pregnancy from the pro-
3 vider or facility; or

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

9 “(2) SERIOUS AND COMPLEX CONDITION.—The
10 term ‘serious and complex condition’ means, with re-
11 spect to a participant, beneficiary, or enrollee under
12 a group health plan—

13 “(A) in the case of an acute illness, a con-
14 dition that is serious enough to require special-
15 ized medical treatment to avoid the reasonable
16 possibility of death or permanent harm; or

17 “(B) in the case of a chronic illness or con-
18 dition, a condition that—

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

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

23 “(3) TERMINATED.—The term ‘terminated’ in-
24 cludes, with respect to a contract, the expiration or
25 nonrenewal of the contract, but does not include a

1 termination of the contract for failure to meet appli-
2 cable quality standards or for fraud.

3 **“SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON**
4 **HEALTH INSURANCE MEMBERSHIP CARDS.**

5 “In the case of a group health plan that provides a
6 physical or electronic card indicating membership in such
7 plan to an individual enrolled under such plan, such group
8 health plan shall include on such card each of the fol-
9 lowing:

10 “(1) The nearest hospital to the primary resi-
11 dence of such individual that has in effect a contrac-
12 tual relationship with such plan for furnishing items
13 and services under such plan.

14 “(2) A telephone number or Internet website
15 address through which such individual may seek con-
16 sumer assistance information, such as information
17 related to hospitals and urgent care facilities that
18 have in effect a contractual relationship with such
19 plan for furnishing items and services under such
20 plan.

21 “(3) Any deductible applicable to such indi-
22 vidual.

23 “(4) Any out-of-pocket maximum applicable to
24 such individual.

1 “(5) Any cost-sharing obligation applicable to
2 such individual for a visit at an emergency depart-
3 ment, or urgent care facility, that has in effect a
4 contractual relationship with such plan for fur-
5 nishing items and services under such plan.

6 **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

7 “In connection with the offering of a group health
8 plan in a geographic region for a plan year, a plan sponsor
9 shall employ an individual to offer price comparison guid-
10 ance, or make available on an Internet website a price
11 comparison tool, that (to the extent practicable) allows an
12 individual enrolled under such plan, with respect to such
13 plan year and such geographic region, to compare the
14 amount (determined by historic claims data of partici-
15 pating providers with respect to such plan) of cost-sharing
16 (including deductibles, copayments, and coinsurance) that
17 the individual would be responsible for paying under such
18 plan with respect to the furnishing of a specific item or
19 service by any such provider.”.

20 (2) CONFORMING AMENDMENT.—Section
21 9815(a) of the Internal Revenue Code of 1986, as
22 amended by section 2(b), is further amended—

23 (A) in paragraph (1), by striking “section
24 2719A” and inserting “section 2719A, 2730,
25 2731, or 2732”; and

1 (B) in paragraph (2), by striking “section
 2 2719A” and inserting “section 2719A, 2730,
 3 2731, or 2732”.

4 (3) CLERICAL AMENDMENT.—The table of sec-
 5 tions for such subchapter, as amended by section
 6 2(b), is further amended by adding at the end the
 7 following new items:

“Sec. 9817. Continuity of care.

“Sec. 9818. Information required to be included on health insurance member-
 ship cards.

“Sec. 9819. Maintenance of price comparison tool.”.

8 (c) EMPLOYEE RETIREMENT INCOME SECURITY
 9 ACT.—

10 (1) IN GENERAL.—Subpart B of part 7 of sub-
 11 title B of title I of the Employee Retirement Income
 12 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
 13 amended by section 2(c), is further amended by add-
 14 ing at the end the following new sections:

15 **“SEC. 717. CONTINUITY OF CARE.**

16 “(a) ENSURING CONTINUITY OF CARE WITH RE-
 17 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
 18 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
 19 NETWORK STATUS.—

20 “(1) IN GENERAL.—In the case of an individual
 21 with benefits under a group health plan or health in-
 22 surance coverage offered by a health insurance
 23 issuer in connection with a group health plan and

1 with respect to a health care provider or facility that
2 has a contractual relationship with such plan or
3 such issuer (as applicable) for furnishing items and
4 services under such plan or such coverage, if, while
5 such individual is a continuing care patient (as de-
6 fined in subsection (b)) with respect to such provider
7 or facility—

8 “(A) such contractual relationship is termi-
9 nated (as defined in paragraph (b));

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

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

22 the plan or issuer, respectively, shall meet the re-
23 quirements of paragraph (2) with respect to such in-
24 dividual.

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

3 “(A) notify each individual enrolled under
4 such plan or coverage who is a continuing care
5 patient with respect to a provider or facility at
6 the time of a termination described in para-
7 graph (1) affecting such provider or facility on
8 a timely basis of such termination and such in-
9 dividual’s right to elect continued transitional
10 care from such provider or facility under this
11 section;

12 “(B) provide such individual with an op-
13 portunity to notify the plan or issuer of the in-
14 dividual’s need for transitional care; and

15 “(C) permit the patient to elect to continue
16 to have benefits provided under such plan or
17 such coverage, under the same terms and condi-
18 tions as would have applied and with respect to
19 such items and services as would have been cov-
20 ered under such plan or coverage had such ter-
21 mination not occurred, with respect to the
22 course of treatment furnished by such provider
23 or facility relating to such individual’s status as
24 a continuing care patient during the period be-
25 ginning on the date on which the notice under

1 subparagraph (A) is provided and ending on the
2 earlier of—

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

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

8 “(b) DEFINITIONS.—In this section:

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

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

15 “(B) is undergoing a course of institu-
16 tional or inpatient care from the provider or fa-
17 cility;

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

22 “(D) is pregnant and undergoing a course
23 of treatment for the pregnancy from the pro-
24 vider or facility; or

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

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

10 “(A) in the case of an acute illness, a con-
11 dition that is serious enough to require special-
12 ized medical treatment to avoid the reasonable
13 possibility of death or permanent harm; or

14 “(B) in the case of a chronic illness or con-
15 dition, a condition that—

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

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

20 “(3) TERMINATED.—The term ‘terminated’ in-
21 cludes, with respect to a contract, the expiration or
22 nonrenewal of the contract, but does not include a
23 termination of the contract for failure to meet appli-
24 cable quality standards or for fraud.

1 **“SEC. 718. INFORMATION REQUIRED TO BE INCLUDED ON**
2 **HEALTH INSURANCE MEMBERSHIP CARDS.**

3 “In the case of a group health plan or health insur-
4 ance issuer offering group health insurance coverage that
5 provides a physical or electronic card indicating member-
6 ship in such plan or coverage to an individual enrolled
7 under such plan or coverage, such group health plan or
8 issuer shall include on such card each of the following:

9 “(1) The nearest hospital to the primary resi-
10 dence of such individual that has in effect a contrac-
11 tual relationship with such plan or coverage for fur-
12 nishing items and services under such plan or cov-
13 erage.

14 “(2) A telephone number or Internet website
15 address through which such individual may seek con-
16 sumer assistance information, such as information
17 related to hospitals and urgent care facilities that
18 have in effect a contractual relationship with such
19 plan or coverage for furnishing items and services
20 under such plan or coverage.

21 “(3) Any deductible applicable to such indi-
22 vidual.

23 “(4) Any out-of-pocket maximum applicable to
24 such individual.

25 “(5) Any cost-sharing obligation applicable to
26 such individual for a visit at an emergency depart-

1 ment, or urgent care facility, that has in effect a
2 contractual relationship with such plan or coverage
3 for furnishing items and services under such plan or
4 coverage.

5 **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

6 “*In connection with the offering of a group health*
7 *plan or group health insurance coverage in a geographic*
8 *region for a plan year, a plan sponsor or health insurance*
9 *issuer, respectively, shall employ an individual to offer*
10 *price comparison guidance, or make available on an Inter-*
11 *net website a price comparison tool, that (to the extent*
12 *practicable) allows an individual enrolled under such plan*
13 *or coverage, with respect to such plan year and such geo-*
14 *graphic region, to compare the amount (determined by*
15 *historic claims data of participating providers with respect*
16 *to such plan or coverage) of cost-sharing (including*
17 *deductibles, copayments, and coinsurance) that the indi-*
18 *vidual would be responsible for paying under such plan*
19 *or coverage with respect to the furnishing of a specific*
20 *item or service by any such provider.”.*

21 (2) CONFORMING AMENDMENT.—Section
22 715(a) of the Employee Retirement Income Security
23 Act of 1974 (29 U.S.C. 1185d(a)), as amended by
24 section 2(c), is further amended—

1 (A) in paragraph (1), by striking “section
 2 2719A” and inserting “section 2719A, 2730,
 3 2731, or 2732”; and

4 (B) in paragraph (2), by striking “section
 5 2719A” and inserting “section 2719A, 2730,
 6 2731, or 2732”.

7 (3) CLERICAL AMENDMENT.—The table of con-
 8 tents in section 1 of the Employee Retirement In-
 9 come Security Act of 1974 is amended by inserting
 10 after the item relating to section 716 the following
 11 new items:

“Sec. 717. Continuity of care.

“Sec. 718. Information required to be included on health insurance membership
 cards.

“Sec. 719. Maintenance of price comparison tool.”.

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

15 **SEC. 10. REPORTING REQUIREMENTS REGARDING AIR AM-**
 16 **BULANCE SERVICES.**

17 (a) REPORTING REQUIREMENTS FOR PROVIDERS OF
 18 AIR AMBULANCE SERVICES.—

19 (1) IN GENERAL.—A provider of air ambulance
 20 services shall submit to the Secretary of Health and
 21 Human Services and the Secretary of Transpor-
 22 tation—

1 (A) not later than the date that is 90 days
2 after the last day of the first plan year begin-
3 ning on or after the date on which a final rule
4 is promulgated pursuant to the rulemaking de-
5 scribed in subsection (d), the information de-
6 scribed in paragraph (2) with respect to such
7 plan year; and

8 (B) not later than the date that is 90 days
9 after the last day of the plan year immediately
10 succeeding the plan year described in subpara-
11 graph (A), such information with respect to
12 such immediately succeeding plan year.

13 (2) INFORMATION DESCRIBED.—For purposes
14 of paragraph (1), information described in this para-
15 graph, with respect to a provider of air ambulance
16 services, is each of the following:

17 (A) Cost data, as determined appropriate
18 by the Secretary of Health and Human Serv-
19 ices, in consultation with the Secretary of
20 Transportation, for air ambulance services fur-
21 nished by such provider, separated to the max-
22 imum extent possible by air transportation costs
23 associated with furnishing such air ambulance
24 services and costs of medical services and sup-

1 plies associated with furnishing such air ambu-
2 lance services.

3 (B) The number and location of all air am-
4 bulance bases operated by such provider.

5 (C) The number and type of aircraft oper-
6 ated by such provider.

7 (D) The number of air ambulance trans-
8 ports, disaggregated by payor mix, including
9 group health plans, health insurance issuers,
10 and Government payors.

11 (E) The number of claims of such provider
12 that have been denied payment by a group
13 health plan or health insurance issuer and the
14 reasons for any such denials.

15 (F) The number of emergency and non-
16 emergency air ambulance transports,
17 disaggregated by air ambulance base and type
18 of aircraft.

19 (b) REPORTING REQUIREMENTS FOR GROUP
20 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

21 (1) IN GENERAL.—Each group health plan and
22 health insurance issuer offering health insurance
23 coverage in the individual or group market shall sub-
24 mit to the Secretary of Health and Human Serv-
25 ices—

1 (A) not later than the date that is 90 days
2 after the last day of the first plan year begin-
3 ning on or after the date on which a final rule
4 is promulgated pursuant to the rulemaking de-
5 scribed in subsection (d), the information de-
6 scribed in paragraph (2) with respect to such
7 plan year; and

8 (B) not later than the date that is 90 days
9 after the last day of the plan year immediately
10 succeeding the plan year described in subpara-
11 graph (A), such information with respect to
12 such immediately succeeding plan year.

13 (2) INFORMATION DESCRIBED.—For purposes
14 of paragraph (1), information described in this para-
15 graph, with respect to a group health plan or a
16 health insurance issuer offering health insurance
17 coverage in the individual or group market, is each
18 of the following:

19 (A) Claims data for air ambulance services
20 furnished by providers of such services,
21 disaggregated by each of the following factors:

22 (i) Whether such services were fur-
23 nished on an emergent or nonemergent
24 basis.

1 (ii) Whether the provider of such serv-
2 ices is part of a hospital-owned or spon-
3 sored program, municipality-sponsored pro-
4 gram, hospital independent partnership
5 (hybrid) program, or independent program.

6 (iii) Whether such services were fur-
7 nished in a rural or urban area.

8 (iv) The type of aircraft (such as
9 rotor transport or fixed wing transport)
10 used to furnish such services.

11 (v) Whether the provider of such serv-
12 ices has a contract with the plan or issuer,
13 as applicable, to furnish such services
14 under the plan or coverage, respectively.

15 (B) Such other information regarding pro-
16 viders of air ambulance services as the Sec-
17 retary of Health and Human Services may
18 specify.

19 (c) PUBLICATION OF COMPREHENSIVE REPORT.—

20 (1) IN GENERAL.—Not later than the date that
21 is one year after the date described in subsection
22 (b)(1)(B), the Secretary of Health and Human Serv-
23 ices, in consultation with the Secretary of Transpor-
24 tation (referred to in this section as the “Secre-
25 taries”), shall develop, and make publicly available

1 (subject to paragraph (3)), a comprehensive report
2 summarizing the information submitted under sub-
3 sections (a) and (b) and including each of the fol-
4 lowing:

5 (A) The percentage of providers of air am-
6 bulance services that are part of a hospital-
7 owned or sponsored program, municipality-
8 sponsored program, hospital-independent part-
9 nership (hybrid) program, or independent pro-
10 gram.

11 (B) An assessment of the extent of com-
12 petition among providers of air ambulance serv-
13 ices on the basis of price and services offered,
14 and any changes in such competition over time.

15 (C) An assessment of the average charges
16 for air ambulance services, amounts paid by
17 group health plans and health insurance issuers
18 offering health insurance coverage in the indi-
19 vidual or group market to providers of air am-
20 bulance services for furnishing such services,
21 and amounts paid out-of-pocket by consumers,
22 and any changes in such amounts paid over
23 time.

24 (D) An assessment of the presence of air
25 ambulance bases in, or with the capability to

1 serve, rural areas, and the relative growth in air
2 ambulance bases in rural and urban areas over
3 time.

4 (E) Any evidence of gaps in rural access to
5 providers of air ambulance services.

6 (F) The percentage of providers of air am-
7 bulance services that have contracts with group
8 health plans or health insurance issuers offering
9 health insurance coverage in the individual or
10 group market to furnish such services under
11 such plans or coverage, respectively.

12 (G) An assessment of whether there are in-
13 stances of unfair, deceptive, or predatory prac-
14 tices by providers of air ambulance services in
15 collecting payments from patients to whom such
16 services are furnished, such as referral of such
17 patients to collections, lawsuits, and liens or
18 wage garnishment actions.

19 (H) An assessment of whether there are
20 instances of group health plans or health insur-
21 ance issuers not providing substantial reasons
22 for refusing to enter into contract negotiations
23 with providers of air ambulance services.

24 (I) An assessment of whether there are,
25 within the air ambulance industry, instances of

1 unreasonable industry concentration, excessive
2 market domination, or other conditions that
3 would allow at least one provider of air ambu-
4 lance services to unreasonably increase prices or
5 exclude competition in air ambulance services in
6 a given geographic region.

7 (J) An assessment of the frequency of pa-
8 tient balance billing, patient referrals to collec-
9 tions, lawsuits to collect balance bills, and liens
10 or wage garnishment actions by providers of air
11 ambulance services as part of a collections proc-
12 ess across hospital-owned or sponsored pro-
13 grams, municipality-sponsored programs, hos-
14 pital-independent partnership (hybrid) pro-
15 grams, or independent programs, providers of
16 air ambulance services operated by public agen-
17 cies (such as a State or county health depart-
18 ment), and other independent providers of air
19 ambulance services.

20 (K) An assessment of the frequency of
21 claims appeals made by providers of air ambu-
22 lance services to group health plans or health
23 insurance issuers offering health insurance cov-
24 erage in the individual or group market with re-

1 spect to air ambulance services furnished to en-
2 rollees of such plans or coverage, respectively.

3 (L) Any other cost, quality, or other data
4 relating to air ambulance services or the air
5 ambulance industry, as determined necessary
6 and appropriate by the Secretaries.

7 (2) OTHER SOURCES OF INFORMATION.—The
8 Secretaries may incorporate information from inde-
9 pendent experts or third-party sources in developing
10 the comprehensive report required under paragraph
11 (1).

12 (3) PROTECTION OF PROPRIETARY INFORMA-
13 TION.—The Secretaries may not make publicly avail-
14 able under this subsection any proprietary informa-
15 tion.

16 (d) RULEMAKING.—Not later than the date that is
17 one year after the date of the enactment of this Act, the
18 Secretary of Health and Human Services, in consultation
19 with the Secretary of Transportation, shall, through notice
20 and comment rulemaking, specify the form and manner
21 in which reports described in subsections (a) and (b) shall
22 be submitted to such Secretaries, taking into consideration
23 (as applicable and to the extent feasible) any recommenda-
24 tions included in the report submitted by the Advisory
25 Committee on Air Ambulance and Patient Billing under

1 section 418(e) of the FAA Reauthorization Act of 2018
2 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

3 (e) CIVIL MONEY PENALTIES.—

4 (1) IN GENERAL.—Subject to paragraph (2), a
5 provider of air ambulance services who fails to sub-
6 mit all information required under subsection (a)(2)
7 by the date described in subparagraph (A) or (B) of
8 subsection (a)(1), as applicable, shall be subject to
9 a civil money penalty of not more than \$10,000.

10 (2) EXCEPTION.—In the case of a provider of
11 air ambulance services that submits only some of the
12 information required under subsection (a)(2) by the
13 date described in subparagraph (A) or (B) of sub-
14 section (a)(1), as applicable, the Secretary of Health
15 and Human Services may waive the civil money pen-
16 alty imposed under paragraph (1) if such provider
17 demonstrates a good faith effort in working with the
18 Secretary to submit the remaining information re-
19 quired under subsection (a)(2).

20 (3) PROCEDURE.—The provisions of section
21 1128A of the Social Security Act (42 U.S.C. 1320a–
22 7a), other than subsections (a) and (b) and the first
23 sentence of subsection (c)(1), shall apply to civil
24 money penalties under this subsection in the same

1 manner as such provisions apply to a penalty or pro-
2 ceeding under such section.

3 (f) UNFAIR AND DECEPTIVE PRACTICES AND UN-
4 FAIR METHODS OF COMPETITION.—The Secretary of
5 Transportation may use any information submitted under
6 subsection (a) in determining whether a provider of air
7 ambulance services has violated section 41712(a) of title
8 49, United States Code.

9 (g) UNDERSTANDING AIR AMBULANCE QUALITY AND
10 PATIENT SAFETY.—Not later than 1 year after the date
11 of the enactment of this Act, the Comptroller General of
12 the United States shall conduct a study and submit to
13 Congress a report on options to establish quality, patient
14 safety, service reliability, and clinical capability standards
15 for each clinical capability level of air ambulances. Such
16 report shall include analysis and recommendations, as ap-
17 propriate, to Congress regarding each of the following with
18 respect to air ambulance services:

19 (1) Qualifications of different clinical capability
20 levels and tiering of such levels.

21 (2) Patient safety and quality standards.

22 (3) Options for improving service reliability
23 during poor weather, night conditions, or other ad-
24 verse conditions.

1 (4) Differences between air ambulance vehicle
2 types, services, and technologies, and other flight ca-
3 pability standards, and the impact of such dif-
4 ferences on patient safety.

5 (5) Clinical triage criteria for air ambulances.

6 (h) DEFINITIONS.—In this section, the terms “group
7 health plan”, “health insurance coverage”, and “health in-
8 surance issuer” have the meanings given such terms in
9 section 2791 of the Public Health Service Act (42 U.S.C.
10 300gg–91).

11 **SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.**

12 Not later than 2 years after the date of the enact-
13 ment of this Act, the Comptroller General of the United
14 States shall submit to Congress a report summarizing the
15 effects of the provisions of this Act, including the amend-
16 ments made by such provisions, on changes during such
17 period in health care provider networks of group health
18 plans and health insurance coverage offered by a health
19 insurance issuer in the group or individual market, in fee
20 schedules and amounts for health care services, and to
21 contracted rates under such plans or coverage. Such re-
22 port shall—

23 (1) to the extent practicable, sample a statis-
24 tically significant group of national health care pro-
25 viders; and

1 (2) examine—

2 (A) provider network participation, includ-
3 ing nonparticipating providers furnishing items
4 and services at participating facilities;

5 (B) health care provider group network
6 participation, including specialty, size, and own-
7 ership; and

8 (C) the impact of State surprise billing
9 laws and network adequacy standards on par-
10 ticipation of health care providers and facilities
11 in provider networks of group health plans and
12 of health insurance coverage offered by health
13 insurance issuers in the group or individual
14 market.

15 **SEC. 12. TRANSITIONAL RULE ALLOWING DEDUCTION FOR**
16 **SURPRISE BILLING EXPENSES BELOW AGI**
17 **FLOOR.**

18 (a) IN GENERAL.—Section 213 of the Internal Rev-
19 enue Code of 1986 is amended by adding at the end the
20 following new subsection:

21 “(g) TRANSITIONAL RULE ALLOWING DEDUCTION
22 FOR SURPRISE BILLING EXPENSES BELOW AGI
23 FLOOR.—

24 “(1) IN GENERAL.—In addition to the deduc-
25 tion allowed by subsection (a) for any taxable year,

1 there shall be allowed as a deduction an amount
2 equal to the lesser of—

3 “(A) the excess of—

4 “(i) the surprise billing expenses
5 which would be allowed as a deduction for
6 such taxable year under subsection (a) if
7 such subsection were applied without re-
8 gard to the limitation based on the tax-
9 payer’s adjusted gross income, over

10 “(ii) \$600, or

11 “(B) the applicable percentage of the tax-
12 payer’s adjusted gross income.

13 “(2) SURPRISE BILLING EXPENSES.—For pur-
14 poses of this subsection, the term ‘surprise billing
15 expenses’ means expenses paid for medical care of
16 an individual who is a participant, beneficiary, or en-
17 rollee in a group health plan or in group or indi-
18 vidual health insurance coverage offered by a health
19 insurance issuer (as such terms are defined in sec-
20 tion 2791 of the Public Health Service Act), if—

21 “(A) benefits are provided for such medical
22 care under such plan or coverage, and

23 “(B) such medical care—

24 “(i) is furnished by a provider without
25 a contractual relationship with such plan

1 or coverage with respect to the furnishing
2 of such medical care during a visit at a fa-
3 cility with a contractual relationship with
4 such plan or coverage, or

5 “(ii) is furnished in an emergency de-
6 partment of a hospital or an independent
7 freestanding emergency department.

8 “(3) APPLICABLE PERCENTAGE.—For purposes
9 of this section, the term ‘applicable percentage’
10 means, with respect to any taxpayer for any taxable
11 year, the percentage in effect under subsection (a)
12 with respect to such taxpayer for such taxable year.

13 “(4) LIMITATIONS.—Surprise billing expenses
14 shall be taken into account under paragraph (1) only
15 if such expenses are paid during the period begin-
16 ning on January 1, 2020, and ending on the date
17 which is 1 year after the day before the date speci-
18 fied in section 2(a)(5) of the Consumer Protections
19 Against Surprise Medical Bills Act of 2020.”.

20 (b) CONFORMING AMENDMENTS.—Sections 105(f),
21 162(l)(3), and 7702B(e)(2) of such Code are each amend-
22 ed by striking “213(a)” and inserting “213”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years ending after De-
3 cember 31, 2019.

○