[DISCUSSION DRAFT]

116TH CONGRESS
2D SESSION

H. R. ____

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

M__. ____________ introduced the following bill; which was referred to the Committee on ____________________________

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,*

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Consumer Protections Against Surprise Medical Bills
4 Act of 2020".

5 (b) TABLE OF CONTENTS.—The table of contents of
6 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. Air ambulance cost data reporting program.
Sec. 11. GAO report on effects of legislation.

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

11 (a) PHSA AMENDMENTS.—
12 (1) IN GENERAL.—Section 2719A of the Public
13 Health Service Act (42 U.S.C. 300gg–19a) is
14 amended—
15 (A) in subsection (b)—

1 (i) in the heading, by striking "COV-
2 ERAGE" and inserting "COST-SHARING
3 AND PAYMENT";
4 (ii) in paragraph (1)—
5 (I) in the matter preceding sub-
6 paragraph (A)—
7 (aa) by striking "a group
8 health plan, or a health insurance
9 issuer offering group or indi-
10 vidual health insurance issuer,"
11 and inserting "a health plan";
12 (bb) by inserting "or, for
13 plan year 2022 or a subsequent
14 plan year, with respect to emer-
15 gency services in an independent
16 freestanding emergency depart-
17 ment" after "emergency depart-
18 ment of a hospital";
19 (cc) by striking "the plan or
20 issuer" and inserting "the plan";
21 and
22 (dd) by striking "(as defined
23 in paragraph (2)(B))";
24 (II) in subparagraph (B), by in-
25 serting "or a participating facility

1 that is an emergency department of a
2 hospital or an independent free-
3 standing emergency department (in
4 this subsection referred to as a 'par-
5 ticipating emergency facility')'' after
6 ''participating provider''; and
7 (III) in subparagraph (C)—
8 (aa) in the matter preceding
9 clause (i), by inserting ''by a
10 nonparticipating provider or a
11 nonparticipating facility that is
12 an emergency department of a
13 hospital or an independent free-
14 standing emergency department''
15 after ''enrollee'';
16 (bb) by striking clause (i);
17 (cc) by striking ''(ii)(I) such
18 services'' and inserting ''(i) such
19 services'';
20 (dd) by striking ''where the
21 provider of services does not have
22 a contractual relationship with
23 the plan for the providing of
24 services'';

1 (ee) by striking "emergency
2 department services received
3 from providers who do have such
4 a contractual relationship with
5 the plan; and" and inserting
6 "emergency services received
7 from participating providers and
8 participating emergency facilities
9 with respect to such plan;";
10 (ff) by striking "(II) if such
11 services" and all that follows
12 through "were provided in-net-
13 work" and inserting the fol-
14 lowing:
15 "(ii) the cost-sharing requirement (ex-
16 pressed as a copayment amount or coinsur-
17 ance rate) is not greater than the require-
18 ment that would apply if such services
19 were furnished by a participating provider
20 or a participating emergency facility, as
21 applicable;"; and
22 (gg) by adding at the end
23 the following new clauses:
24 "(iii) such cost-sharing requirement is
25 calculated as if the contracted rate for

1 such services if furnished by a partici-
2 pating provider or a participating emer-
3 gency facility were equal to the recognized
4 amount for such services;
5 ''(iv) the health plan pays to such pro-
6 vider or facility, respectively, the amount
7 by which the out-of-network rate for such
8 services exceeds the cost-sharing amount
9 for such services (as determined in accord-
10 ance with clauses (ii) and (iii)); and
11 ''(v) any deductible or out-of-pocket
12 maximum that would apply if such services
13 were furnished by a participating provider
14 or a participating emergency facility shall
15 be the deductible or out-of-pocket max-
16 imum that applies; and''; and
17 (iii) by striking paragraph (2) and in-
18 serting the following new paragraph:
19 ''(2) AUDIT PROCESS AND RULEMAKING PROC-
20 ESS FOR MEDIAN CONTRACTED RATES.—
21 ''(A) AUDIT PROCESS.—
22 ''(i) IN GENERAL.—Not later than
23 July 1, 2021, the Secretary, in coordina-
24 tion with the Secretary of the Treasury
25 and the Secretary of Labor and in con-

1 sultation with the National Association of
2 Insurance Commissioners, shall establish
3 through rulemaking a process, in accord-
4 ance with clause (ii), under which health
5 plans are audited by the Secretary to en-
6 sure that—
7 "(I) such plans are in compliance
8 with the requirement of applying a
9 median contracted rate under this sec-
10 tion; and
11 "(II) that such median con-
12 tracted rate so applied satisfies the
13 definition under subsection (k)(8)
14 with respect to the year involved.
15 "(ii) AUDIT SAMPLES.—Under the
16 process established pursuant to clause (i),
17 the Secretary—
18 "(I) shall conduct audits de-
19 scribed in such clause of a sample of
20 health plans; and
21 "(II) may audit any health plan
22 if the Secretary has received any com-
23 plaint about such plan that involves
24 the compliance of the plan with the
25 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 the
4 Treasury, shall establish through rulemaking—
5 "(i) the methodology the sponsor or
6 issuer of a health plan shall use to deter-
7 mine the median contracted rate, which
8 shall account for relevant payment adjust-
9 ments that take into account facility type
10 that are otherwise taken into account for
11 purposes of determining payment amounts
12 with respect to participating facilities; and
13 "(ii) the information such sponsor or
14 issuer shall share with the nonparticipating
15 provider involved when making such a de-
16 termination."; and
17 (B) by adding at the end the following new
18 subsection:
19 "(k) DEFINITIONS.—For purposes of this section:
20 "(1) CONTRACTED RATE.—The term 'con-
21 tracted rate' means, with respect to a health plan
22 and a health care provider or health care facility fur-
23 nishing an item or service to a beneficiary, partici-
24 pant, or enrollee of such plan, the agreed upon total

1 payment amount (inclusive of any cost-sharing) to
2 such provider or facility for such item or service.

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

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

17 "(4) EMERGENCY MEDICAL CONDITION.—The
18 term 'emergency medical condition' means a medical
19 condition manifesting itself by acute symptoms of
20 sufficient severity (including severe pain) such that
21 a prudent layperson, who possesses an average
22 knowledge of health and medicine, could reasonably
23 expect the absence of immediate medical attention to
24 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

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 RELATED 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), items and services furnished as part of outpatient observation or an inpatient or outpatient stay during a visit in which such individual is so stabilized if such items and services would otherwise be covered under such plan if furnished by a participating provider or participating facility that is an emergency department of a hospital or an independent freestanding emergency department, unless each of the following conditions are met:

1 "(i) Such a provider or hospital or
2 independent freestanding emergency de-
3 partment determines such individual is
4 able to travel using nonmedical transpor-
5 tation or nonemergency medical transpor-
6 tation.

7 "(ii) The criteria described in sub-
8 paragraph (C) are satisfied with respect to
9 such provider or hospital or independent
10 freestanding emergency department, indi-
11 vidual, and items and services.

12 "(C) SIGNED NOTICE CRITERIA.—For pur-
13 poses of subparagraph (B)(ii), the criteria de-
14 scribed in this subparagraph, with respect to an
15 individual described in subparagraph (B), any
16 item or service that may be considered needed
17 to be furnished (after stabilization but during
18 the visit in which the individual is stabilized, as
19 described in the matter preceding clause (i) of
20 such subparagraph), and the hospital or inde-
21 pendent freestanding emergency department
22 furnishing such items or services, are the fol-
23 lowing:

24 "(i) A written notice (as specified by
25 the Secretary) is provided by the hospital

1 or independent freestanding emergency de-
2 partment to such individual, not later than
3 24 hours after the time of such stabiliza-
4 tion of such individual, that includes the
5 following information:

6 "(I) In the case the hospital or
7 independent freestanding emergency
8 department is a nonparticipating facil-
9 ity, with respect to the health plan of
10 such individual, that the hospital or
11 independent freestanding emergency
12 department is a nonparticipating facil-
13 ity (or, in the case the hospital or
14 independent freestanding emergency
15 department is a participating facility,
16 that potentially a provider that may
17 furnish such an item or service during
18 such visit, may be a nonparticipating
19 provider with respect to such health
20 plan).

21 "(II) To the extent practicable,
22 the estimated amount that such non-
23 participating facility or such a non-
24 participating provider may charge the
25 individual for such an item or service.

1 "(III) A statement that the indi-
2 vidual may seek such an item or serv-
3 ice from a provider that is a partici-
4 pating provider or a hospital or inde-
5 pendent freestanding emergency de-
6 partment that is a participating facil-
7 ity.
8 "(ii) Before the end of such 24 hours,
9 the individual signs and dates such notice
10 confirming receipt of the notice.
11 "(iii) The health plan of such indi-
12 vidual and the hospital or independent
13 freestanding emergency department ar-
14 range for such continued care as nec-
15 essary, similar to the process relating to
16 promoting efficient and timely coordination
17 of appropriate maintenance and post-sta-
18 bilization care under section 1852(d)(2) of
19 the Social Security Act.
20 "(6) HEALTH PLAN.—The term 'health plan'
21 means a group health plan and health insurance cov-
22 erage offered by a heath insurance issuer in the
23 group or individual market and includes a grand-
24 fathered health plan (as defined in section 1251(e)
25 of the Patient Protection and Affordable Care Act).

1 "(7) INDEPENDENT FREESTANDING EMER-
2 GENCY DEPARTMENT.—The term 'independent free-
3 standing emergency department' means a health
4 care facility that—
5 "(A) is geographically separate and dis-
6 tinct and licensed separately from a hospital
7 under applicable State law; and
8 "(B) provides emergency services.
9 "(8) MEDIAN CONTRACTED RATE.—
10 "(A) IN GENERAL.—Subject to subpara-
11 graph (B), the term 'median contracted rate'
12 means, with respect to a health plan—
13 "(i) for an item or service furnished
14 during 2022, the median of the contracted
15 rates recognized by the sponsor or issuer
16 of such plan (determined with respect to
17 all such plans of such sponsor or such
18 issuer that are within the same line of
19 business (as specified in subparagraph (C))
20 as the plan involved) as the total maximum
21 payment under such plans in 2019 for the
22 same or a similar item or service that is
23 provided by a provider or facility in the
24 same or similar specialty and provided in
25 the geographic region (established (and up-

1 dated, as appropriate) by the Secretary, in
2 consultation with the National Association
3 of Insurance Commissioners) in which the
4 item or service is furnished, consistent with
5 the methodology established by the Sec-
6 retary under subsection (b)(2)(B), in-
7 creased by the percentage increase in the
8 consumer price index for all urban con-
9 sumers (United States city average) over
10 2019, 2020, and 2021;
11 "(ii) for an item or service furnished
12 during 2023 or a subsequent year through
13 2026, the median contracted rate for the
14 previous year, increased by the percentage
15 increase in the consumer price index for all
16 urban consumers (United States city aver-
17 age) over such previous year;
18 "(iii) for an item or service furnished
19 during a rebasing year (as defined in sub-
20 paragraph (D)), the median of the con-
21 tracted rates recognized by the sponsor or
22 issuer of such plan (determined with re-
23 spect to all such plans of such sponsor or
24 such issuer that are within the same line
25 of business (as specified in subparagraph

1 (C)) as the plan involved) as the total max-
2 imum payment under such plans in such
3 year for the same or a similar item or serv-
4 ice that is provided by a provider or facility
5 in the same or similar specialty and pro-
6 vided in the geographic region (as estab-
7 lished pursuant to clause (i)) in which the
8 item or service is furnished, consistent with
9 the methodology established by the Sec-
10 retary under subsection (b)(2)(B); and
11 "(iv) for an item or service furnished
12 during any of the 4 years following a re-
13 basing year, the median contracted rate for
14 the previous year, increased by the per-
15 centage increase in the consumer price
16 index for all urban consumers (United
17 States city average) over such previous
18 year.
19 "(B) USE OF SUBSTITUTE RATE IN CASE
20 OF INSUFFICIENT DATA.—
21 "(i) IN GENERAL.—In the case the
22 sponsor or issuer of a health plan has in-
23 sufficient information (as specified by the
24 Secretary) to calculate the median of the
25 contracted rates in accordance with sub-

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

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

21 "(I) if sufficient information (as
22 specified by the Secretary) exists to
23 determine the median of the con-
24 tracted rates recognized by all health
25 plans offered in the same line of busi-

1 ness (as specified in subparagraph
2 (C)) by any group health plan or
3 health insurance issuer for such an
4 item or service furnished in such re-
5 gion by such a provider or facility
6 during such year using a database or
7 other source of information deter-
8 mined appropriate by the Secretary,
9 such median; and

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

24 The Secretary shall develop a methodology
25 for determining a substitute rate based on

a similarly situated health plan that is not a Federal health care program (as defined in section 1128B(f) of the Social Security Act) in the case a substitute rate is not calculable under the previous sentence with respect to an item or service.

"(C) LINE OF BUSINESS.—A line of business specified in this subparagraph is one of the following:

"(i) The individual market.

"(ii) The small group market.

"(iii) The large group market.

"(iv) In the case of a self-insured group health plan, other self-insured group health plans.

"(D) REBASING YEAR DEFINED.—For purposes of subparagraph (A), the term 'rebasing year' means 2027 and every 5 years thereafter.

"(9) NONPARTICIPATING FACILITY; PARTICIPATING FACILITY.—

"(A) NONPARTICIPATING FACILITY.—The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a health care facility described in subparagraph (B)(ii) that does not have a contractual rela-

1 tionship with the plan for furnishing such item
2 or service.
3 "(B) PARTICIPATING FACILITY.—
4 "(i) IN GENERAL.—The term 'partici-
5 pating facility' means, with respect to an
6 item or service and a health plan, a health
7 care facility described in clause (ii) that
8 has a contractual relationship with the
9 plan for furnishing such item or service.
10 "(ii) HEALTH CARE FACILITY DE-
11 SCRIBED.—A health care facility described
12 in this clause is each of the following:
13 "(I) A hospital (as defined in
14 1861(e) of the Social Security Act),
15 including an emergency department of
16 a hospital.
17 "(II) A critical access hospital
18 (as defined in section 1861(mm) of
19 such Act).
20 "(III) An ambulatory surgical
21 center (as defined in section
22 1833(i)(1)(A) of such Act).
23 "(IV) A laboratory.
24 "(V) A radiology facility or imag-
25 ing center.

1 "(VI) An independent free-
2 standing emergency department.
3 "(VII) Any other facility speci-
4 fied by the Secretary.
5 "(10) NONPARTICIPATING PROVIDERS; PARTICI-
6 PATING PROVIDERS.—
7 "(A) NONPARTICIPATING PROVIDER.—The
8 term 'nonparticipating provider' means, with re-
9 spect to an item or service and a health plan,
10 a physician or other health care provider who
11 does not have a contractual relationship with
12 the plan for furnishing such item or service
13 under the plan.
14 "(B) PARTICIPATING PROVIDER.—The
15 term 'participating provider' means, with re-
16 spect to an item or service and a health plan,
17 a physician or other health care provider who
18 has a contractual relationship with the plan for
19 furnishing such item or service under the plan.
20 "(11) OUT-OF-NETWORK RATE.—The term
21 'out-of-network rate' means, with respect to an item
22 or service furnished in a State during a year to a
23 participant, beneficiary, or enrollee of a health plan
24 receiving such item or service from a nonpartici-
25 pating provider or facility—

1 "(A) subject to subparagraphs (C) and
2 (D), in the case such State has in effect a State
3 law that provides for a method for determining
4 the amount payable (by the plan and the partic-
5 ipant, beneficiary, or enrollee) under such
6 health plan regulated by such State with re-
7 spect to such item or service furnished by such
8 provider or facility, such amount (including
9 cost-sharing) determined in accordance with
10 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) subject to subparagraph (D), in the
7 case such State has an All-Payer Model Agree-
8 ment under section 1115A of the Social Secu-
9 rity Act, the amount (including cost-sharing)
10 that the State approves under such system for
11 such item or service so 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 amount payable (by the
19 plan and the participant, beneficiary, or en-
20 rollee) under such health plan with respect to
21 such item or service furnished by such provider
22 or facility, such amount (including cost-sharing)
23 determined in accordance with such method.

24 "(12) RECOGNIZED AMOUNT.—The term 'recog-
25 nized amount' means, with respect to an item or

1 service furnished in a State during a year to a par-
2 ticipant, beneficiary, or enrollee of a health plan by
3 a nonparticipating provider or nonparticipating facil-
4 ity—
5 "(A) subject to subparagraphs (C) and
6 (D), in the case such State has in effect a law
7 described in paragraph (11)(A) with respect to
8 such item or service, provider or facility, and
9 plan, the amount determined in accordance with
10 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, an amount that is the median
14 contracted rate for such item or service for such
15 year;
16 "(C) subject to subparagraph (D), in the
17 case such State is described in paragraph
18 (11)(C) with respect to such item or service so
19 furnished, the amount that the State approves
20 under such system for such item or service so
21 furnished; or
22 "(D) in the case such health plan is a self-
23 insured group health plan and in the case of a
24 State with an agreement with such plan in ef-
25 fect as of the date of the enactment of the Con-

1 sumer Protections Against Surprise Medical
2 Bills Act of 2020, that provides for a method
3 for determining the amount payable (by the
4 plan and the participant, beneficiary, or en-
5 rollee) under such health plan with respect to
6 such item or service furnished by such provider
7 or facility, such amount determined in accord-
8 ance with such method.
9 ''(13) STABILIZE.—The term 'to stabilize', with
10 respect to an emergency medical condition, has the
11 meaning give in section 1867(e)(3) of the Social Se-
12 curity Act).''.
13 (2) EFFECTIVE DATE.—The amendments made
14 by paragraph (1) shall apply with respect to plan
15 years beginning on or after January 1, 2022.
16 (b) IRC AMENDMENTS.—
17 (1) IN GENERAL.—Subchapter B of chapter
18 100 of the Internal Revenue Code of 1986 is amend-
19 ed by adding at the end the following new section:
20 **''SEC. 9816. PATIENT PROTECTIONS.**
21 ''(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
22 a health plan requires or provides for designation by a par-
23 ticipant or beneficiary of a participating primary care pro-
24 vider, then the plan shall permit each participant or bene-

1 ficiary to designate any participating primary care pro-
2 vider who is available to accept such individual.
3 "(b) COST-SHARING AND PAYMENT OF EMERGENCY
4 SERVICES.—
5 "(1) IN GENERAL.—If a health plan provides or
6 covers any benefits with respect to services in an
7 emergency department of a hospital or, for plan year
8 2022 or a subsequent plan year, with respect to
9 emergency services in an independent freestanding
10 emergency department, the plan shall cover emer-
11 gency services—
12 "(A) without the need for any prior au-
13 thorization determination;
14 "(B) whether the health care provider fur-
15 nishing such services is a participating provider
16 or a participating facility that is an emergency
17 department of a hospital or an independent
18 freestanding emergency department (in this
19 subsection referred to as a 'participating emer-
20 gency facility') with respect to such services;
21 "(C) in a manner so that, if such services
22 are provided to a participant or beneficiary by
23 a nonparticipating provider or a nonpartici-
24 pating facility that is an emergency department

1 of a hospital or an independent freestanding
2 emergency department—
3 "(i) such services will be provided
4 without imposing any requirement under
5 the plan for prior authorization of services
6 or any limitation on coverage that is more
7 restrictive than the requirements or limita-
8 tions that apply to emergency services re-
9 ceived from participating providers and
10 participating emergency facilities with re-
11 spect to such plan;
12 "(ii) the cost-sharing requirement (ex-
13 pressed as a copayment amount or coinsur-
14 ance rate) is not greater than the require-
15 ment that would apply if such services
16 were furnished by a participating provider
17 or a participating emergency facility, as
18 applicable;
19 "(iii) such cost-sharing requirement is
20 calculated as if the contracted rate for
21 such services if furnished by a partici-
22 pating provider or a participating emer-
23 gency facility were equal to the recognized
24 amount for such services;

1 "(iv) the health plan pays to such pro-
2 vider or facility, respectively, the amount
3 by which the out-of-network rate for such
4 services exceeds the cost-sharing amount
5 for such services (as determined in accord-
6 ance with clauses (ii) and (iii)); and
7 "(v) any deductible or out-of-pocket
8 maximum that would apply if such services
9 were furnished by a participating provider
10 or a participating emergency facility shall
11 be the deductible or out-of-pocket max-
12 imum that applies; and
13 "(D) without regard to any other term or
14 condition of such coverage (other than exclusion
15 or coordination of benefits, or an affiliation or
16 waiting period, permitted under section 2704 of
17 the Public Health Service Act, including as in-
18 corporated pursuant to section 715 of the Em-
19 ployee Retirement Income Security Act of 1974
20 and section 9815, and other than applicable
21 cost-sharing).
22 "(2) AUDIT PROCESS AND RULEMAKING PROC-
23 ESS FOR MEDIAN CONTRACTED RATES.—
24 "(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
5 Labor 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 Labor and the Secretary of Health
9 and Human Services, shall establish through
10 rulemaking—
11 "(i) the methodology the sponsor of a
12 health plan shall use to determine the me-
13 dian contracted rate, which shall account
14 for relevant payment adjustments that
15 take into account facility type that are oth-
16 erwise taken into account for purposes of
17 determining payment amounts with respect
18 to participating facilities; and
19 "(ii) the information such sponsor
20 shall share with the nonparticipating pro-
21 vider involved when making such a deter-
22 mination.
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-

1 cluding procedures regarding referrals and ob-
2 taining prior authorization and providing serv-
3 ices pursuant to a treatment plan (if any) ap-
4 proved by the plan.

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

15 "(2) APPLICATION OF PARAGRAPH.—A health
16 plan described in this paragraph is a health plan
17 that—

18 "(A) provides coverage for obstetric or
19 gynecologic care; and

20 "(B) requires the designation by a partici-
21 pant or beneficiary of a participating primary
22 care provider.

23 "(3) CONSTRUCTION.—Nothing in paragraph
24 (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 gyneco-
4 logical care; or
5 "(B) preclude the health plan involved
6 from requiring that the obstetrical or gyneco-
7 logical provider notify the primary care health
8 care professional or the plan of treatment deci-
9 sions.
10 "(k) DEFINITIONS.—For purposes of this section:
11 "(1) CONTRACTED RATE.—The term 'con-
12 tracted rate' means, with respect to a health plan
13 and a health care provider or health care facility fur-
14 nishing an item or service to a beneficiary or partici-
15 pant of such plan, the agreed upon total payment
16 amount (inclusive of any cost-sharing) to such pro-
17 vider 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 fur-
20 nished items and services at a participating facility,
21 include equipment and devices, telemedicine services,
22 imaging services, laboratory services, preoperative
23 and postoperative services, and such other items and
24 services as the Secretary may specify furnished to
25 such individual, regardless of 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 RELATED
22 SERVICES.—In the case of an individual en-
23 rolled in a health plan who is furnished services
24 described 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 if such items and services
9 would otherwise be covered under such plan if
10 furnished by a participating provider or partici-
11 pating facility that is an emergency department
12 of a hospital or an independent freestanding
13 emergency department, unless each of the fol-
14 lowing conditions are met:

15 "(i) Such a provider or hospital or
16 independent freestanding emergency de-
17 partment determines such individual is
18 able to travel using nonmedical transpor-
19 tation or nonemergency medical transpor-
20 tation.

21 "(ii) The criteria described in sub-
22 paragraph (C) are satisfied with respect to
23 such provider or hospital or independent
24 freestanding emergency department, indi-
25 vidual, and items and services.

1 "(C) SIGNED NOTICE CRITERIA.—For pur-
2 poses of subparagraph (B)(ii), the criteria de-
3 scribed in this subparagraph, with respect to an
4 individual described in subparagraph (B), any
5 item or service that may be considered needed
6 to be furnished (after stabilization but during
7 the visit in which the individual is stabilized, as
8 described in the matter preceding clause (i) of
9 such subparagraph), and the hospital or inde-
10 pendent freestanding emergency department
11 furnishing such items or services, are the fol-
12 lowing:
13 "(i) A written notice (as specified by
14 the Secretary) is provided by the hospital
15 or independent freestanding emergency de-
16 partment to such individual, not later than
17 24 hours after the time of such stabiliza-
18 tion of such individual, that includes the
19 following information:
20 "(I) In the case the hospital or
21 independent freestanding emergency
22 department is a nonparticipating facil-
23 ity, with respect to the health plan of
24 such individual, that the hospital or
25 independent freestanding emergency

1 department is a nonparticipating facil-
2 ity (or, in the case the hospital or
3 independent freestanding emergency
4 department is a participating facility,
5 that potentially a provider that may
6 furnish such an item or service during
7 such visit, may be a nonparticipating
8 provider with respect to such health
9 plan).
10 ‘‘(II) To the extent practicable,
11 the estimated amount that such non-
12 participating facility or such a non-
13 participating provider may charge the
14 individual for such an item or service.
15 ‘‘(III) A statement that the indi-
16 vidual may seek such an item or serv-
17 ice from a provider that is a partici-
18 pating provider or a hospital or inde-
19 pendent freestanding emergency de-
20 partment that is a participating facil-
21 ity.
22 ‘‘(ii) Before the end of such 24 hours,
23 the individual signs and dates such notice
24 confirming receipt of the notice.

1 "(iii) The health plan of such indi-
2 vidual and the hospital or independent
3 freestanding emergency department ar-
4 range for such continued care as nec-
5 essary, similar to the process relating to
6 promoting efficient and timely coordination
7 of appropriate maintenance and post-sta-
8 bilization care under section 1852(d)(2) of
9 the Social Security Act.

10 "(6) HEALTH PLAN.—The term 'health plan'
11 means a group health plan, including any group
12 health plan that is a grandfathered health plan (as
13 defined in section 1251(e) of the Patient Protection
14 and Affordable Care Act).

15 "(7) INDEPENDENT FREESTANDING EMER-
16 GENCY DEPARTMENT.—The term 'independent free-
17 standing emergency department' means a health
18 care facility that—

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

22 "(B) provides emergency services.

23 "(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 of such
7 plan (determined with respect to all such
8 plans of such sponsor that are within the
9 same line of business (as specified in sub-
10 paragraph (C)) as the plan involved) as the
11 total maximum payment under such plans
12 in 2019 for the same or a similar item or
13 service that is provided by a provider or fa-
14 cility in the same or similar specialty and
15 provided in the geographic region (estab-
16 lished (and updated, as appropriate) by the
17 Secretary, in consultation with the Na-
18 tional Association of Insurance Commis-
19 sioners) in which the item or service is fur-
20 nished, consistent with the methodology es-
21 tablished by the Secretary under sub-
22 section (b)(2)(B), increased by the percent-
23 age increase in the consumer price index
24 for all urban consumers (United States
25 city average) over 2019, 2020, and 2021;

1 “(ii) for an item or service furnished
2 during 2023 or a subsequent year through
3 2026, the median contracted rate for the
4 previous year, increased by the percentage
5 increase in the consumer price index for all
6 urban consumers (United States city aver-
7 age) over such previous year;
8 “(iii) for an item or service furnished
9 during a rebasing year (as defined in sub-
10 paragraph (D)), the median of the con-
11 tracted rates recognized by the sponsor of
12 such plan (determined with respect to all
13 such plans of such sponsor that are within
14 the same line of business (as specified in
15 subparagraph (C)) as the plan involved) as
16 the total maximum payment under such
17 plans in such year for the same or a simi-
18 lar item or service that is provided by a
19 provider or facility in the same or similar
20 specialty and provided in the geographic
21 region (as established pursuant to clause
22 (i)) in which the item or service is fur-
23 nished, consistent with the methodology es-
24 tablished by the Secretary under sub-
25 section (b)(2)(B); and

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

9 "(B) USE OF SUBSTITUTE RATE IN CASE
10 OF INSUFFICIENT DATA.—

11 "(i) IN GENERAL.—In the case the
12 sponsor of a health plan has insufficient
13 information (as specified by the Secretary)
14 to calculate the median of the contracted
15 rates in accordance with subparagraph (A)
16 for a year for an item or service furnished
17 in a particular geographic region (as estab-
18 lished pursuant to subparagraph (A)(i)) by
19 a type of provider or facility, the substitute
20 rate (as defined in clause (ii)) for such
21 item or service shall be deemed to be the
22 median contracted rate for such item or
23 service furnished in such region during
24 such year by such a provider or facility for

1 such year under such subparagraph (A) for
2 such plan.
3 "(ii) SUBSTITUTE RATE.—For pur-
4 poses of clause (i), the term 'substitute
5 rate' means, with respect to an item or
6 service furnished by a provider or facility
7 in a geographic region (established pursu-
8 ant to subparagraph (A)(i)) during a year
9 for which a health plan is required to make
10 payment pursuant to subsection (b)(1),
11 (e)(1), or (i)(1)—
12 "(I) if sufficient information (as
13 specified by the Secretary) exists to
14 determine the median of the con-
15 tracted rates recognized by all health
16 plans offered in the same line of busi-
17 ness (as specified in subparagraph
18 (C)) by any group health plan for
19 such an item or service furnished in
20 such region by such a provider or fa-
21 cility during such year using a data-
22 base or other source of information
23 determined appropriate by the Sec-
24 retary, such median; and

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

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

22 "(C) LINE OF BUSINESS.—A line of busi-
23 ness specified in this subparagraph is one of the
24 following:

25 "(i) The small group market.

1 "(ii) The large group market.
2 "(iii) In the case of a self-insured
3 group health plan, other self-insured group
4 health plans.
5 "(D) REBASING YEAR DEFINED.—For pur-
6 poses of subparagraph (A), the term 'rebasing
7 year' means 2027 and every 5 years thereafter.
8 "(9) NONPARTICIPATING FACILITY; PARTICI-
9 PATING FACILITY.—
10 "(A) NONPARTICIPATING FACILITY.—The
11 term 'nonparticipating facility' means, with re-
12 spect to an item or service and a health plan,
13 a health care facility described in subparagraph
14 (B)(ii) that does not have a contractual rela-
15 tionship with the plan for furnishing such item
16 or service.
17 "(B) PARTICIPATING FACILITY.—
18 "(i) IN GENERAL.—The term 'partici-
19 pating facility' means, with respect to an
20 item or service and a health plan, a health
21 care facility described in clause (ii) that
22 has a contractual relationship with the
23 plan for furnishing such item or service.

1 "(ii) HEALTH CARE FACILITY DE-
2 SCRIBED.—A health care facility described
3 in this clause is each of the following:
4 "(I) A hospital (as defined in
5 1861(e) of the Social Security Act),
6 including an emergency department of
7 a hospital.
8 "(II) A critical access hospital
9 (as defined in section 1861(mm) of
10 such Act).
11 "(III) An ambulatory surgical
12 center (as defined in section
13 1833(i)(1)(A) of such Act).
14 "(IV) A laboratory.
15 "(V) A radiology facility or imag-
16 ing center.
17 "(VI) An independent free-
18 standing emergency department.
19 "(VII) Any other facility speci-
20 fied by the Secretary.
21 "(10) NONPARTICIPATING PROVIDERS; PARTICI-
22 PATING PROVIDERS.—
23 "(A) NONPARTICIPATING PROVIDER.—The
24 term 'nonparticipating provider' means, with re-
25 spect to an item or service and a health plan,

1 a physician or other health care provider who
2 does not have a contractual relationship with
3 the plan for furnishing such item or service
4 under the plan.

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

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

17 ‘‘(A) subject to subparagraphs (C) and
18 (D), in the case such State has in effect a State
19 law that provides for a method for determining
20 the amount payable (by the plan and the partic-
21 ipant or beneficiary) under such health plan
22 regulated by such State with respect to such
23 item or service furnished by such provider or
24 facility, such amount (including cost-sharing)
25 determined in accordance with 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 with respect to such item or
4 service, plan, and provider or facility—
5 "(i) subject to clause (ii), if the pro-
6 vider or facility (as applicable) and such
7 plan agree on an amount of payment (in-
8 cluding if agreed on through open negotia-
9 tions under subsection (j)(1)) with respect
10 to such item or service, such agreed on
11 amount; or
12 "(ii) if such provider or facility (as
13 applicable) and such plan enter the medi-
14 ated dispute process under subsection (j)
15 and do not so agree before the date on
16 which a selected independent entity (as de-
17 fined in paragraph (3) of such subsection)
18 makes a determination with respect to
19 such item or service under such subsection,
20 the amount of such determination;
21 "(C) subject to subparagraph (D), in the
22 case such State has an All-Payer Model Agree-
23 ment under section 1115A of the Social Secu-
24 rity Act, the amount (including cost-sharing)

1 that the State approves under such system for
2 such item 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 amount payable (by the
10 plan and the participant or beneficiary) under
11 such health plan with respect to such item or
12 service furnished by such provider or facility,
13 such amount (including cost-sharing) deter-
14 mined in accordance with such method.
15 ‘‘(12) RECOGNIZED AMOUNT.—The term ‘recog-
16 nized amount’ means, with respect to an item or
17 service furnished in a State during a year to a par-
18 ticipant or beneficiary of a health plan by a non-
19 participating provider or nonparticipating facility—
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 amount payable (by the
19 plan and the participant or beneficiary) 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) of the Social Se-
2 curity Act).''.
3 (2) CONFORMING AMENDMENTS.—
4 (A) APPLICATION PROVISIONS.—Section
5 9815(a) of the Internal Revenue Code of 1986
6 is amended—
7 (i) in paragraph (1), by striking ''(as
8 amended by the Patient Protection and Af-
9 fordable Care Act)'' and inserting ''(other
10 than, with respect to a plan year beginning
11 on or after January 1, 2022, the provisions
12 of section 2719A of such Act)''; and
13 (ii) in paragraph (2), by inserting
14 ''(other than, with respect to a plan year
15 beginning on or after January 1, 2022, the
16 provisions of section 2719A of such Act)''
17 after ''such part A''.
18 (B) APPLICATION TO RETIREE-ONLY
19 PLANS.—Section 9831(a) of the Internal Rev-
20 enue Code of 1986 is amended by inserting
21 ''(other than, with respect to a group health
22 plan described in paragraph (2), the require-
23 ments of section 9816)'' before ''shall not
24 apply''.

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

"Sec. 9815. Additional market reforms.
"Sec. 9816. Patient protections.".

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

7 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT
8 OF 1974 AMENDMENTS.—

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

14 **"SEC. 716. PATIENT PROTECTIONS.**

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

21 "(b) COST-SHARING AND PAYMENT OF EMERGENCY
22 SERVICES.—

23 "(1) IN GENERAL.—If a health plan provides or
24 covers any benefits with respect to services in an

1 emergency department of a hospital or, for plan year
2 2022 or a subsequent plan year, with respect to
3 emergency services in an independent freestanding
4 emergency department, the plan shall cover emer-
5 gency services—
6 "(A) without the need for any prior au-
7 thorization determination;
8 "(B) whether the health care provider fur-
9 nishing such services is a participating provider
10 or a participating facility that is an emergency
11 department of a hospital or an independent
12 freestanding emergency department (in this
13 subsection referred to as a 'participating emer-
14 gency facility') with respect to such services;
15 "(C) in a manner so that, if such services
16 are provided to a participant or beneficiary by
17 a nonparticipating provider or a nonpartici-
18 pating facility that is an emergency department
19 of a hospital or an independent freestanding
20 emergency department—
21 "(i) such services will be provided
22 without imposing any requirement under
23 the plan for prior authorization of services
24 or any limitation on coverage that is more
25 restrictive than the requirements or limita-

1 tions that apply to emergency services re-
2 ceived from participating providers and
3 participating emergency facilities with re-
4 spect to such plan;
5 ''(ii) the cost-sharing requirement (ex-
6 pressed as a copayment amount or coinsur-
7 ance rate) is not greater than the require-
8 ment that would apply if such services
9 were furnished by a participating provider
10 or a participating emergency facility, as
11 applicable;
12 ''(iii) such cost-sharing requirement is
13 calculated as if the contracted rate for
14 such services if furnished by a partici-
15 pating provider or a participating emer-
16 gency facility were equal to the recognized
17 amount for such services;
18 ''(iv) the health plan pays to such pro-
19 vider or facility, respectively, the amount
20 by which the out-of-network rate for such
21 services exceeds the cost-sharing amount
22 for such services (as determined in accord-
23 ance with clauses (ii) and (iii)); and
24 ''(v) any deductible or out-of-pocket
25 maximum that would apply if such services

1 were furnished by a participating provider
2 or a participating emergency facility shall
3 be the deductible or out-of-pocket max-
4 imum that applies; and
5 "(D) without regard to any other term or
6 condition of such coverage (other than exclusion
7 or coordination of benefits, or an affiliation or
8 waiting period, permitted under section 2704 of
9 the Public Health Service Act, including as in-
10 corporated pursuant to section 715 and section
11 9815 of the Internal Revenue Code of 1986,
12 and other than applicable cost-sharing).
13 "(2) AUDIT PROCESS AND RULEMAKING PROC-
14 ESS FOR MEDIAN CONTRACTED RATES.—
15 "(A) AUDIT PROCESS.—
16 "(i) IN GENERAL.—Not later than
17 July 1, 2021, the Secretary, in coordina-
18 tion with the Secretary of Health and
19 Human Services and the Secretary of the
20 Treasury and in consultation with the Na-
21 tional Association of Insurance Commis-
22 sioners, shall establish through rulemaking
23 a process, in accordance with clause (ii),
24 under which health plans are audited by
25 the Secretary to ensure that—

1 "(I) such plans are in compliance
2 with the requirement of applying a
3 median contracted rate under this sec-
4 tion; and

5 "(II) that such median con-
6 tracted rate so applied satisfies the
7 definition under subsection (k)(8)
8 with respect to the year involved.

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

12 "(I) shall conduct audits de-
13 scribed in such clause of a sample of
14 health plans; and

15 "(II) may audit any health plan
16 if the Secretary has received any com-
17 plaint about such plan that involves
18 the compliance of the plan with the
19 requirement described in such clause.

20 "(B) RULEMAKING.—Not later than July
21 1, 2021, the Secretary, in coordination with the
22 Secretary of the Treasury and the Secretary of
23 Health and Human Services, shall establish
24 through rulemaking—

1 "(i) the methodology the sponsor or
2 issuer of a health plan shall use to deter-
3 mine the median contracted rate, which
4 shall account for relevant payment adjust-
5 ments that take into account facility type
6 that are otherwise taken into account for
7 purposes of determining payment amounts
8 with respect to participating facilities; and
9 "(ii) the information such sponsor or
10 issuer shall share with the nonparticipating
11 provider involved when making such a de-
12 termination.
13 "(c) ACCESS TO PEDIATRIC CARE.—
14 "(1) PEDIATRIC CARE.—In the case of a person
15 who has a child who is a participant or beneficiary
16 under a health plan, if the plan requires or provides
17 for the designation of a participating primary care
18 provider for the child, the plan shall permit such
19 person to designate a physician (allopathic or osteo-
20 pathic) who specializes in pediatrics as the child's
21 primary care provider if such provider participates
22 in the network of the plan.
23 "(2) CONSTRUCTION.—Nothing in paragraph
24 (1) shall be construed to waive any exclusions of cov-

1 erage under the terms and conditions of the plan
2 with respect to coverage of pediatric care.
3 "(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
4 COLOGICAL CARE.—
5 "(1) GENERAL RIGHTS.—
6 "(A) DIRECT ACCESS.—A health plan de-
7 scribed in paragraph (2) may not require au-
8 thorization or referral by the plan or any per-
9 son (including a primary care provider de-
10 scribed in paragraph (2)(B)) in the case of a fe-
11 male participant or beneficiary who seeks cov-
12 erage for obstetrical or gynecological care pro-
13 vided by a participating health care professional
14 who specializes in obstetrics or gynecology.
15 Such professional shall agree to otherwise ad-
16 here to such plan's policies and procedures, in-
17 cluding procedures regarding referrals and ob-
18 taining prior authorization and providing serv-
19 ices pursuant to a treatment plan (if any) ap-
20 proved by the plan.
21 "(B) OBSTETRICAL AND GYNECOLOGICAL
22 CARE.—A health plan described in paragraph
23 (2) shall treat the provision of obstetrical and
24 gynecological care, and the ordering of related
25 obstetrical and gynecological items and services,

1 pursuant to the direct access described under
2 subparagraph (A), by a participating health
3 care professional who specializes in obstetrics or
4 gynecology as the authorization of the primary
5 care provider.
6 ''(2) APPLICATION OF PARAGRAPH.—A health
7 plan described in this paragraph is a health plan
8 that—
9 ''(A) provides coverage for obstetric or
10 gynecologic care; and
11 ''(B) requires the designation by a partici-
12 pant or beneficiary of a participating primary
13 care provider.
14 ''(3) CONSTRUCTION.—Nothing in paragraph
15 (1) shall be construed to—
16 ''(A) waive any exclusions of coverage
17 under the terms and conditions of the plan with
18 respect to coverage of obstetrical or gyneco-
19 logical care; or
20 ''(B) preclude the health plan involved
21 from requiring that the obstetrical or gyneco-
22 logical provider notify the primary care health
23 care professional or the plan of treatment deci-
24 sions.
25 ''(k) DEFINITIONS.—For purposes of this section:

1 "(1) CONTRACTED RATE.—The term 'con-
2 tracted rate' means, with respect to a health plan
3 and a health care provider or health care facility fur-
4 nishing an item or service to a beneficiary or partici-
5 pant of such plan, the agreed upon total payment
6 amount (inclusive of any cost-sharing) to such pro-
7 vider or facility for such item or service.

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

18 "(3) EMERGENCY DEPARTMENT OF A HOS-
19 PITAL.—The term 'emergency department of a hos-
20 pital' includes a hospital outpatient department that
21 provides emergency services.

22 "(4) EMERGENCY MEDICAL CONDITION.—The
23 term 'emergency medical condition' means a medical
24 condition manifesting itself by acute symptoms of
25 sufficient severity (including severe pain) such that

1 a prudent layperson, who possesses an average
2 knowledge of health and medicine, could reasonably
3 expect the absence of immediate medical attention to
4 result in a condition described in clause (i), (ii), or
5 (iii) of section 1867(e)(1)(A) of the Social Security
6 Act.
7 ''(5) EMERGENCY SERVICES.—
8 ''(A) IN GENERAL.—The term 'emergency
9 services', with respect to an emergency medical
10 condition, means—
11 ''(i) a medical screening examination
12 (as required under section 1867 of the So-
13 cial Security Act, or as would be required
14 under such section if such section applied
15 to an independent freestanding emergency
16 department) that is within the capability of
17 the emergency department of a hospital or
18 of an independent freestanding emergency
19 department, as applicable, including ancil-
20 lary services routinely available to the
21 emergency department to evaluate such
22 emergency medical condition; and
23 ''(ii) within the capabilities of the
24 staff and facilities available at the hospital
25 or the independent freestanding emergency

1 department, as applicable, such further
2 medical examination and treatment as are
3 required under section 1867 of such Act,
4 or as would be required under such section
5 if such section applied to an independent
6 freestanding emergency department, to
7 stabilize the patient (regardless of the de-
8 partment of the hospital in which such fur-
9 ther examination or treatment is fur-
10 nished).

11 ‘‘(B) INCLUSION OF ADDITIONAL RELATED
12 SERVICES.—In the case of an individual en-
13 rolled in a health plan who is furnished services
14 described in subparagraph (A) by a provider or
15 hospital or independent freestanding emergency
16 department to stabilize such individual with re-
17 spect to an emergency medical condition, the
18 term ‘emergency services’ shall include, in addi-
19 tion to those described in subparagraph (A),
20 items and services furnished as part of out-
21 patient observation or an inpatient or out-
22 patient stay during a visit in which such indi-
23 vidual is so stabilized if such items and services
24 would otherwise be covered under such plan if
25 furnished by a participating provider or partici-

1 pating facility that is an emergency department
2 of a hospital or an independent freestanding
3 emergency department, unless each of the fol-
4 lowing conditions are met:
5 ''(i) Such a provider or hospital or
6 independent freestanding emergency de-
7 partment determines such individual is
8 able to travel using nonmedical transpor-
9 tation or nonemergency medical transpor-
10 tation.
11 ''(ii) The criteria described in sub-
12 paragraph (C) are satisfied with respect to
13 such provider or hospital or independent
14 freestanding emergency department, indi-
15 vidual, and items and services.
16 ''(C) SIGNED NOTICE CRITERIA.—For pur-
17 poses of subparagraph (B)(ii), the criteria de-
18 scribed in this subparagraph, with respect to an
19 individual described in subparagraph (B), any
20 item or service that may be considered needed
21 to be furnished (after stabilization but during
22 the visit in which the individual is stabilized, as
23 described in the matter preceding clause (i) of
24 such subparagraph), and the hospital or inde-
25 pendent freestanding emergency department

1 furnishing such items or services, are the fol-
2 lowing:

3 ''(i) A written notice (as specified by
4 the Secretary) is provided by the hospital
5 or independent freestanding emergency de-
6 partment to such individual, not later than
7 24 hours after the time of such stabiliza-
8 tion of such individual, that includes the
9 following information:

10 ''(I) In the case the hospital or
11 independent freestanding emergency
12 department is a nonparticipating facil-
13 ity, with respect to the health plan of
14 such individual, that the hospital or
15 independent freestanding emergency
16 department is a nonparticipating facil-
17 ity (or, in the case the hospital or
18 independent freestanding emergency
19 department is a participating facility,
20 that potentially a provider that may
21 furnish such an item or service during
22 such visit, may be a nonparticipating
23 provider with respect to such health
24 plan).

1 "(II) To the extent practicable,
2 the estimated amount that such non-
3 participating facility or such a non-
4 participating provider may charge the
5 individual for such an item or service.
6 "(III) A statement that the indi-
7 vidual may seek such an item or serv-
8 ice from a provider that is a partici-
9 pating provider or a hospital or inde-
10 pendent freestanding emergency de-
11 partment that is a participating facil-
12 ity.
13 "(ii) Before the end of such 24 hours,
14 the individual signs and dates such notice
15 confirming receipt of the notice.
16 "(iii) The health plan of such indi-
17 vidual and the hospital or independent
18 freestanding emergency department ar-
19 range for such continued care as nec-
20 essary, similar to the process relating to
21 promoting efficient and timely coordination
22 of appropriate maintenance and post-sta-
23 bilization care under section 1852(d)(2) of
24 the Social Security Act.

1 "(6) HEALTH PLAN.—The term 'health plan'
2 means a group health plan and health insurance cov-
3 erage offered by a health insurance issuer in the
4 group market and includes a grandfathered health
5 plan (as defined in section 1251(e) of the Patient
6 Protection and Affordable Care Act) that is such a
7 plan or coverage.
8 "(7) INDEPENDENT FREESTANDING EMER-
9 GENCY DEPARTMENT.—The term 'independent free-
10 standing emergency department' means a health
11 care facility that—
12 "(A) is geographically separate and dis-
13 tinct and licensed separately from a hospital
14 under applicable State law; and
15 "(B) provides emergency services.
16 "(8) MEDIAN CONTRACTED RATE.—
17 "(A) IN GENERAL.—Subject to subpara-
18 graph (B), the term 'median contracted rate'
19 means, with respect to a health plan—
20 "(i) for an item or service furnished
21 during 2022, the median of the contracted
22 rates recognized by the sponsor or issuer
23 of such plan (determined with respect to
24 all such plans of such sponsor or such
25 issuer that are within the same line of

1 business (as specified in subparagraph (C))
2 as the plan involved) as the total maximum
3 payment under such plans in 2019 for the
4 same or a similar item or service that is
5 provided by a provider or facility in the
6 same or similar specialty and provided in
7 the geographic region (established (and up-
8 dated, as appropriate) by the Secretary, in
9 consultation with the National Association
10 of Insurance Commissioners) in which the
11 item or service is furnished, consistent with
12 the methodology established by the Sec-
13 retary under subsection (b)(2)(B), in-
14 creased by the percentage increase in the
15 consumer price index for all urban con-
16 sumers (United States city average) over
17 2019, 2020, and 2021;
18 ‘‘(ii) for an item or service furnished
19 during 2023 or a subsequent year through
20 2026, the median contracted rate for the
21 previous year, increased by the percentage
22 increase in the consumer price index for all
23 urban consumers (United States city aver-
24 age) over such previous year;

1 "(iii) for an item or service furnished
2 during a rebasing year (as defined in sub-
3 paragraph (D)), the median of the con-
4 tracted rates recognized by the sponsor or
5 issuer of such plan (determined with re-
6 spect to all such plans of such sponsor or
7 issuer that are within the same line of
8 business (as specified in subparagraph (C))
9 as the plan involved) as the total maximum
10 payment under such plans in such year for
11 the same or a similar item or service that
12 is provided by a provider or facility in the
13 same or similar specialty and provided in
14 the geographic region (as established pur-
15 suant to clause (i)) in which the item or
16 service is furnished, consistent with the
17 methodology established by the Secretary
18 under subsection (b)(2)(B); and
19 "(iv) for an item or service furnished
20 during any of the 4 years following a re-
21 basing year, the median contracted rate for
22 the previous year, increased by the per-
23 centage increase in the consumer price
24 index for all urban consumers (United

1 States city average) over such previous
2 year.
3 "(B) USE OF SUBSTITUTE RATE IN CASE
4 OF INSUFFICIENT DATA.—
5 "(i) IN GENERAL.—In the case the
6 sponsor or issuer of a health plan has in-
7 sufficient information (as specified by the
8 Secretary) to calculate the median of the
9 contracted rates in accordance with sub-
10 paragraph (A) for a year for an item or
11 service furnished in a particular geographic
12 region (as established pursuant to subpara-
13 graph (A)(i)) by a type of provider or facil-
14 ity, the substitute rate (as defined in
15 clause (ii)) for such item or service shall be
16 deemed to be the median contracted rate
17 for such item or service furnished in such
18 region during such year by such a provider
19 or facility for such year under such sub-
20 paragraph (A) for such plan.
21 "(ii) SUBSTITUTE RATE.—For pur-
22 poses of clause (i), the term 'substitute
23 rate' means, with respect to an item or
24 service furnished by a provider or facility
25 in a geographic region (established pursu-

1 ant to subparagraph (A)(i)) during a year
2 for which a health plan is required to make
3 payment pursuant to subsection (b)(1),
4 (e)(1), or (i)(1)—
5 ''(I) if sufficient information (as
6 specified by the Secretary) exists to
7 determine the median of the con-
8 tracted rates recognized by all health
9 plans offered in the same line of busi-
10 ness (as specified in subparagraph
11 (C)) by any group health plan for
12 such an item or service furnished in
13 such region by such a provider or fa-
14 cility during such year using a data-
15 base or other source of information
16 determined appropriate by the Sec-
17 retary, such median; and
18 ''(II) if such sufficient informa-
19 tion does not exist, the median of the
20 contracted rates recognized by all
21 health plans offered in the same line
22 of business (as specified in subpara-
23 graph (C)) by any group health plan
24 for such an item or service furnished
25 in a similarly situated geographic re-

gion (as determined by the Secretary) with such sufficient information by such a provider or facility during such year using such a database or such other source of information.

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

"(C) LINE OF BUSINESS.—A line of business specified in this subparagraph is one of the following:

"(i) The small group market.

"(ii) The large group market.

"(iii) In the case of a self-insured group health plan, other self-insured group health plans.

"(D) REBASING YEAR DEFINED.—For purposes of subparagraph (A), the term 'rebasing year' means 2027 and every 5 years thereafter.

1 "(9) NONPARTICIPATING FACILITY; PARTICI-
2 PATING FACILITY.—
3 "(A) NONPARTICIPATING FACILITY.—The
4 term 'nonparticipating facility' means, with re-
5 spect to an item or service and a health plan,
6 a health care facility described in subparagraph
7 (B)(ii) that does not have a contractual rela-
8 tionship with the plan for furnishing such item
9 or service.
10 "(B) PARTICIPATING FACILITY.—
11 "(i) IN GENERAL.—The term 'partici-
12 pating facility' means, with respect to an
13 item or service and a health plan, a health
14 care facility described in clause (ii) that
15 has a contractual relationship with the
16 plan for furnishing such item or service.
17 "(ii) HEALTH CARE FACILITY DE-
18 SCRIBED.—A health care facility described
19 in this clause is each of the following:
20 "(I) A hospital (as defined in
21 1861(e) of the Social Security Act),
22 including an emergency department of
23 a hospital.

1 "(II) A critical access hospital
2 (as defined in section 1861(mm) of
3 such Act).
4 "(III) An ambulatory surgical
5 center (as defined in section
6 1833(i)(1)(A) of such Act).
7 "(IV) A laboratory.
8 "(V) A radiology facility or imag-
9 ing center.
10 "(VI) An independent free-
11 standing emergency department.
12 "(VII) Any other facility speci-
13 fied by the Secretary.
14 "(10) NONPARTICIPATING PROVIDERS; PARTICI-
15 PATING PROVIDERS.—
16 "(A) NONPARTICIPATING PROVIDER.—The
17 term 'nonparticipating 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 does not have a contractual relationship with
21 the plan for furnishing such item or service
22 under the plan.
23 "(B) PARTICIPATING PROVIDER.—The
24 term 'participating provider' means, with re-
25 spect to an item or service and a health plan,

1 a physician or other health care provider who
2 has a contractual relationship with the plan for
3 furnishing such item or service under the plan.
4 "(11) OUT-OF-NETWORK RATE.—The term
5 'out-of-network rate' means, with respect to an item
6 or service furnished in a State during a year to a
7 participant or beneficiary of a health plan receiving
8 such item or service from a nonparticipating pro-
9 vider or facility—
10 "(A) subject to subparagraphs (C) and
11 (D), in the case such State has in effect a State
12 law that provides for a method for determining
13 the amount payable (by the plan and the partic-
14 ipant or beneficiary) under such health plan
15 regulated by such State with respect to such
16 item or service furnished by such provider or
17 facility, such amount (including cost-sharing)
18 determined in accordance with such law;
19 "(B) subject to subparagraphs (C) and
20 (D),, in the case such State does not have in ef-
21 fect such a law with respect to such item or
22 service, plan, and provider or facility—
23 "(i) subject to clause (ii), if the pro-
24 vider or facility (as applicable) and such
25 plan agree on an amount of payment (in-

1 cluding if agreed on through open negotia-
2 tions under subsection (j)(1)) with respect
3 to such item or service, such agreed on
4 amount; or
5 "(ii) if such provider or facility (as
6 applicable) and such plan enter the medi-
7 ated dispute process under subsection (j)
8 and do not so agree before the date on
9 which a selected independent entity (as de-
10 fined in paragraph (3) of such subsection)
11 makes a determination with respect to
12 such item or service under such subsection,
13 the amount of such determination;
14 "(C) subject to subparagraph (D), in the
15 case such State has an All-Payer Model Agree-
16 ment under section 1115A of the Social Secu-
17 rity Act, the amount (including cost-sharing)
18 that the State approves under such system for
19 such item or service so furnished; or
20 "(D) in the case such health plan is a self-
21 insured group health plan and in the case of a
22 State with an agreement with such plan in ef-
23 fect as of the date of the enactment of the Con-
24 sumer Protections Against Surprise Medical
25 Bills Act of 2020, that provides for a method

1 for determining the amount payable (by the
2 plan and the participant or beneficiary) under
3 such health plan with respect to such item or
4 service furnished by such provider or facility,
5 such amount (including cost-sharing) deter-
6 mined in accordance with such method.

7 ''(12) RECOGNIZED AMOUNT.—The term 'recog-
8 nized amount' means, with respect to an item or
9 service furnished in a State during a year to a par-
10 ticipant or beneficiary of a health plan by a non-
11 participating provider or nonparticipating facility—

12 ''(A) subject to subparagraphs (C) and
13 (D), in the case such State has in effect a law
14 described in paragraph (11)(A) with respect to
15 such item or service, provider or facility, and
16 plan, the amount determined in accordance with
17 such law;

18 ''(B) subject to subparagraphs (C) and
19 (D), in the case such State does not have in ef-
20 fect such a law, an amount that is the median
21 contracted rate for such item or service for such
22 year;

23 ''(C) subject to subparagraph (D), in the
24 case such State is described in paragraph
25 (11)(C) with respect to such item or service so

1 furnished, the amount that the State approves
2 under such system for such item or service so
3 furnished; or

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

16 "(13) STABILIZE.—The term 'to stabilize', with
17 respect to an emergency medical condition, has the
18 meaning give in section 1867(e)(3) of the Social Se-
19 curity Act).".

20 (2) CONFORMING AMENDMENT.—

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

1 (i) in paragraph (1), by striking "(as
2 amended by the Patient Protection and Af-
3 fordable Care Act)" and inserting "(other
4 than, with respect to a plan year beginning
5 on or after January 1, 2022, the provisions
6 of section 2719A of such Act)"; and
7 (ii) in paragraph (2), by inserting
8 "(other than, with respect to a plan year
9 beginning on or after January 1, 2022, the
10 provisions of section 2719A of such Act)"
11 after "such part A".
12 (B) APPLICATION TO RETIREE-ONLY
13 PLANS.—Section 732(a) of the Employee Re-
14 tirement Income Security Act of 1974 (29
15 U.S.C. 1191a(a)) is amended by striking "sec-
16 tion 711" and inserting "sections 711 and
17 716".
18 (3) CLERICAL AMENDMENT.—The table of con-
19 tents in section 1 of the Employee Retirement In-
20 come Security Act of 1974 is amended by inserting
21 after the item relating to section 714 the following
22 new items:

"Sec. 715. Additional market reforms.
"Sec. 716. Patient protections.".

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

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

10 (a) PHSA AMENDMENTS.—
11 (1) IN GENERAL.—Section 2719A of the Public
12 Health Service Act (42 U.S.C. 300gg–19a), as
13 amended by section 2(a), is further amended by in-
14 serting before subsection (k) the following new sub-
15 section:
16 "(e) COST-SHARING AND PAYMENT OF NON-EMER-
17 GENCY SERVICES PERFORMED BY NONPARTICIPATING
18 PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—
19 "(1) IN GENERAL.—Subject to paragraph (2),
20 in the case of items or services (other than emer-
21 gency services to which subsection (b) applies or
22 items and services to which subsection (i) applies)
23 furnished to a participant, beneficiary, or enrollee of
24 a health plan by a nonparticipating provider during
25 a visit (as defined by the Secretary in accordance

1 with subsection (k)(2)) at a participating facility, if
2 such items and services would otherwise be covered
3 under such plan if furnished by a participating pro-
4 vider, the plan—
5 ‘‘(A) shall not impose on such participant,
6 beneficiary, or enrollee a cost-sharing amount
7 (expressed as a copayment amount or coinsur-
8 ance rate) for such items and services so fur-
9 nished that is greater than the cost-sharing
10 amount that would apply under such plan had
11 such items or services been furnished by a par-
12 ticipating provider;
13 ‘‘(B) shall calculate such cost-sharing
14 amount as if the contracted rate for such serv-
15 ices if furnished by a participating provider
16 were equal to the recognized amount for such
17 items and services;
18 ‘‘(C) shall pay to such provider furnishing
19 such items and services to such participant,
20 beneficiary, or enrollee the amount by which the
21 out-of-network rate for such items and services
22 exceeds the cost-sharing amount imposed under
23 the plan for such items and services (as deter-
24 mined in accordance with subparagraphs (A)
25 and (B)); and

1 "(D) shall apply the deductible or out-of-
2 pocket maximum, if any, that would apply if
3 such services were furnished by a participating
4 provider.
5 "(2) EXCEPTION.—Paragraph (1) shall not
6 apply to a health plan in the case of items or serv-
7 ices furnished to a participant, beneficiary, or en-
8 rollee of a health plan by a nonparticipating provider
9 during a visit (as so defined by the Secretary in ac-
10 cordance with subsection (k)(2)) at a participating
11 facility if the requirement described in paragraph (1)
12 of section 1150C(b) of the Social Security Act does
13 not apply with respect to such provider and such
14 items and services due to the application of para-
15 graph (2) of such section.".
16 (2) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) shall apply with respect to plan
18 years beginning on or after January 1, 2022.
19 (b) IRC AMENDMENTS.—
20 (1) IN GENERAL.—Section 9816 of the Internal
21 Revenue Code of 1986, as added by section 2(b), is
22 amended by inserting before subsection (k) the fol-
23 lowing 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 (expressed
17 as a copayment amount or coinsurance rate) for
18 such items and services so furnished that is
19 greater than the cost-sharing amount that
20 would apply under such plan had such items or
21 services been furnished by a participating pro-
22 vider;
23 "(B) shall calculate such cost-sharing
24 amount as if the contracted rate for such serv-
25 ices if furnished by a participating provider

1 were equal to the recognized amount for such
2 items and services;
3 "(C) shall pay to such provider furnishing
4 such items and services to such participant or
5 beneficiary the amount by which the out-of-net-
6 work rate for such items and services exceeds
7 the cost-sharing amount imposed under the
8 plan for such items and services (as determined
9 in accordance with subparagraphs (A) and (B));
10 and
11 "(D) shall apply the deductible or out-of-
12 pocket maximum, if any, that would apply if
13 such services were furnished by a participating
14 provider.
15 "(2) EXCEPTION.—Paragraph (1) shall not
16 apply to a health plan in the case of items or serv-
17 ices furnished to a participant or beneficiary of a
18 health plan by a nonparticipating provider during a
19 visit (as so defined by the Secretary in accordance
20 with subsection (k)(2)) at a participating facility if
21 the requirement described in paragraph (1) of sec-
22 tion 1150C(b) of the Social Security Act does not
23 apply with respect to such provider and such items
24 and services due to the application of paragraph (2)
25 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 (c) ERISA AMENDMENTS.—
5 (1) IN GENERAL.—Section 716 of the Employee
6 Retirement Income Security Act of 1974, as added
7 by section 2(c), is amended by inserting before sub-
8 section (k) the following new subsection:
9 ''(e) COST-SHARING AND PAYMENT OF NON-EMER-
10 GENCY SERVICES PERFORMED BY NONPARTICIPATING
11 PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—
12 ''(1) IN GENERAL.—Subject to paragraph (2),
13 in the case of items or services (other than emer-
14 gency services to which subsection (b) applies or
15 items and services to which subsection (i) applies)
16 furnished to a participant or beneficiary of a health
17 plan by a nonparticipating provider during a visit
18 (as defined by the Secretary in accordance with sub-
19 section (k)(2)) at a participating facility, if such
20 items and services would otherwise be covered under
21 such plan if furnished by a participating provider,
22 the plan—
23 ''(A) shall not impose on such participant
24 or beneficiary a cost-sharing amount (expressed
25 as a copayment amount or coinsurance rate) for

1 such items and services so furnished that is
2 greater than the cost-sharing amount that
3 would apply under such plan had such items or
4 services been furnished by a participating pro-
5 vider;

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

11 "(C) shall pay to such provider furnishing
12 such items and services to such participant or
13 beneficiary the amount by which the out-of-net-
14 work rate for such items and services exceeds
15 the cost-sharing amount imposed under the
16 plan for such items and services (as determined
17 in accordance with subparagraphs (A) and (B));
18 and

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

23 "(2) EXCEPTION.—Paragraph (1) shall not
24 apply to a health plan in the case of items or serv-
25 ices furnished to a participant or beneficiary of a

1 health plan by a nonparticipating provider during a
2 visit (as so defined by the Secretary in accordance
3 with subsection (k)(2)) at a participating facility if
4 the requirement described in paragraph (1) of sec-
5 tion 1150C(b) of the Social Security Act does not
6 apply with respect to such provider and such items
7 and services due to the application of paragraph (2)
8 of such section.''.

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

12 **SEC. 4. CONSUMER PROTECTIONS THROUGH APPLICATION**
13 **OF HEALTH PLAN EXTERNAL REVIEW IN**
14 **CASES OF CERTAIN SURPRISE MEDICAL**
15 **BILLS.**

16 Section 2719(b)(1) of the Public Health Service Act
17 (42 U.S.C. 300gg–19(b)(1)) is amended—

18 (1) by striking ''at a minimum, includes'' and
19 inserting ''at a minimum—

20 ''(A) includes'';

21 (2) by striking at the end ''or'' and inserting
22 ''and''; and

23 (3) by adding at the end the following new sub-
24 paragraph:

1 "(B) beginning not later than January 1,
2 2022, applies such external review process with
3 respect to any adverse determination by such
4 plan or issuer under subsection (b) of section
5 2719A, subsection (e) of such section, or sub-
6 section (i) of such section, including with re-
7 spect to whether an item or service that is the
8 subject to such a determination is an item or
9 service to which such subsection (b), (e), or (i)
10 applies; or".

11 **SEC. 5. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
12 **TRANSPARENCY REQUIREMENTS.**

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

18 "(f) PROVIDER DIRECTORY REQUIREMENTS.—
19 "(1) IN GENERAL.—Beginning not later than
20 January 1, 2022, each health plan shall—
21 "(A) establish the verification process de-
22 scribed in paragraph (2);
23 "(B) establish the response protocol de-
24 scribed in paragraph (3);

1 "(C) establish the database described in
2 paragraph (4); and
3 "(D) include in any directory (other than
4 the database described in subparagraph (C))
5 containing provider directory information with
6 respect to such plan the information described
7 in paragraph (5).
8 "(2) VERIFICATION PROCESS.—The verification
9 process described in this paragraph is, with respect
10 to a health plan, a process—
11 "(A) under which such plan verifies and
12 updates the provider directory information in-
13 cluded on the database described in paragraph
14 (4) of such plan of—
15 "(i) not less frequently than once
16 every 90 days, a random sample of at least
17 10 percent of health care providers and
18 health care facilities included in such data-
19 base; and
20 "(ii) any such provider or such facility
21 included in such database that has not
22 submitted any claim to such plan during a
23 12-month period;
24 "(B) that establishes a procedure for the
25 removal from such database of such a provider

1 or facility with respect to which such plan has
2 been unable to verify such information during a
3 period specified by the plan; and
4 "(C) that provides for the update of such
5 database within 2 business days of such plan
6 receiving from such a provider or facility infor-
7 mation pursuant to section 1150D of the Social
8 Security Act.
9 "(3) RESPONSE PROTOCOL.—The response pro-
10 tocol described in this paragraph is, in the case of
11 an individual enrolled in a health plan who requests
12 information through a telephone call or email on
13 whether a health care provider or health care facility
14 has a contractual relationship to furnish items and
15 services under such plan, a protocol under which
16 such plan—
17 "(A) responds to such individual as soon
18 as practicable, and in no case later than 1 busi-
19 ness day after such call or email is received,
20 through a written electronic communication;
21 and
22 "(B) retains such communication in such
23 individual's file for at least 2 years following
24 such response.

1 "(4) DATABASE.—The database described in
2 this paragraph is, with respect to a health plan, a
3 database on the public website of such plan or issuer
4 that contains—
5 "(A) a list of each health care provider and
6 health care facility with which such plan has a
7 contractual relationship for furnishing items
8 and services under such plan; and
9 "(B) provider directory information with
10 respect to each such provider and facility.
11 "(5) INFORMATION.—The information de-
12 scribed in this paragraph is, with respect to a direc-
13 tory containing provider directory information with
14 respect to a health plan, a notification that such in-
15 formation contained in such directory was accurate
16 as of the date of publication of such directory and
17 that an individual enrolled under such plan should
18 consult the database described in paragraph (4) with
19 respect to such plan or contact such plan to obtain
20 the most current provider directory information with
21 respect to such plan.
22 "(6) DEFINITION.—For purposes of this sec-
23 tion, the term 'provider directory information' in-
24 cludes, with respect to a health plan, the name, ad-
25 dress, specialty, and telephone number of each

1 health care provider or health care facility with
2 which such plan has a contractual relationship for
3 furnishing items and services under such plan.

4 "(g) DISCLOSURE ON PATIENT PROTECTIONS
5 AGAINST BALANCE BILLING.—Beginning not later than
6 January 1, 2022, each health plan shall make publicly
7 available, post on a website of such plan available to indi-
8 viduals enrolled under such plan, and include on each ex-
9 planation of benefits for an item or service with respect
10 to which the requirements under subsection (b), (e), or
11 (i) applies—

12 "(1) information in plain language on—

13 "(A) the requirements and prohibitions ap-
14 plied under section 1150C of the Social Secu-
15 rity Act (relating to prohibitions on balance bill-
16 ing in certain circumstances);

17 "(B) if provided for under applicable State
18 law, any other requirements on providers and
19 facilities regarding the amounts such providers
20 and facilities may, with respect to an item or
21 service, charge a participant, beneficiary, or en-
22 rollee of such plan with respect to which such
23 a provider is a nonparticipating provider or fa-
24 cility is a nonparticipating facility, with respect
25 to such plan, for furnishing such item or service

1 after receiving payment from the plan for such
2 item or service and any applicable cost-sharing
3 payment from such participant, beneficiary, or
4 enrollee; and
5 "(C) the requirements applied under sub-
6 sections (b), (e), and (i); and
7 "(2) information in plain language on con-
8 tacting appropriate State and Federal agencies in
9 the case that an individual believes that such a
10 health plan, provider, or facility has violated any re-
11 quirement described in paragraph (1) with respect to
12 such individual.".
13 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
14 nal Revenue Code of 1986, as added by section 2(b) and
15 amended by section 3(b), is further amended by inserting
16 before subsection (k) the following new subsections:
17 "(f) PROVIDER DIRECTORY REQUIREMENTS.—
18 "(1) IN GENERAL.—Beginning not later than
19 January 1, 2022, each health plan shall—
20 "(A) establish the verification process de-
21 scribed in paragraph (2);
22 "(B) establish the response protocol de-
23 scribed in paragraph (3);
24 "(C) establish the database described in
25 paragraph (4); and

1 "(D) include in any directory (other than
2 the database described in subparagraph (C))
3 containing provider directory information with
4 respect to such plan the information described
5 in paragraph (5).
6 "(2) VERIFICATION PROCESS.—The verification
7 process described in this paragraph is, with respect
8 to a health plan, a process—
9 "(A) under which such plan verifies and
10 updates the provider directory information in-
11 cluded on the database described in paragraph
12 (4) of such plan of—
13 "(i) not less frequently than once
14 every 90 days, a random sample of at least
15 10 percent of health care providers and
16 health care facilities included in such data-
17 base; and
18 "(ii) any such provider or such facility
19 included in such database that has not
20 submitted any claim to such plan during a
21 12-month period;
22 "(B) that establishes a procedure for the
23 removal from such database of such a provider
24 or facility with respect to which such plan has

1 been unable to verify such information during a
2 period specified by the plan; and

3 "(C) that provides for the update of such
4 database within 2 business days of such plan
5 receiving from such a provider or facility infor-
6 mation pursuant to section 1150D of the Social
7 Security Act.

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

16 "(A) responds to such individual as soon
17 as practicable, and in no case later than 1 busi-
18 ness day after such call or email is received,
19 through a written electronic communication;
20 and

21 "(B) retains such communication in such
22 individual's file for at least 2 years following
23 such response.

24 "(4) DATABASE.—The database described in
25 this paragraph is, with respect to a health plan, a

1 database on the public website of such plan or issuer
2 that contains—
3 ‘‘(A) a list of each health care provider and
4 health care facility with which such plan has a
5 contractual relationship for furnishing items
6 and services under such plan; and
7 ‘‘(B) provider directory information with
8 respect to each such provider and facility.
9 ‘‘(5) INFORMATION.—The information de-
10 scribed in this paragraph is, with respect to a direc-
11 tory containing provider directory information with
12 respect to a health plan, a notification that such in-
13 formation contained in such directory was accurate
14 as of the date of publication of such directory and
15 that an individual enrolled under such plan should
16 consult the database described in paragraph (4) with
17 respect to such plan or contact such plan to obtain
18 the most current provider directory information with
19 respect to such plan.
20 ‘‘(6) DEFINITION.—For purposes of this sec-
21 tion, the term ‘provider directory information’ in-
22 cludes, with respect to a health plan, the name, ad-
23 dress, specialty, and telephone number of each
24 health care provider or health care facility with

1 which such plan has a contractual relationship for
2 furnishing items and services under such plan.
3 "(g) DISCLOSURE ON PATIENT PROTECTIONS
4 AGAINST BALANCE BILLING.—Beginning not later than
5 January 1, 2022, each health plan shall make publicly
6 available, post on a website of such plan available to indi-
7 viduals enrolled under such plan, and include on each ex-
8 planation of benefits for an item or service with respect
9 to which the requirements under subsection (b), (e), or
10 (i) applies—
11 "(1) information in plain language on—
12 "(A) the requirements and prohibitions ap-
13 plied under section 1150C of the Social Secu-
14 rity Act (relating to prohibitions on balance bill-
15 ing in certain circumstances);
16 "(B) if provided for under applicable State
17 law, any other requirements on providers and
18 facilities regarding the amounts such providers
19 and facilities may, with respect to an item or
20 service, charge a participant or beneficiary of
21 such plan with respect to which such a provider
22 is a nonparticipating provider or facility is a
23 nonparticipating facility, with respect to such
24 plan, for furnishing such item or service after
25 receiving payment from the plan for such item

1 or service and any applicable cost-sharing pay-
2 ment from such participant or beneficiary; and
3 "(C) the requirements applied under sub-
4 sections (b), (e), and (i); and
5 "(2) information in plain language on con-
6 tacting appropriate State and Federal agencies in
7 the case that an individual believes that such a
8 health plan, provider, or facility has violated any re-
9 quirement described in paragraph (1) with respect to
10 such individual.".
11 (c) ERISA AMENDMENTS.—Section 716 of the Em-
12 ployee Retirement Income Security Act of 1974, as added
13 by section 2(c) and amended by section 3(c), is further
14 amended by inserting before subsection (k) the following
15 new subsections:
16 "(f) PROVIDER DIRECTORY REQUIREMENTS.—
17 "(1) IN GENERAL.—Beginning not later than
18 January 1, 2022, each health plan shall—
19 "(A) establish the verification process de-
20 scribed in paragraph (2);
21 "(B) establish the response protocol de-
22 scribed in paragraph (3);
23 "(C) establish the database described in
24 paragraph (4); and

1 "(D) include in any directory (other than
2 the database described in subparagraph (C))
3 containing provider directory information with
4 respect to such plan the information described
5 in paragraph (5).

6 "(2) VERIFICATION PROCESS.—The verification
7 process described in this paragraph is, with respect
8 to a health plan, a process—

9 "(A) under which such plan verifies and
10 updates the provider directory information in-
11 cluded on the database described in paragraph
12 (4) of such plan of—

13 "(i) not less frequently than once
14 every 90 days, a random sample of at least
15 10 percent of health care providers and
16 health care facilities included in such data-
17 base; and

18 "(ii) any such provider or such facility
19 included in such database that has not
20 submitted any claim to such plan during a
21 12-month period;

22 "(B) that establishes a procedure for the
23 removal from such database of such a provider
24 or facility with respect to which such plan has

1 been unable to verify such information during a
2 period specified by the plan; and
3 ‘‘(C) that provides for the update of such
4 database within 2 business days of such plan
5 receiving from such a provider or facility infor-
6 mation pursuant to section 1150D of the Social
7 Security Act.
8 ‘‘(3) RESPONSE PROTOCOL.—The response pro-
9 tocol described in this paragraph is, in the case of
10 an individual enrolled in a health plan who requests
11 information through a telephone call or email on
12 whether a health care provider or health care facility
13 has a contractual relationship to furnish items and
14 services under such plan, a protocol under which
15 such plan—
16 ‘‘(A) responds to such individual as soon
17 as practicable, and in no case later than 1 busi-
18 ness day after such call or email is received,
19 through a written electronic communication;
20 and
21 ‘‘(B) retains such communication in such
22 individual’s file for at least 2 years following
23 such response.
24 ‘‘(4) DATABASE.—The database described in
25 this paragraph is, with respect to a health plan, a

1 database on the public website of such plan or issuer
2 that contains—
3 ‘‘(A) a list of each health care provider and
4 health care facility with which such plan has a
5 contractual relationship for furnishing items
6 and services under such plan; and
7 ‘‘(B) provider directory information with
8 respect to each such provider and facility.
9 ‘‘(5) INFORMATION.—The information de-
10 scribed in this paragraph is, with respect to a direc-
11 tory containing provider directory information with
12 respect to a health plan, a notification that such in-
13 formation contained in such directory was accurate
14 as of the date of publication of such directory and
15 that an individual enrolled under such plan should
16 consult the database described in paragraph (4) with
17 respect to such plan or contact such plan to obtain
18 the most current provider directory information with
19 respect to such plan.
20 ‘‘(6) DEFINITION.—For purposes of this sec-
21 tion, the term ‘provider directory information’ in-
22 cludes, with respect to a health plan, the name, ad-
23 dress, specialty, and telephone number of each
24 health care provider or health care facility with

1 which such plan has a contractual relationship for
2 furnishing items and services under such plan.

3 "(g) DISCLOSURE ON PATIENT PROTECTIONS
4 AGAINST BALANCE BILLING.—Beginning not later than
5 January 1, 2022, each health plan shall make publicly
6 available, post on a website of such plan available to indi-
7 viduals enrolled under such plan, and include on each ex-
8 planation of benefits for an item or service with respect
9 to which the requirements under subsection (b), (e), or
10 (i) applies—

11 "(1) information in plain language on—

12 "(A) the requirements and prohibitions ap-
13 plied under section 1150C of the Social Secu-
14 rity Act (relating to prohibitions on balance bill-
15 ing in certain circumstances);

16 "(B) if provided for under applicable State
17 law, any other requirements on providers and
18 facilities regarding the amounts such providers
19 and facilities may, with respect to an item or
20 service, charge a participant or beneficiary of
21 such plan with respect to which such a provider
22 is a nonparticipating provider or facility is a
23 nonparticipating facility, with respect to such
24 plan, for furnishing such item or service after
25 receiving payment from the plan for such item

1 or service and any applicable cost-sharing pay-
2 ment from such participant or beneficiary; and
3 "(C) the requirements applied under sub-
4 sections (b), (e), and (i); and
5 "(2) information in plain language on con-
6 tacting appropriate State and Federal agencies in
7 the case that an individual believes that such a
8 health plan, provider, or facility has violated any re-
9 quirement described in paragraph (1) with respect to
10 such individual.".

11 **SEC. 6. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
12 **REQUIREMENT FOR FAIR AND HONEST AD-**
13 **VANCE COST ESTIMATE.**

14 (a) PHSA AMENDMENT.—Section 2719A of the Pub-
15 lic Health Service Act (42 U.S.C. 300gg–19a), as amend-
16 ed by sections 2(a), 3(a), and 5(a), is further amended
17 by inserting before subsection (k) the following new sub-
18 sections:
19 "(h) ADVANCED EXPLANATION OF BENEFITS.—Be-
20 ginning on January 1, 2022, each health plan shall, with
21 respect to a notification submitted under section
22 1150D(b)(2)(A) of the Social Security Act by a health
23 care provider or health care facility, respectively, to the
24 health plan for a participant, beneficiary, or enrollee under
25 such health plan scheduled to receive an item or service

1 from the provider or facility, not later than 1 business day
2 (or, in the case such item or service was so scheduled at
3 least 10 business days before such item or service is to
4 be furnished (or in the case such notification was made
5 pursuant to a request by such participant, beneficiary, or
6 enrollee), 3 business days) after the date on which the
7 health plan receives such notification, provide to the par-
8 ticipant, beneficiary, or enrollee (through mail or elec-
9 tronic means, as requested by the participant, beneficiary,
10 or enrollee) a notification including the following:
11 "(1) Whether or not the provider or facility is
12 a participating provider or a participating facility
13 with respect to the health plan with respect to the
14 furnishing of such item or service and—
15 "(A) in the case the provider or facility is
16 a participating provider or facility with respect
17 to the health plan with respect to the furnishing
18 of such item or service, the contracted rate
19 under such plan for such item or service; and
20 "(B) in the case the provider or facility is
21 a nonparticipating provider or facility with re-
22 spect to such plan, a description of how such
23 individual may obtain information on providers
24 and facilities that, with respect to such health
25 plan, are participating providers and facilities.

1 "(2) The good faith estimate included in the
2 notification received from the provider or facility.
3 "(3) A good faith estimate of the amount the
4 health plan is responsible for paying for items and
5 services included in the estimate described in para-
6 graph (2).
7 "(4) A good faith estimate of the amount of
8 any cost-sharing (including with respect to the de-
9 ductible and any copayment or coinsurance obliga-
10 tion) for which the participant, beneficiary, or en-
11 rollee would be responsible for such item or service
12 (as of the date of such notification).
13 "(5) A good faith estimate of the amount that
14 the participant, beneficiary, or enrollee has incurred
15 toward meeting the limit of the financial responsi-
16 bility (including with respect to deductibles and out-
17 of-pocket maximums) under the health plan (as of
18 the date of such notification).
19 "(6) In the case such item or service is subject
20 to a medical management technique (including con-
21 current review, prior authorization, and step-therapy
22 or fail-first protocols) for coverage under the health
23 plan, a disclaimer that coverage for such item or
24 service is subject to such medical management tech-
25 nique.

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

6 "(8) Any other information or disclaimer the
7 health plan determines appropriate that is consistent
8 with information and disclaimers required under this
9 section.

10 "(i) COST-SHARING AND PAYMENT FOR SERVICES
11 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-
12 VIDER NETWORK INFORMATION.—

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

24 "(A) shall not impose on such enrollee a
25 cost-sharing amount (expressed as a copayment

1 amount or coinsurance rate) for such item or
2 service so furnished that is greater than the
3 cost-sharing amount that would apply under
4 such plan had such item or service been fur-
5 nished by a participating provider;

6 ''(B) shall calculate such cost-sharing
7 amount as if the contracted rate for such item
8 or service furnished by such a participating pro-
9 vider or facility were equal to—

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

16 ''(ii) if no contracted rate described in
17 clause (i) exists, the recognized amount for
18 such item or service;

19 ''(C) shall pay to such nonparticipating
20 provider or facility furnishing such item or serv-
21 ice to such participant, beneficiary, or enrollee
22 the amount by which—

23 ''(i) if a contracted rate described in
24 subparagraph (B)(i) exists, the most re-

1 cent (as of the date such item or services
2 was furnished) such rate; or
3 "(ii) if no contracted rate described in
4 such subparagraph exists, the out-of-net-
5 work rate;
6 for such items and services exceeds the cost-
7 sharing amount imposed under the plan for
8 such items and services (as determined in ac-
9 cordance with subparagraphs (A) and (B)); and
10 "(D) shall apply the deductible or out-of-
11 pocket maximum, if any, that would apply if
12 such services were furnished by a participating
13 provider or a participating facility.
14 "(2) CRITERIA DESCRIBED.—For purposes of
15 paragraph (1), the criteria described in this para-
16 graph, with respect to an item or service furnished
17 to a participant, beneficiary, or enrollee of a health
18 plan by a nonparticipating provider or a nonpartici-
19 pating facility, are the following:
20 "(A) The participant, beneficiary, or en-
21 rollee received a notification under subsection
22 (h) with respect to such item and service to be
23 furnished and such notification provided infor-
24 mation that the provider was a participating
25 provider or facility was a participating facility,

1 with respect to the plan for furnishing such
2 item or service.
3 ''(B) A notification was not provided, in
4 accordance with subsection (h), to the partici-
5 pant, beneficiary, or enrollee, and the partici-
6 pant, beneficiary, or enrollee requested through
7 the response protocol of the plan under sub-
8 section (f)(3) information on whether the pro-
9 vider was a participating provider or facility
10 was a participating facility with respect to the
11 plan for furnishing such item or service and
12 was informed through such protocol that the
13 provider was such a participating provider or
14 facility was such a participating facility.''.
15 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
16 nal Revenue Code of 1986, as added by section 2(b) and
17 amended by sections 3(b) and 5(b), is further amended
18 by inserting before subsection (k) the following new sub-
19 sections:
20 ''(h) ADVANCED EXPLANATION OF BENEFITS.—Be-
21 ginning on January 1, 2022, each health plan shall, with
22 respect to a notification submitted under section
23 1150D(b)(2)(A) of the Social Security Act by a health
24 care provider or health care facility, respectively, to the
25 health plan for a participant or beneficiary under such

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

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

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

21 ''(B) in the case the provider or facility is
22 a nonparticipating provider or facility with re-
23 spect to such plan, a description of how such
24 individual may obtain information on providers

1 and facilities that, with respect to such health
2 plan, are participating providers and facilities.
3 "(2) The good faith estimate included in the
4 notification received from the provider or facility.
5 "(3) A good faith estimate of the amount the
6 health plan is responsible for paying for items and
7 services included in the estimate described in para-
8 graph (2).
9 "(4) A good faith estimate of the amount of
10 any cost-sharing (including with respect to the de-
11 ductible and any copayment or coinsurance obliga-
12 tion) for which the participant or beneficiary would
13 be responsible for such item or service (as of the
14 date of such notification).
15 "(5) A good faith estimate of the amount that
16 the participant or beneficiary has incurred toward
17 meeting the limit of the financial responsibility (in-
18 cluding with respect to deductibles and out-of-pocket
19 maximums) under the health plan (as of the date of
20 such notification).
21 "(6) In the case such item or service is subject
22 to a medical management technique (including con-
23 current review, prior authorization, and step-therapy
24 or fail-first protocols) for coverage under the health
25 plan, a disclaimer that coverage for such item or

1 service is subject to such medical management tech-
2 nique.

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

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

12 "(i) COST-SHARING AND PAYMENT FOR SERVICES
13 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-
14 VIDER NETWORK INFORMATION.—

15 "(1) IN GENERAL.—For plan years beginning
16 on or after January 1, 2022, in the case of an item
17 or service furnished to a participant or beneficiary of
18 a health plan by a nonparticipating provider or a
19 nonparticipating facility, if such item or service
20 would otherwise be covered under such plan if fur-
21 nished by a participating provider or participating
22 facility and if either of the criteria described in para-
23 graph (2) applies with respect to such participant or
24 beneficiary and item or service, the plan—

1 "(A) shall not impose on such enrollee a
2 cost-sharing amount (expressed as a copayment
3 amount or coinsurance rate) for such item or
4 service so furnished that is greater than the
5 cost-sharing amount that would apply under
6 such plan had such item or service been fur-
7 nished by a participating provider;
8 "(B) shall calculate such cost-sharing
9 amount as if the contracted rate for such item
10 or service furnished by such a participating pro-
11 vider or facility were equal to—
12 "(i) the most recent (as of the date
13 such item or service was furnished) con-
14 tracted rate in effect between such pro-
15 vider or facility and such plan for such
16 item or service furnished under such plan,
17 if any; or
18 "(ii) if no contracted rate described in
19 clause (i) exists, the recognized amount for
20 such item or service;
21 "(C) shall pay to such nonparticipating
22 provider or facility furnishing such item or serv-
23 ice to such participant or beneficiary the
24 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 or beneficiary of a health plan by
20 a nonparticipating provider or a nonparticipating fa-
21 cility, are the following:
22 "(A) The participant or beneficiary re-
23 ceived a notification under subsection (h) with
24 respect to such item and service to be furnished
25 and such notification provided information that

1 the provider was a participating provider or fa-
2 cility was a participating facility, with respect
3 to the plan for furnishing such item or service.

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

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

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

health plan for a participant or beneficiary under such health plan scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case such notification was made pursuant to a request by such participant or beneficiary), 3 business days) after the date on which the health plan receives such notification, provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification including the following:

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

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

"(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan, a description of how such individual may obtain information on providers

1 and facilities that, with respect to such health
2 plan, are participating providers and facilities.
3 "(2) The good faith estimate included in the
4 notification received from the provider or facility.
5 "(3) A good faith estimate of the amount the
6 health plan is responsible for paying for items and
7 services included in the estimate described in para-
8 graph (2).
9 "(4) A good faith estimate of the amount of
10 any cost-sharing (including with respect to the de-
11 ductible and any copayment or coinsurance obliga-
12 tion) for which the participant or beneficiary would
13 be responsible for such item or service (as of the
14 date of such notification).
15 "(5) A good faith estimate of the amount that
16 the participant or beneficiary has incurred toward
17 meeting the limit of the financial responsibility (in-
18 cluding with respect to deductibles and out-of-pocket
19 maximums) under the health plan (as of the date of
20 such notification).
21 "(6) In the case such item or service is subject
22 to a medical management technique (including con-
23 current review, prior authorization, and step-therapy
24 or fail-first protocols) for coverage under the health
25 plan, a disclaimer that coverage for such item or

service is subject to such medical management technique.

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

"(8) Any other information or disclaimer the health plan determines appropriate that is consistent with information and disclaimers required under this section.

"(i) COST-SHARING AND PAYMENT FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant or beneficiary of a health plan by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant or beneficiary and item or service, the plan—

1 "(A) shall not impose on such enrollee a
2 cost-sharing amount (expressed as a copayment
3 amount or coinsurance rate) for such item or
4 service so furnished that is greater than the
5 cost-sharing amount that would apply under
6 such plan had such item or service been fur-
7 nished by a participating provider;
8 "(B) shall calculate such cost-sharing
9 amount as if the contracted rate for such item
10 or service furnished by such a participating pro-
11 vider or facility were equal to—
12 "(i) the most recent (as of the date
13 such item or service was furnished) con-
14 tracted rate in effect between such pro-
15 vider or facility and such plan for such
16 item or service furnished under such plan,
17 if any; or
18 "(ii) if no contracted rate described in
19 clause (i) exists, the recognized amount for
20 such item or service;
21 "(C) shall pay to such nonparticipating
22 provider or facility furnishing such item or serv-
23 ice to such participant or beneficiary the
24 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 or beneficiary of a health plan by
20 a nonparticipating provider or a nonparticipating fa-
21 cility, are the following:
22 "(A) The participant or beneficiary re-
23 ceived a notification under subsection (h) with
24 respect to such item and service to be furnished
25 and such notification provided information that

1 the provider was a participating provider or fa-
2 cility was a participating facility, with respect
3 to the plan for furnishing such item or service.

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

16 **SEC. 7. DETERMINATION THROUGH OPEN NEGOTIATION**
17 **AND MEDIATION OF OUT-OF-NETWORK RATES**
18 **TO BE PAID BY HEALTH PLANS.**

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

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

1 "(1) DETERMINATION THROUGH OPEN NEGO-
2 TIATION.—
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

negotiations with respect to such item or service.

"(B) EXCHANGE OF INFORMATION.—In carrying out negotiations initiated under subparagraph (A), with respect to an item or service described in such subparagraph furnished in a year, not later than the fifth business day of the open negotiation period described in such subparagraph with respect to such item or service—

"(i) the health plan that is party to such negotiations shall notify the provider or facility that is party to such negotiations of the median contracted rate for such item or service and year; and

"(ii) such provider or facility shall notify such health plan of—

"(I) the median of the total amount of reimbursement (including any cost-sharing) paid, for the most recent year for which information is available, to such provider or facility for furnishing such item or service to a participant, beneficiary, or enrollee of a health plan that, at the time such

item or service was furnished, had a contract in effect with such provider or facility with respect to the furnishing of such item or service;

"(II) in the case that information described in subclause (I) is not available, such information as specified by the Secretary; and

"(III) any additional information specified by the Secretary.

"(C) ACCESSING MEDIATED DISPUTE PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or health plan that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the mediated dispute process under paragraph (2) with respect to such 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 the Treasury and the Sec-
17 retary of Labor, shall establish a process (in
18 this subsection referred to as the 'mediated dis-
19 pute process') under which, in the case of an
20 item or service with respect to which a provider
21 or facility (as applicable) or health plan submits
22 a notification under paragraph (1)(C) (in this
23 subsection referred to as a 'qualified mediated
24 dispute item or service'), an entity selected
25 under paragraph (3) determines, subject to sub-

paragraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the health plan for such item or service furnished by such provider or facility.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the mediated dispute process, in the case that the parties to a determination for a qualified mediated dispute item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (3) makes such determination, such amount shall be treated for purposes of subsection (k)(11)(B) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the mediated dispute process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

"(3) SELECTION UNDER MEDIATED DISPUTE 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 the Treas-
17 ury and the Secretary of Labor, periodically
18 study and submit to Congress a report on—

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

(b)(1), (e)(1), or (i)(1))) differs from the median contracted rate for such item or service and year, including the number of times such determined (or agreed to) amount exceeds such median contracted rate; and

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

"(B) PUBLICATION OF INFORMATION.—Beginning with July 1, 2023, and for each calendar quarter thereafter, the Secretary shall, in coordination with the Secretary of the Treasury and the Secretary of Labor, make publicly available a summary of the following:

"(i) The information described in subclauses (I) through (V) of clause (ii) of paragraph (7)(F) that was submitted to the Secretary under clause (i) of such paragraph during such quarter.

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

1 "(iii) The total amount of fees paid
2 under paragraph (8) during such quarter.
3 "(iv) The total amount of compensa-
4 tion paid to selected independent entities
5 under paragraph (6) during such quar-
6 ter.".
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 sections 3(b), 5(b), and 6(b), is further
10 amended by inserting before subsection (k) the following
11 new subsection:
12 "(j) DETERMINATION OF OUT-OF-NETWORK RATES
13 TO BE PAID BY HEALTH PLANS.—
14 "(1) DETERMINATION THROUGH OPEN NEGO-
15 TIATION.—
16 "(A) IN GENERAL.—With respect to an
17 item or service furnished in a year by a non-
18 participating provider or a nonparticipating fa-
19 cility, with respect to a health plan, in a State
20 described in subparagraph (B) of subsection
21 (k)(11) with respect to such plan and provider
22 or facility, and for which a payment is required
23 to be made by the health plan pursuant to sub-
24 section (b)(1), (e)(1), or (i)(1), the provider or
25 facility (as applicable) or plan may, during the

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

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

24 "(i) the health plan that is party to
25 such negotiations shall notify the provider

1 or facility that is party to such negotia-
2 tions of the median contracted rate for
3 such item or service and year; and
4 "(ii) such provider or facility shall no-
5 tify such health plan of—
6 "(I) the median of the total
7 amount of reimbursement (including
8 any cost-sharing) paid, for the most
9 recent year for which information is
10 available, to such provider or facility
11 for furnishing such item or service to
12 a participant or beneficiary of a
13 health plan that, at the time such
14 item or service was furnished, had a
15 contract in effect with such provider
16 or facility with respect to the fur-
17 nishing of such item or service;
18 "(II) in the case that information
19 described in subclause (I) is not avail-
20 able, such information as specified by
21 the Secretary; and
22 "(III) any additional information
23 specified by the Secretary.
24 "(C) ACCESSING MEDIATED DISPUTE
25 PROCESS IN CASE OF FAILED NEGOTIATIONS.—

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

1 "(2) MEDIATED DISPUTE PROCESS AVAILABLE
2 IN CASE OF FAILED OPEN NEGOTIATIONS.—
3 "(A) ESTABLISHMENT.—Not later than
4 July 1, 2021, the Secretary, in coordination
5 with the Secretary of Health and Human Serv-
6 ices and the Secretary of Labor, shall establish
7 a process (in this subsection referred to as the
8 'mediated dispute process') under which, in the
9 case of an item or service with respect to which
10 a provider or facility (as applicable) or health
11 plan submits a notification under paragraph
12 (1)(C) (in this subsection referred to as a
13 'qualified mediated dispute item or service'), an
14 entity selected under paragraph (3) determines,
15 subject to subparagraph (B) and in accordance
16 with the succeeding provisions of this sub-
17 section, the amount of payment under the
18 health plan for such item or service furnished
19 by such provider or facility.
20 "(B) AUTHORITY TO CONTINUE NEGOTIA-
21 TIONS.—Under the mediated dispute process, in
22 the case that the parties to a determination for
23 a qualified mediated dispute item or service
24 agree on a payment amount for such item or
25 service during such process but before the date

1 on which the entity selected with respect to
2 such determination under paragraph (3) makes
3 such determination, such amount shall be treat-
4 ed for purposes of subsection (k)(11)(B) as the
5 amount agreed to by such parties for such item
6 or service. In the case of an agreement de-
7 scribed in the previous sentence, the mediated
8 dispute process shall provide for a method to
9 determine how to allocate between the parties
10 to such determination the payment of the com-
11 pensation of the entity selected with respect to
12 such determination.
13 ‘‘(3) SELECTION UNDER MEDIATED DISPUTE
14 PROCESS.—Under the mediated dispute process, the
15 Secretary shall, with respect to the determination of
16 the amount of payment under this subsection of a
17 qualified mediated dispute item or service, provide
18 for a method—
19 ‘‘(A) that allows the parties to such deter-
20 mination to jointly select, not later than the last
21 day of the 3-day period following the date of
22 the initiation of the process with respect to such
23 item or service, for purposes of making such de-
24 termination, an entity certified under paragraph
25 (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-

1 graph (5)(B) was not selected by the entity
2 shall pay to such entity a fee in compensation
3 for the services of such entity in accordance
4 with the guidelines on such compensation estab-
5 lished by the Secretary under subparagraph
6 (B).
7 "(B) GUIDELINES ON COMPENSATION.—
8 For purposes of subparagraph (A), the Sec-
9 retary shall establish guidelines with respect to
10 the compensation of a selected independent en-
11 tity for the services of such entity with respect
12 to determinations under the mediated dispute
13 process. Such guidelines shall provide that such
14 compensation reimburses the entity for at least
15 the costs of such entity in performing the duties
16 of the entity under the mediated dispute proc-
17 ess.
18 "(7) CERTIFICATION OF ENTITIES.—
19 "(A) IN GENERAL.—The Secretary shall
20 establish or recognize a process to certify (in-
21 cluding recertification of) entities under this
22 paragraph. Such process shall ensure that an
23 entity so certified—
24 "(i) has (directly or through contracts
25 or other arrangements) sufficient medical,

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

"(ii) is not—

"(I) a health plan, provider, or facility;

"(II) an affiliate or a subsidiary of a health plan, provider, or facility; or

"(III) an affiliate or subsidiary of a professional or trade association of health plans or of providers or facilities;

"(iii) carries out the responsibilities of such an entity in accordance with this subsection;

"(iv) meets appropriate indicators of fiscal integrity;

"(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

"(vi) does not under the mediated dispute 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.

"(VI) The compensation paid to such entity with respect to each such determination.

"(VII) Any other information specified by the Secretary.

"(8) ADMINISTRATIVE FEE.—

"(A) IN GENERAL.—Each party to a determination to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the mediated dispute process with respect to such determination in an amount described in subparagraph (B) for such year.

"(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the mediated dispute process.

"(9) SECRETARIAL REPORT; PUBLICATION OF INFORMATION.—

1 "(A) SECRETARIAL REPORT.—Beginning
2 not later than July 1, 2023, the Secretary shall,
3 in coordination with the Secretary of Health
4 and Human Services and the Secretary of
5 Labor, periodically study and submit to Con-
6 gress a report on—
7 "(i) the extent to which the payment
8 amount determined under this subsection
9 for an item or service furnished in a year
10 (or otherwise agreed to by a health plan
11 and provider or facility for purposes of de-
12 termining payment by the plan to the pro-
13 vider or facility pursuant to subsection
14 (b)(1), (e)(1), or (i)(1)) differs from the
15 median contracted rate for such item or
16 service and year, including the number of
17 times such determined (or agreed to)
18 amount exceeds such median contracted
19 rate; and
20 "(ii) the effect of such difference on
21 the cost-sharing for such item or service
22 for a participant or beneficiary of a health
23 plan.
24 "(B) PUBLICATION OF INFORMATION.—
25 Beginning with July 1, 2023, and for each cal-

1 endar quarter thereafter, the Secretary shall, in
2 coordination with the Secretary of Health and
3 Human Services and the Secretary of Labor,
4 make publicly available a summary of the fol-
5 lowing:

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

11 "(ii) The amount of expenditures
12 made by the Secretary during such year to
13 carry out the mediated dispute process.

14 "(iii) The total amount of fees paid
15 under paragraph (8) during such quarter.

16 "(iv) The total amount of compensa-
17 tion paid to selected independent entities
18 under paragraph (6) during such quar-
19 ter.".

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), 5(c), and
23 6(c), is further amended by inserting before subsection (k)
24 the following new subsection:

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

1 with respect to an item or service, is the 30-day
2 period beginning on the date of initiation of the
3 negotiations with respect to such item or serv-
4 ice.
5 "(B) EXCHANGE OF INFORMATION.—In
6 carrying out negotiations initiated under sub-
7 paragraph (A), with respect to an item or serv-
8 ice described in such subparagraph furnished in
9 a year, not later than the fifth business day of
10 the open negotiation period described in such
11 subparagraph with respect to such item or serv-
12 ice—
13 "(i) the health plan that is party to
14 such negotiations shall notify the provider
15 or facility that is party to such negotia-
16 tions of the median contracted rate for
17 such item or service and year; and
18 "(ii) such provider or facility shall no-
19 tify such health plan of—
20 "(I) the median of the total
21 amount of reimbursement (including
22 any cost-sharing) paid, for the most
23 recent year for which information is
24 available, to such provider or facility
25 for furnishing such item or service to

1 a participant or beneficiary of a
2 health plan that, at the time such
3 item or service was furnished, had a
4 contract in effect with such provider
5 or facility with respect to the fur-
6 nishing of such item or service;
7 "(II) in the case that information
8 described in subclause (I) is not avail-
9 able, such information as specified by
10 the Secretary; and
11 "(III) any additional information
12 specified by the Secretary.
13 "(C) ACCESSING MEDIATED DISPUTE
14 PROCESS IN CASE OF FAILED NEGOTIATIONS.—
15 In the case of open negotiations pursuant to
16 subparagraph (A), with respect to an item or
17 service, that do not result in a determination of
18 an amount of payment for such item or service
19 by the last day of the open negotiation period
20 described in such subparagraph with respect to
21 such item or service, the provider or facility (as
22 applicable) or health plan that was party to
23 such negotiations may, during the 2-day period
24 beginning on the day after such open negotia-
25 tion period, initiate the mediated dispute proc-

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

14 "(2) MEDIATED DISPUTE PROCESS AVAILABLE
15 IN CASE OF FAILED OPEN NEGOTIATIONS.—

16 "(A) ESTABLISHMENT.—Not later than
17 July 1, 2021, the Secretary, in coordination
18 with the Secretary of Health and Human Serv-
19 ices and the Secretary of the Treasury, shall es-
20 tablish a process (in this subsection referred to
21 as the 'mediated dispute process') under which,
22 in the case of an item or service with respect
23 to which a provider or facility (as applicable) or
24 health plan submits a notification under para-
25 graph (1)(C) (in this subsection referred to as

1 a 'qualified mediated dispute item or service'),
2 an entity selected under paragraph (3) deter-
3 mines, subject to subparagraph (B) and in ac-
4 cordance with the succeeding provisions of this
5 subsection, the amount of payment under the
6 health plan for such item or service furnished
7 by such provider or facility.

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

1 "(3) SELECTION UNDER MEDIATED DISPUTE
2 PROCESS.—Under the mediated dispute process, the
3 Secretary shall, with respect to the determination of
4 the amount of payment under this subsection of a
5 qualified mediated dispute item or service, provide
6 for a method—
7 "(A) that allows the parties to such deter-
8 mination to jointly select, not later than the last
9 day of the 3-day period following the date of
10 the initiation of the process with respect to such
11 item or service, for purposes of making such de-
12 termination, an entity certified under paragraph
13 (7) that—
14 "(i) is not a party to such determina-
15 tion or an employee or agent of such a
16 party;
17 "(ii) does not have a material familial,
18 financial, or professional relationship with
19 such a party; and
20 "(iii) does not otherwise have a con-
21 flict of interest with such a party (as de-
22 termined by the Secretary); and
23 "(B) that requires, in the case such parties
24 do not make such selection by such last day,

the Secretary to, not later than 6 days after such date of initiation—

"(i) select such an entity that satisfies clauses (i) through (iii) of subparagraph (A); and

"(ii) provide notification of such selection to the provider or facility (as applicable) and the health plan party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'selected independent entity' with respect to such determination.

"(4) TREATMENT OF CONSIDERATION OF MULTIPLE ITEMS AND SERVICES.—

"(A) IN GENERAL.—Under the mediated dispute process, the Secretary shall specify criteria under which multiple qualified mediated dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the mediated dispute process. Such items and 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

"(bb) the type of providers and facilities party to such determinations.

"(II) A description of each item or service included in each such determination.

"(III) The amount of each offer submitted to the entity for each such determination.

"(IV) The amount of each such determination.

"(V) The length of time in making each such determination.

"(VI) The compensation paid to such entity with respect to each such determination.

"(VII) Any other information specified by the Secretary.

"(8) ADMINISTRATIVE FEE.—

"(A) IN GENERAL.—Each party to a determination to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the mediated dispute process with re-

spect to such determination in an amount described in subparagraph (B) for such year.

"(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the mediated dispute process.

"(9) SECRETARIAL REPORT; PUBLICATION OF INFORMATION.—

"(A) SECRETARIAL REPORT.—Beginning not later than July 1, 2023, the Secretary shall, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, periodically study and submit to Congress a report on—

"(i) the extent to which the payment amount determined under this subsection for an item or service furnished in a year (or otherwise agreed to by a health plan and provider or facility for purposes of determining 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 (d) RULE OF CONSTRUCTION.—Nothing in this Act,
11 or the amendment made by this Act, shall be construed
12 as removing any obligation of a health plan (as defined
13 in section 2719A of the Public Health Service Act (42
14 U.S.C. 300gg–19A), as amended by this Act) to provide
15 payment to a health care provider or health care facility
16 for items and services furnished by such provider or facil-
17 ity to an individual enrolled in such plan.

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.

(a) NO BALANCE BILLING.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING PRACTICES.

"(a) EMERGENCY SERVICES.—In the case of an individual with benefits under a group health plan or health insurance coverage offered in the group or individual market who is furnished in a plan year that begins on or after January 1, 2022, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent freestanding emergency department—

"(1) if the hospital or independent freestanding emergency department does not have a contractual relationship with such plan or coverage for furnishing such services, the hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the individual for a payment amount for such emergency services so fur-

1 nished that is more than the cost-sharing amount
2 for such services (as determined in accordance with
3 section 2719A(b) of the Public Health Service Act,
4 section 716(b) of the Employee Retirement Income
5 Security Act of 1974, or section 9816(b) of the In-
6 ternal Revenue Code of 1986, as applicable); and
7 "(2) a health care provider without a contrac-
8 tual relationship with such plan or coverage for fur-
9 nishing such services shall not bill, and shall not
10 hold liable, such individual for a payment amount
11 for such services furnished to such individual by
12 such provider with respect to such emergency med-
13 ical condition and visit for which the individual re-
14 ceives emergency services at the emergency depart-
15 ment of the hospital or independent freestanding
16 emergency department that is more than the cost-
17 sharing amount for such services furnished by the
18 provider (as determined in accordance with section
19 2719A(b) of the Public Health Service Act, section
20 716(b) of the Employee Retirement Income Security
21 Act of 1974, or section 9816(b) of the Internal Rev-
22 enue Code of 1986, as applicable).
23 "(b) SERVICES FURNISHED BY NONPARTICIPATING
24 PROVIDER AT PARTICIPATING FACILITY.—

1 "(1) IN GENERAL.—Subject to paragraph (2),
2 in the case of an individual with benefits under a
3 health plan who is furnished items or services (other
4 than emergency services to which subsection (a) ap-
5 plies or items and services to which subsection (c)
6 applies) in a plan year that, with respect to such
7 plan or such coverage (as applicable), begins on or
8 after January 1, 2022, at a participating facility by
9 a nonparticipating provider, such provider shall not
10 bill, and shall not hold liable, such individual for a
11 payment amount for such an item or service fur-
12 nished by such provider during a visit at such facil-
13 ity that is more than the cost-sharing amount for
14 such item or service (as determined in accordance
15 with section 2719A(e) of the Public Health Service
16 Act, section 716(e) of the Employee Retirement In-
17 come Security Act of 1974, or section 9816(e) of the
18 Internal Revenue Code of 1986, as applicable).
19 "(2) EXCEPTION IN CASE NOTICE PROVIDED.—
20 Paragraph (1) shall not apply with respect to items
21 and services (other than items and services described
22 in paragraph (3)) furnished to an individual enrolled
23 in a group health plan or in health insurance cov-
24 erage offered in the group or individual market by
25 a health care provider that does not have a contrac-

1 tual relationship with such plan or coverage for fur-
2 nishing such items and services if the following cri-
3 teria are met:
4 ''(A) A written notice (as specified by the
5 Secretary) is provided by the provider to such
6 individual, not later than 48 hours before such
7 items and services are to be so furnished, that
8 includes the following information:
9 ''(i) That the provider does not have
10 such a relationship with such plan or cov-
11 erage.
12 ''(ii) The estimated amount that such
13 provider may charge the individual for
14 such items and services.
15 ''(iii) A statement that the individual
16 may seek such items or services from a
17 health care provider that does have such a
18 contractual relationship.
19 ''(B) On the date such item or service is
20 to be furnished, before such item or service is
21 so furnished, the individual signs and dates
22 such notice confirming receipt of the notice and
23 consent of the individual to be so furnished
24 such items and services.

1 "(C) A copy of such signed and dated no-
2 tice is provided by the provider to the plan or
3 coverage.

4 "(3) ITEMS AND SERVICES DESCRIBED.—The
5 items and services described in this paragraph are
6 items and services furnished by a specified provider
7 (as defined in subsection (f)(3)).

8 "(c) RELIANCE ON INCORRECT PROVIDER INFORMA-
9 TION.—In the case of an individual who is furnished items
10 or services by a health care provider or health care facility
11 for which a group health plan or health insurance issuer
12 is required to make payment under section 2719A(i) of
13 the Public Health Service Act, section 716(i) of the Em-
14 ployee Retirement Income Security Act of 1974, or section
15 9816(i) of the Internal Revenue Code of 1986, such pro-
16 vider or facility shall not bill, and shall not hold liable,
17 such individual for a payment amount for such an item
18 or service that is more than the cost-sharing amount for
19 such item or service (as determined in accordance with
20 section 2719A(i) of the Public Health Service Act, section
21 716(i) of the Employee Retirement Income Security Act
22 of 1974, or section 9816(i) of the Internal Revenue Code
23 of 1986, as applicable).

24 "(d) COMPLIANCE WITH REQUIREMENTS UNDER
25 OPEN NEGOTIATION AND MEDIATED DISPUTE RESOLU-

1 TION PROCESSES.—A health care provider or health care
2 facility shall comply with any requirement imposed on
3 such provider or facility, respectively, under section
4 2719A(j) of the Public Health Service Act, 9816(j) of the
5 Internal Revenue Code of 1986, or 716(j) of the Employee
6 Retirement Income Security Act of 1974.

7 ''(e) PENALTY.—

8 ''(1) GENERAL PENALTY.—

9 ''(A) IN GENERAL.—Subject to paragraph
10 (2), any health care provider or health care fa-
11 cility that violates a provision of this section
12 shall be subject to a civil monetary penalty in
13 an amount not to exceed $10,000 for each such
14 violation.

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), and subsection (o)) shall
19 apply with respect to a civil monetary penalty
20 imposed under this paragraph in the same man-
21 ner as such provisions apply with respect to a
22 penalty or proceeding under subsection (a) of
23 such section.

24 ''(2) ADDITIONAL PENALTY FOR FACILITY
25 FAILURE TO PROVIDE CERTAIN NOTICE.—

1 "(A) IN GENERAL.—In the case of a hos-
2 pital or independent freestanding emergency de-
3 partment that furnishes emergency services de-
4 scribed in subparagraph (A) of section
5 2719A(k)(5) to an individual enrolled in a
6 health plan, after stabilization of such indi-
7 vidual, if the hospital or independent free-
8 standing emergency department does not pro-
9 vide such individual a notice in accordance with
10 subparagraph (C)(i) of such section and—
11 "(i) in the case the hospital or inde-
12 pendent freestanding emergency depart-
13 ment is a nonparticipating facility with re-
14 spect to such plan, if the hospital or de-
15 partment furnishes services described in
16 subparagraph (B) of such section to such
17 individual and bills the individual in viola-
18 tion of subsection (a) of this section; or
19 "(ii) in the case the hospital or inde-
20 pendent freestanding emergency depart-
21 ment is a participating facility with respect
22 to such plan and a nonparticipating pro-
23 vider furnishes services described in such
24 subparagraph (B) during the visit at such

1 hospital or independent freestanding emer-
2 gency department;
3 in addition to any penalty applicable to the hos-
4 pital or department under paragraph (1), the
5 hospital or department shall be subject to a civil
6 monetary penalty of $50,000.
7 ‘‘(B) APPLICATION OF PROVISIONS.—The
8 provisions of section 1128A (other than sub-
9 section (a), subsection (b), the first sentence of
10 subsection (c)(1), subsection (d), and subsection
11 (o)) shall apply with respect to a civil monetary
12 penalty imposed under this paragraph in the
13 same manner as such provisions apply with re-
14 spect to a penalty or proceeding under sub-
15 section (a) of such section.
16 ‘‘(f) DEFINITIONS.—For purposes of this section and
17 sections 1150D and 1150E:
18 ‘‘(1) The terms ‘during a visit’,‘emergency de-
19 partment of a hospital’, ‘emergency medical condi-
20 tion’, ‘emergency services’, ‘independent freestanding
21 emergency department’, ‘nonparticipating provider’,
22 ‘nonparticipating facility’, ‘participating facility’,
23 ‘participating provider’ have the meanings given
24 such terms, respectively, in section 2719A(k) of the
25 Public Health Service Act.

1 "(2) The terms 'group health plan', 'group mar-
2 ket', 'health insurance issuer', 'health insurance cov-
3 erage', and 'individual market' have the meanings
4 given such terms, respectively, in section 2791 of the
5 Public Health Service Act.

6 "(3) The term 'specified provider', with respect
7 to an individual with benefits under a group health
8 plan or health insurance coverage and a hospital
9 with a contractual relationship with such plan or
10 coverage for furnishing items and services—

11 "(A) means an ancillary health care pro-
12 vider, including emergency medicine providers
13 or suppliers, anesthesiologists, pathologists, ra-
14 diologists, neonatologists, assistant surgeons,
15 hospitalists, intensivists, or other providers de-
16 termined by the Secretary (including providers
17 who furnish similar items and services as the
18 providers specified in this paragraph); and

19 "(B) includes, with respect to an item or
20 service, any health care provider furnishing
21 such item or service at such hospital if there is
22 no health care provider at such hospital who
23 can furnish such item or service who has such
24 a relationship with such plan or coverage for
25 furnishing such item or service.".

1 (b) PROVIDER DIRECTORY; PATIENT-PROVIDER DIS-
2 PUTE RESOLUTION PROCESS.—Part A of title XI of the
3 Social Security Act (42 U.S.C. 1301 et seq.), as amended
4 by subsection (a), is further amended by adding at the
5 end the following new sections:

6 **"SEC. 1150D. PATIENT PROTECTIONS AGAINST SURPRISE**
7 **BILLING THROUGH TRANSPARENCY.**

8 "(a) SUBMISSION OF INFORMATION TO HEALTH
9 PLANS OF CERTAIN PROVIDER INFORMATION.—Begin-
10 ning not later than 1 year after the date of the enactment
11 of this section, each health care provider and health care
12 facility shall establish a process under which such provider
13 or facility transmits, to each health insurance issuer offer-
14 ing group or individual health insurance coverage and
15 group health plan with which such provider or supplier
16 has in effect a contractual relationship for furnishing
17 items and services under such coverage or such plan, pro-
18 vider directory information (as defined in section
19 2719A(f)(6) of the Public Health Service Act, section
20 716(f)(6) of the Employee Retirement Income Security
21 Act of 1974, or section 9816(f)(6) of the Internal Revenue
22 Code of 1986, as applicable) with respect to such provider
23 or facility, as applicable. Such provider or facility shall so
24 transmit such information to such issuer offering such
25 coverage or such group health plan—

1 "(1) when there are any material changes (in-
2 cluding a change in address, telephone number, or
3 other contact information) to such provider directory
4 information of the provider or facility with respect to
5 such coverage offered by such issuer or with respect
6 to such plan; and

7 "(2) at any other time (including upon the re-
8 quest of such issuer or plan) determined appropriate
9 by the provider, facility, or the Secretary.

10 "(b) PROVISION OF INFORMATION UPON REQUEST
11 AND FOR SCHEDULED APPOINTMENTS.—Each health care
12 provider and health care facility shall, beginning January
13 1, 2022, in the case of an individual who schedules an
14 item or service to be furnished to such individual by such
15 provider or facility at least 3 business days before the date
16 such item or service is to be so furnished, not later than
17 1 business day after the date of such scheduling (or, in
18 the case of such an item or service scheduled at least 10
19 business days before the date such item or service is to
20 be so furnished (or if requested by the individual), not
21 later than 3 business days after the date of such sched-
22 uling or such request)—

23 "(1) inquire if such individual is enrolled in a
24 group health plan, group or individual health insur-
25 ance coverage offered by a health insurance issuer,

1 or a Federal health care program (and if is so en-
2 rolled in such plan or coverage, seeking to have a
3 claim for such item or service submitted to such
4 plan or coverage); and
5 "(2) provide a notification of the good faith es-
6 timate of the expected charges for furnishing such
7 item or service (including any item or service that is
8 reasonably expected to be provided in conjunction
9 with such scheduled item or service) to—
10 "(A) in the case the individual is enrolled
11 in such a plan or such coverage (and is seeking
12 to have a claim for such item or service sub-
13 mitted to such plan or coverage), such plan or
14 issuer of such coverage; and
15 "(B) in the case the individual is not de-
16 scribed in subparagraph (A) and not enrolled in
17 a Federal health care program, the individual.
18 "(c) CONTINUITY OF CARE.—A health care provider
19 or health care facility shall, in the case of an individual
20 furnished items and services by such provider or facility
21 for which coverage is provided under a group health plan
22 or group or individual health insurance coverage pursuant
23 to section 2730 of such Act, section 9817 of the Internal
24 Revenue Code of 1986, or section 717 of the Employee
25 Retirement Income Security Act of 1974—

1 "(1) accept payment from such plan or such
2 issuer (as applicable) (and cost-sharing from such
3 individual, if applicable, in accordance with sub-
4 section (a)(2)(C) of such section 2730, 9817, or
5 717) for such items and services as payment in full
6 for such items and services; and
7 "(2) continue to adhere to all policies, proce-
8 dures, and quality standards imposed by such plan
9 or issuer with respect to such individual and such
10 items and services in the same manner as if such
11 termination had not occurred.
12 "(d) LIMITATION.—Beginning on January 1, 2022,
13 a health care provider or health care facility may not ini-
14 tiate a process to seek reimbursement of payment for
15 items and services furnished to an individual enrolled in
16 a group health plan or health insurance coverage offered
17 in the group or individual market more than 1 year after
18 the date on which such items and services were so fur-
19 nished.
20 "(e) PENALTY.—
21 "(1) GENERAL PENALTY.—
22 "(A) IN GENERAL.—Except as provided in
23 paragraph (2), any health care provider or
24 health care facility that violates a provision of
25 this section shall be subject to a civil monetary

1 penalty in an amount not to exceed $10,000 for
2 each such violation.
3 "(B) APPLICATION OF PROVISIONS.—The
4 provisions of section 1128A (other than sub-
5 section (a), subsection (b), the first sentence of
6 subsection (c)(1), and subsection (o)) shall
7 apply with respect to a civil monetary penalty
8 imposed under this paragraph in the same man-
9 ner as such provisions apply with respect to a
10 penalty or proceeding under subsection (a) of
11 such section.
12 "(2) PROVIDER DIRECTORY INFORMATION PEN-
13 ALTY.—
14 "(A) IN GENERAL.—Each health care pro-
15 vider or health care facility that fails to trans-
16 mit information as required under subsection
17 (a) shall be subject to a civil monetary penalty
18 of $1,000 for each day such provider or facility
19 (as applicable) fails to so transmit such infor-
20 mation.
21 "(B) APPLICATION OF PROVISIONS.—The
22 provisions of section 1128A (other than sub-
23 section (a), subsection (b), the first sentence of
24 subsection (c)(1), subsection (d), and subsection
25 (o)) shall apply with respect to a civil monetary

1 penalty imposed under this paragraph in the
2 same manner as such provisions apply with re-
3 spect to a penalty or proceeding under sub-
4 section (a) of such section.

5 **"SEC. 1150E. PATIENT-PROVIDER DISPUTE RESOLUTION.**

6 "(a) IN GENERAL.—Not later than July 1, 2021, the
7 Secretary shall establish a process (in this subsection re-
8 ferred to as the 'patient-provider dispute resolution proc-
9 ess') under which an uninsured individual, with respect
10 to an item or service, who received, pursuant to section
11 1150D(b), from a health care provider or health care facil-
12 ity an estimate of the expected charges for furnishing such
13 item or service to such individual and who after being fur-
14 nished such item or service by such provider or facility
15 is billed by such provider or facility for such item or serv-
16 ice for charges that are substantially in excess of such esti-
17 mate, may seek a determination from a selected dispute
18 resolution entity for the charges to be paid by such indi-
19 vidual (in lieu of such amount so billed) to such provider
20 or facility for such item or service. For purposes of this
21 subsection, the term 'uninsured individual' means, with re-
22 spect to an item or service, an individual who does not
23 have benefits for such item or service under a group health
24 plan, health insurance coverage offered in the group or
25 individual market by a health insurance issuer, Federal

1 health care program (as defined in section 1128B(f)), or
2 a health benefits plan under chapter 89 of title 5, United
3 States Code (or an individual who has benefits for such
4 item or service under a group health plan or health insur-
5 ance coverage offered in the group or individual market
6 by a health insurance issuer, but who does not seek to
7 have a claim for such item or service submitted to such
8 plan or coverage).

9 "(b) SELECTION OF ENTITIES.—Under the patient-
10 provider dispute resolution process, the Secretary shall,
11 with respect to a determination sought by an individual
12 under subsection (a), with respect to charges to be paid
13 by such individual to a health care provider or health care
14 facility described in such paragraph for an item or service
15 furnished to such individual by such provider or facility,
16 provide for—

17 "(1) a method to select to make such deter-
18 mination an entity certified under subsection (d)
19 that—

20 "(A) is not a party to such determination
21 or an employee or agent of such party;

22 "(B) does not have a material familial, fi-
23 nancial, or professional relationship with such a
24 party; and

1 "(C) does not otherwise have a conflict of
2 interest with such a party (as determined by
3 the Secretary); and
4 "(2) the provision of a notification of such se-
5 lection to the individual and the provider or facility
6 (as applicable) party to such determination.
7 An entity selected pursuant to the previous sentence to
8 make a determination described in such sentence shall be
9 referred to in this subsection as the 'selected dispute reso-
10 lution entity' with respect to such determination.
11 "(c) ADMINISTRATIVE FEE.—The Secretary shall es-
12 tablish a fee to participate in the patient-provider dispute
13 resolution process in such a manner as to not create a
14 barrier to an uninsured individual's access to such process.
15 "(d) CERTIFICATION.—The Secretary shall establish
16 or recognize a process to certify entities under this sub-
17 paragraph. Such process shall ensure that an entity so cer-
18 tified satisfies at least the criteria specified in section
19 2719A(j)(7) of the Public Health Service Act.".
20 **SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.**
21 (a) PUBLIC HEALTH SERVICE ACT.—Subpart II of
22 part A of title XXVII of the Public Health Service Act
23 (42 U.S.C. 300gg–11 et seq.) is amended by adding at
24 the end the following new sections:

1 **"SEC. 2730. CONTINUITY OF CARE.**

2 "(a) ENSURING CONTINUITY OF CARE WITH RE-
3 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
4 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
5 NETWORK STATUS.—

6 "(1) IN GENERAL.—In the case of an individual
7 with benefits under a group health plan or group or
8 individual health insurance coverage offered by a
9 health insurance issuer and with respect to a health
10 care provider or facility that has a contractual rela-
11 tionship with such plan or such issuer (as applica-
12 ble) for furnishing items and services under such
13 plan or such coverage, if, while such individual is a
14 continuing care patient (as defined in subsection (b))
15 with respect to such provider or facility—

16 "(A) such contractual relationship is termi-
17 nated (as defined in subsection (b));

18 "(B) benefits provided under such plan or
19 such health insurance coverage with respect to
20 such provider or facility are terminated because
21 of a change in the terms of the participation of
22 such provider or facility in such plan or cov-
23 erage; or

24 "(C) a contract between such group health
25 plan and a health insurance issuer offering
26 health insurance coverage in connection with

such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

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

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

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

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

"(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been cov-

1 ered under such plan or coverage had such ter-
2 mination not occurred, with respect to the
3 course of treatment furnished by such provider
4 or facility relating to such individual's status as
5 a continuing care patient during the period be-
6 ginning on the date on which the notice under
7 subparagraph (A) is provided and ending on the
8 earlier of—
9 "(i) the 90-day period beginning on
10 such date; or
11 "(ii) the date on which such individual
12 is no longer a continuing care patient with
13 respect to such provider or facility.
14 "(b) DEFINITIONS.—In this section:
15 "(1) CONTINUING CARE PATIENT.—The term
16 'continuing care patient' means an individual who,
17 with respect to a provider or facility—
18 "(A) is undergoing a course of treatment
19 for a serious and complex condition from the
20 provider or facility;
21 "(B) is undergoing a course of institu-
22 tional or inpatient care from the provider or fa-
23 cility;
24 "(C) is scheduled to undergo nonelective
25 surgery from the provider, including receipt of

1 postoperative care from such provider or facility
2 with respect to such a surgery;
3 "(D) is pregnant and undergoing a course
4 of treatment for the pregnancy from the pro-
5 vider or facility; or
6 "(E) is or was determined to be terminally
7 ill (as determined under section 1861(dd)(3)(A)
8 of the Social Security Act) and is receiving
9 treatment for such illness from such provider or
10 facility.
11 "(2) SERIOUS AND COMPLEX CONDITION.—The
12 term 'serious and complex condition' means, with re-
13 spect to a participant, beneficiary, or enrollee under
14 a group health plan or health insurance coverage—
15 "(A) in the case of an acute illness, a con-
16 dition that is serious enough to require special-
17 ized medical treatment to avoid the reasonable
18 possibility of death or permanent harm; or
19 "(B) in the case of a chronic illness or con-
20 dition, a condition that is—
21 "(i) is life-threatening, degenerative,
22 potentially disabling, or congenital; and
23 "(ii) requires specialized medical care
24 over a prolonged period of time.

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

"SEC. 2731. INFORMATION REQUIRED TO BE INCLUDED ON HEALTH INSURANCE MEMBERSHIP CARDS.

"In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that provides a physical or electronic card indicating membership in such plan or coverage to an individual enrolled under such plan or coverage, such group health plan or issuer shall include on such card each of the following:

"(1) The nearest hospital to the primary residence of such individual that has in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

"(2) A telephone number or Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such

1 plan or coverage for furnishing items and services
2 under such plan or coverage.

3 ‘‘(3) Any deductible applicable to such indi-
4 vidual.

5 ‘‘(4) Any out-of-pocket maximum applicable to
6 such individual.

7 ‘‘(5) Any cost-sharing obligation applicable to
8 such individual for a visit at an emergency depart-
9 ment, or urgent care facility, that has in effect a
10 contractual relationship with such plan or coverage
11 for furnishing items and services under such plan or
12 coverage.

13 **‘‘SEC. 2732. MAINTENANCE OF PRICE COMPARISON TOOL.**

14 ‘‘In connection with the offering of a group health
15 plan or group or individual health insurance coverage in
16 a geographic region for a plan year, a plan sponsor or
17 health insurance issuer, respectively, shall employ an indi-
18 vidual to offer price comparison guidance, or make avail-
19 able on an Internet website a price comparison tool, that
20 (to the extent practicable) allows an individual enrolled
21 under such plan or coverage, with respect to such plan
22 year and such geographic region, to compare the amount
23 (determined by historic claims data of participating pro-
24 viders with respect to such plan or coverage) of cost-shar-
25 ing (including deductibles, copayments, and coinsurance)

1 that the individual would be responsible for paying under
2 such plan or coverage with respect to the furnishing of
3 a specific item or service by any such provider.

4 **"SEC. 2733. ASSIGNMENT OF BENEFITS.**

5 "With respect to an item or service furnished to a
6 beneficiary, participant, or enrollee of a group health plan
7 or health insurance coverage offered by a health insurance
8 issuer in the group or individual market by a nonpartici-
9 pating provider (as defined in subparagraph (G) of section
10 2719A(k)(10)(A)) or a nonparticipating facility (as de-
11 fined in section 2719A(k)(9)(A)) and for which a payment
12 is required to be made by the health plan or coverage pur-
13 suant to subsection (b)(1), (e)(1), or (i)(1) of section
14 2719A, if the beneficiary, participant, or enrollee assigns
15 the benefits, or right to payment of benefits, of such bene-
16 ficiary, participant, or enrollee to the provider or facility,
17 then payment for such item or service by such plan or
18 coverage shall be made directly to the provider or facil-
19 ity.".

20 (b) INTERNAL REVENUE CODE.—

21 (1) IN GENERAL.—Subchapter B of chapter
22 100 of the Internal Revenue Code of 1986, as
23 amended by the previous sections, is further amend-
24 ed by adding at the end the following new sections:

1 **"SEC. 9817. CONTINUITY OF CARE.**

2 "(a) ENSURING CONTINUITY OF CARE WITH RE-
3 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
4 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
5 NETWORK STATUS.—

6 "(1) IN GENERAL.—In the case of an individual
7 with benefits under a group health plan and with re-
8 spect to a health care provider or facility that has
9 a contractual relationship with such plan for fur-
10 nishing items and services under such plan, if, while
11 such individual is a continuing care patient (as de-
12 fined in subsection (b)) with respect to such provider
13 or facility—

14 "(A) such contractual relationship is termi-
15 nated (as defined in paragraph (b));

16 "(B) benefits provided under such plan
17 with respect to such provider or facility are ter-
18 minated because of a change in the terms of the
19 participation of such provider or facility in such
20 plan; or

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

1 the plan shall meet the requirements of paragraph
2 (2) with respect to such individual.
3 "(2) REQUIREMENTS.—The requirements of
4 this paragraph are that the plan—
5 "(A) notify each individual enrolled under
6 such plan who is a continuing care patient with
7 respect to a provider or facility at the time of
8 a termination described in paragraph (1) affect-
9 ing such provider on a timely basis of such ter-
10 mination and such individual's right to elect
11 continued transitional care from such provider
12 or facility under this section;
13 "(B) provide such individual with an op-
14 portunity to notify the plan of the individual's
15 need for transitional care; and
16 "(C) permit the patient to elect to continue
17 to have benefits provided under such plan,
18 under the same terms and conditions as would
19 have applied and with respect to such items and
20 services as would have been covered under such
21 plan had such termination not occurred, with
22 respect to the course of treatment furnished by
23 such provider or facility relating to such indi-
24 vidual's status as a continuing care patient dur-
25 ing the period beginning on the date on which

1 the notice under subparagraph (A) is provided
2 and ending on the 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 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—
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.

"SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON HEALTH INSURANCE MEMBERSHIP CARDS.

"In the case of a group health plan that provides a physical or electronic card indicating membership in such plan to an individual enrolled under such plan, such group health plan shall include on such card each of the following:

"(1) The nearest hospital to the primary residence of such individual that has in effect a contractual relationship with such plan for furnishing items and services under such plan.

"(2) A telephone number or Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan for furnishing items and services under such plan.

"(3) Any deductible applicable to such individual.

"(4) Any out-of-pocket maximum applicable to such individual.

"(5) Any cost-sharing obligation applicable to such individual for a visit at an emergency department, or urgent care facility, that has in effect a

1 contractual relationship with such plan for fur-
2 nishing items and services under such plan.

3 **"SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

4 "In connection with the offering of a group health
5 plan in a geographic region for a plan year, a plan sponsor
6 shall employ an individual to offer price comparison guid-
7 ance, or make available on an Internet website a price
8 comparison tool, that (to the extent practicable) allows an
9 individual enrolled under such plan, with respect to such
10 plan year and such geographic region, to compare the
11 amount (determined by historic claims data of partici-
12 pating providers with respect to such plan) of cost-sharing
13 (including deductibles, copayments, and coinsurance) that
14 the individual would be responsible for paying under such
15 plan with respect to the furnishing of a specific item or
16 service by any such provider.

17 **"SEC. 9820. ASSIGNMENT OF BENEFITS.**

18 "With respect to an item or service furnished to a
19 beneficiary, participant, or enrollee of a group health plan
20 by a nonparticipating provider (as defined in section
21 2719A(k)(10)(A)) or a nonparticipating facility (as de-
22 fined in section 2719A(k)(9)(A)) and for which a payment
23 is required to be made by the group health plan pursuant
24 to subsection (b)(1), (e)(1), or (i)(1) of section 2719A, if
25 the beneficiary, participant, or enrollee assigns the bene-

1 fits, or right to payment of benefits, of such beneficiary,
2 participant, or enrollee to the provider or facility, then
3 payment for such item or service by such group health
4 plan shall be made directly to the provider or facility.''.
5 (2) CONFORMING AMENDMENT.—Section
6 9815(a) of the Internal Revenue Code of 1986, as
7 amended by section 2(b), is further amended—
8 (A) in paragraph (1), by striking ''section
9 2719A'' and inserting ''section 2719A, 2730,
10 2731, 2732, or 2733''; and
11 (B) in paragraph (2), by striking ''section
12 2719A'' and inserting ''section 2719A, 2730,
13 2731, 2732, or 2733''.
14 (3) CLERICAL AMENDMENT.—The table of sec-
15 tions for such subchapter, as amended by section
16 2(b), is further amended by adding at the end the
17 following new items:

''Sec. 9817. Continuity of care.
''Sec. 9818. Information required to be included on health insurance membership cards.
''Sec. 9819. Maintenance of price comparison tool.
''Sec. 9820. Assignment of benefits.''.

18 (c) EMPLOYEE RETIREMENT INCOME SECURITY
19 ACT.—
20 (1) IN GENERAL.—Subpart B of part 7 of sub-
21 title B of title I of the Employee Retirement Income
22 Security Act of 1974 (29 U.S.C. 1185 et seq.), as

1 amended by section 2(c), is further amended by add-
2 ing at the end the following new sections:

3 **"SEC. 717. 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 or health in-
10 surance coverage offered by a health insurance
11 issuer in connection with a group health plan and
12 with respect to a health care provider or facility that
13 has a contractual relationship with such plan or
14 such issuer (as applicable) for furnishing items and
15 services under such plan or such coverage, if, while
16 such individual is a continuing care patient (as de-
17 fined in subsection (b)) with respect to such provider
18 or facility—

19 "(A) such contractual relationship is termi-
20 nated (as defined in paragraph (b));

21 "(B) benefits provided under such plan or
22 such health insurance coverage with respect to
23 such provider or facility are terminated because
24 of a change in the terms of the participation of

1 the provider or facility in such plan or coverage;
2 or

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

9 the plan or issuer, respectively, shall meet the re-
10 quirements of paragraph (2) with respect to such in-
11 dividual.

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

14 ''(A) notify each individual enrolled under
15 such plan or coverage who is a continuing care
16 patient with respect to a provider or facility at
17 the time of a termination described in para-
18 graph (1) affecting such provider or facility on
19 a timely basis of such termination and such in-
20 dividual's right to elect continued transitional
21 care from such provider or facility under this
22 section;

23 ''(B) provide such individual with an op-
24 portunity to notify the plan or issuer of the in-
25 dividual's need for transitional care; and

1 "(C) permit the patient to elect to continue
2 to have benefits provided under such plan or
3 such coverage, under the same terms and condi-
4 tions as would have applied and with respect to
5 such items and services as would have been cov-
6 ered under such plan or coverage had such ter-
7 mination not occurred, with respect to the
8 course of treatment furnished by such provider
9 or facility relating to such individual's status as
10 a continuing care patient during the period be-
11 ginning on the date on which the notice under
12 subparagraph (A) is provided and ending on the
13 earlier of—

14 "(i) the 90-day period beginning on
15 such date; or

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

19 "(b) DEFINITIONS.—In this section:

20 "(1) CONTINUING CARE PATIENT.—The term
21 'continuing care patient' means an individual who,
22 with respect to a provider or facility—

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

1 "(B) is undergoing a course of institu-
2 tional or inpatient care from the provider or fa-
3 cility;
4 "(C) is scheduled to undergo nonelective
5 surgery from the provide or facility, including
6 receipt of postoperative care from such provider
7 or facility with respect to such a surgery;
8 "(D) is pregnant and undergoing a course
9 of treatment for the pregnancy from the pro-
10 vider or facility; or
11 "(E) is or was determined to be terminally
12 ill (as determined under section 1861(dd)(3)(A)
13 of the Social Security Act) and is receiving
14 treatment for such illness from such provider or
15 facility.
16 "(2) SERIOUS AND COMPLEX CONDITION.—The
17 term 'serious and complex condition' means, with re-
18 spect to a participant, beneficiary, or enrollee under
19 a group health plan or health insurance coverage—
20 "(A) in the case of an acute illness, a con-
21 dition that is serious enough to require special-
22 ized medical treatment to avoid the reasonable
23 possibility of death or permanent harm; or
24 "(B) in the case of a chronic illness or con-
25 dition, a condition that—

1 "(i) is life-threatening, degenerative,
2 potentially disabling, or congenital; and
3 "(ii) requires specialized medical care
4 over a prolonged period of time.
5 "(3) TERMINATED.—The term 'terminated' in-
6 cludes, with respect to a contract, the expiration or
7 nonrenewal of the contract, but does not include a
8 termination of the contract for failure to meet appli-
9 cable quality standards or for fraud.

10 **"SEC. 718. INFORMATION REQUIRED TO BE INCLUDED ON**
11 **HEALTH INSURANCE MEMBERSHIP CARDS.**

12 "In the case of a group health plan or health insur-
13 ance issuer offering group health insurance coverage that
14 provides a physical or electronic card indicating member-
15 ship in such plan or coverage to an individual enrolled
16 under such plan or coverage, such group health plan or
17 issuer shall include on such card each of the following:
18 "(1) The nearest hospital to the primary resi-
19 dence of such individual that has in effect a contrac-
20 tual relationship with such plan or coverage for fur-
21 nishing items and services under such plan or cov-
22 erage.
23 "(2) A telephone number or Internet website
24 address through which such individual may seek con-
25 sumer assistance information, such as information

1 related to hospitals and urgent care facilities that
2 have in effect a contractual relationship with such
3 plan or coverage for furnishing items and services
4 under such plan or coverage.

5 ''(3) Any deductible applicable to such indi-
6 vidual.

7 ''(4) Any out-of-pocket maximum applicable to
8 such individual.

9 ''(5) Any cost-sharing obligation applicable to
10 such individual for a visit at an emergency depart-
11 ment, or urgent care facility, that has in effect a
12 contractual relationship with such plan or coverage
13 for furnishing items and services under such plan or
14 coverage.

15 **''SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

16 ''In connection with the offering of a group health
17 plan or group health insurance coverage in a geographic
18 region for a plan year, a plan sponsor or health insurance
19 issuer, respectively, shall employ an individual to offer
20 price comparison guidance, or make available on an Inter-
21 net website a price comparison tool, that (to the extent
22 practicable) allows an individual enrolled under such plan
23 or coverage, with respect to such plan year and such geo-
24 graphic region, to compare the amount (determined by
25 historic claims data of participating providers with respect

1 to such plan or coverage) of cost-sharing (including
2 deductibles, copayments, and coinsurance) that the indi-
3 vidual would be responsible for paying under such plan
4 or coverage with respect to the furnishing of a specific
5 item or service by any such provider.

6 **"SEC. 720. ASSIGNMENT OF BENEFITS.**

7 "With respect to an item or service furnished to a
8 beneficiary, participant, or enrollee of a group health plan
9 or health insurance coverage offered by a health insurance
10 issuer in the group market by a nonparticipating provider
11 (as defined in section 2719A(k)(10)(A)) or a nonpartici-
12 pating facility (as defined in section 2719A(k)(9)(A)) and
13 for which a payment is required to be made by the plan
14 or coverage pursuant to subsection (b)(1), (e)(1), or (i)(1)
15 of section 2719A, if the beneficiary, participant, or en-
16 rollee assigns the benefits, or right to payment of benefits,
17 of such beneficiary, participant, or enrollee to the provider
18 or facility, then payment for such item or service by such
19 plan or coverage shall be made directly to the provider
20 or facility.".

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, 2732, or 2733"; and
4 (B) in paragraph (2), by striking "section
5 2719A" and inserting "section 2719A, 2730,
6 2731, 2732, or 2733".
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.
"Sec. 720. Assignment of benefits.".

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. AIR AMBULANCE COST DATA REPORTING PRO-**
16 **GRAM.**

17 (a) COST DATA REPORTING PROGRAM.—
18 (1) IN GENERAL.—Not later than 1 year after
19 the date of the enactment of this Act, and annually
20 thereafter, a provider of emergency air medical serv-
21 ices shall submit to the Secretary of Health and
22 Human Services the information specified in sub-
23 section (b) with respect to the preceding 180-day pe-

1 riod (in the case of the initial period) and the pre-
2 ceding 1-year period (in each subsequent period).
3 (2) PUBLICATION.—Not later than 180 days
4 after the date the Secretary of Health and Human
5 Services receives from a provider described in para-
6 graph (1) the information specified in subsection (b),
7 the Secretary shall make publicly available such in-
8 formation.
9 (b) SPECIFIED INFORMATION.—For purposes of sub-
10 section (a), information specified in this subsection is—
11 (1) information, with respect to a claim for an
12 item or service—
13 (A) identified as paid by health insurance
14 coverage offered in the group or individual mar-
15 ket or a group health plan (including a self-in-
16 sured plan);
17 (B) identified as paid for non-emergent
18 transport requiring prior authorization and
19 emergent transport;
20 (C) identified as paid for hospital-affiliated
21 providers and independent providers;
22 (D) identified as paid for rural transport
23 and urban transport;
24 (E) identified as provided using rotor
25 transport and fixed wing transport; and

1 (F) identified as furnished by a provider of
2 emergency air medical services that has a con-
3 tractual relationship with the plan or coverage
4 of an individual for which such item or service
5 is provided and such a provider that does not
6 have a contractual relationship with the plan or
7 coverage or such an individual; and
8 (2) cost data for an air ambulance service fur-
9 nished by such a provider of emergency air medical
10 services that the Secretary of Health and Human
11 Services, in consultation with suppliers and pro-
12 viders of such services, determines appropriate, sepa-
13 rated by the cost of air travel and the cost of emer-
14 gency medical services and supplies.
15 (c) RULEMAKING.—Not later than 1 year after the
16 date of the enactment of this Act, the Secretary of Health
17 and Human Services shall determine the form and manner
18 for submitting the information described in subsection (b)
19 through notice and comment rulemaking.
20 (d) CIVIL MONETARY PENALTIES.—
21 (1) IN GENERAL.—A provider of emergency air
22 medical services who violates the requirements of
23 subsection (a)(1) shall be subject to a civil monetary
24 penalty of not more than $10,000 for each act con-
25 stituting such violation.

1 (2) PROCEDURE.—The provisions of section
2 1128A of the Social Security Act (42 U.S.C. 1320a–
3 7a) (other than subsection (a), subsection (b), the
4 first sentence of subsection (c)(1) of such subsection,
5 and subsection (o)) shall apply to civil monetary
6 penalties under this subsection in the same manner
7 as such provisions apply to a penalty or proceeding
8 under such section.
9 (e) REPORTING.—
10 (1) SECRETARY OF HEALTH AND HUMAN SERV-
11 ICES.—Not later than July 1, 2023, the Secretary of
12 Health and Human Services shall submit to Con-
13 gress a report summarizing the information specified
14 in subsection (b).
15 (2) COMPTROLLER GENERAL.—Not later than
16 July 1, 2023, the Comptroller General of the United
17 States shall submit to Congress a report that in-
18 cludes—
19 (A) an analysis of the cost variation of
20 suppliers and providers emergency air ambu-
21 lance services by geography and status; and
22 (B) any other recommendations the Comp-
23 troller General determines appropriate, which
24 may include a recommendation of an adequate
25 amount of reimbursement for such services that

reflects operational costs of providers in order to preserve access to emergency air ambulance services.

(f) LIMITATION.—The information publicly disclosed under subsection (a) and the reports under subsection (e) may not contain any proprietary information.

SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.

Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report summarizing the effects of the provisions of this Act, including the amendments made by such provisions, on changes during such period in health care provider networks of group health plans and health insurance coverage offered by a health insurance issuer in the group or individual market, in fee schedules and amounts for health care services, and to contracted rates under such plans or coverage. Such report shall—

(1) to the extent practicable, sample a statistically significant group of national health care providers; and

(2) examine—

(A) provider network participation, including nonparticipating providers furnishing items and services at participating facilities;

1 (B) health care provider group network
2 participation, including specialty, size, and own-
3 ership; and
4 (C) the impact of State surprise billing
5 laws and network adequacy standards on par-
6 ticipation of health care providers and facilities
7 in provider networks of group health plans and
8 of health insurance coverage offered by health
9 insurance issuers in the group or individual
10 market.