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(Original Signature of Member)

116TH CONGRESS
2D SESSION

H. R. ______

To end surprise medical billing and increase transparency in health coverage.

IN THE HOUSE OF REPRESENTATIVES

Mr. SCOTT of Virginia (for himself and Ms. FOXX of North Carolina) introduced the following bill; which was referred to the Committee on ______________________________

A BILL

To end surprise medical billing and increase transparency in health coverage.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Ban Surprise Billing
5 Act".

6 **SEC. 2. PREVENTING SURPRISE MEDICAL BILLS.**

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

1 (1) by amending subsection (b) to read as fol-
2 lows:
3 "(b) COVERAGE OF EMERGENCY SERVICES.—
4 "(1) IN GENERAL.—If a group health plan, or
5 a health insurance issuer offering group or indi-
6 vidual health insurance coverage, provides or covers
7 any benefits with respect to services in an emergency
8 department of a hospital or with respect to emer-
9 gency services in an independent freestanding emer-
10 gency department (as defined in paragraph (3)(D)),
11 the plan or issuer shall cover emergency services (as
12 defined in paragraph (3)(C))—
13 "(A) without the need for any prior au-
14 thorization determination;
15 "(B) whether the health care provider fur-
16 nishing such services is a participating provider
17 or a participating emergency facility, as appli-
18 cable, with respect to such services;
19 "(C) in a manner so that, if such services
20 are provided to a participant, beneficiary, or en-
21 rollee by a nonparticipating provider or a non-
22 participating emergency facility—
23 "(i) such services will be provided
24 without imposing any requirement under
25 the plan or coverage for prior authoriza-

1 tion of services or any limitation on cov-
2 erage that is more restrictive than the re-
3 quirements or limitations that apply to
4 emergency services received from partici-
5 pating providers and participating emer-
6 gency facilities with respect to such plan or
7 coverage, respectively;
8 ‘‘(ii) the cost-sharing requirement (ex-
9 pressed as a copayment amount or coinsur-
10 ance rate) is not greater than the require-
11 ment that would apply if such services
12 were provided by a participating provider
13 or a participating emergency facility;
14 ‘‘(iii) such cost-sharing requirement is
15 calculated as if the total amount that
16 would have been charged for such services
17 by such participating provider or partici-
18 pating emergency facility were equal to the
19 recognized amount (as defined in para-
20 graph (3)(H)) for such services, plan or
21 coverage, and year;
22 ‘‘(iv) the group health plan or health
23 insurance issuer, respectively, pays to such
24 provider or facility, respectively the
25 amount by which the recognized amount

1 for such services and year involved exceeds
2 the cost-sharing amount for such services
3 (as determined in accordance with clauses
4 (ii) and (iii)) and year; and
5 ''(v) any cost-sharing payments made
6 by the participant, beneficiary, or enrollee
7 with respect to such emergency services so
8 furnished shall be counted toward any in-
9 network deductible or out-of-pocket maxi-
10 mums applied under the plan or coverage,
11 respectively (and such in-network deduct-
12 ible and out-of-pocket maximums shall be
13 applied) in the same manner as if such
14 cost-sharing payments were made with re-
15 spect to emergency services furnished by a
16 participating provider or a participating
17 emergency facility; and
18 ''(D) without regard to any other term or
19 condition of such coverage (other than exclusion
20 or coordination of benefits, or an affiliation or
21 waiting period, permitted under section 2704 of
22 this Act, including as incorporated pursuant to
23 section 715 of the Employee Retirement Income
24 Security Act of 1974 and section 9815 of the

1 Internal Revenue Code of 1986, and other than
2 applicable cost-sharing).
3 "(2) AUDIT PROCESS AND REGULATIONS FOR
4 MEDIAN CONTRACTED RATES.—
5 "(A) AUDIT PROCESS.—
6 "(i) IN GENERAL.—Not later than
7 July 1, 2021, the Secretary, in consulta-
8 tion with appropriate State agencies and
9 the Secretary of Labor and the Secretary
10 of the Treasury, shall establish through
11 rulemaking a process, in accordance with
12 clause (ii), under which group health plans
13 and health insurance issuers offering
14 health insurance coverage in the group or
15 individual market are audited by the Sec-
16 retary or applicable State authority to en-
17 sure that—
18 "(I) such plans and coverage are
19 in compliance with the requirement of
20 applying a median contracted rate
21 under this section; and
22 "(II) such median contracted
23 rate so applied satisfies the definition
24 under paragraph (3)(E) with respect
25 to the year involved, including with re-

1 spect to a group health plan or health
2 insurance issuer described in clause
3 (ii) of such paragraph (3)(E).
4 "(ii) AUDIT SAMPLES.—Under the
5 process established pursuant to clause (i),
6 the Secretary—
7 "(I) shall conduct audits de-
8 scribed in such clause, with respect to
9 a year (beginning with 2022), of a
10 sample with respect to such year of
11 claims data from not more than 25
12 group health plans and health insur-
13 ance issuers offering health insurance
14 coverage in the group or individual
15 market; and
16 "(II) may audit any group health
17 plan or health insurance issuer offer-
18 ing health insurance coverage in the
19 group or individual market if the Sec-
20 retary has received any complaint
21 about such plan or coverage, respec-
22 tively, that involves the compliance of
23 the plan or coverage, respectively,
24 with either of the requirements de-

1 scribed in subclauses (I) and (II) of
2 such clause.
3 "(iii) REPORTS.—Beginning for 2022,
4 the Secretary shall annually submit to
5 Congress a report on the number of plans
6 and issuers with respect to which audits
7 were conducted during such year pursuant
8 to this subparagraph.
9 "(B) RULEMAKING.—Not later than July
10 1, 2021, the Secretary, in consultation with the
11 Secretary of Labor and the Secretary of the
12 Treasury, shall establish through rulemaking—
13 "(i) the methodology the group health
14 plan or health insurance issuer offering
15 health insurance coverage in the group or
16 individual market shall use to determine
17 the median contracted rate, differentiating
18 by line of business;
19 "(ii) the information such plan or
20 issuer, respectively, shall share with the
21 nonparticipating provider or nonpartici-
22 pating facility, as applicable, when making
23 such a determination;
24 "(iii) the geographic regions applied
25 for purposes of this subparagraph, taking

1 into account access to items and services in
2 rural and underserved areas, including
3 health professional shortage areas, as de-
4 fined in section 332; and
5 "(iv) a process to receive complaints
6 of violations of the requirements described
7 in subclauses (I) and (II) of subparagraph
8 (A)(i) by group health plans and health in-
9 surance issuers offering health insurance
10 coverage in the group or individual market.
11 Such rulemaking shall take into account pay-
12 ments that are made by such plan or issuer, re-
13 spectively, that are not on a fee-for-service
14 basis. Such methodology may account for rel-
15 evant payment adjustments that take into ac-
16 count quality or facility type (including higher
17 acuity settings and the case-mix of various fa-
18 cility types) that are otherwise taken into ac-
19 count for purposes of determining payment
20 amounts with respect to participating facilities.
21 In carrying out clause (iii), the Secretary shall
22 consult with the National Association of Insur-
23 ance Commissioners to establish the geographic
24 regions under such clause and shall periodically
25 update such regions, as appropriate.

1 “(3) DEFINITIONS.—In this part:
2 “(A) EMERGENCY DEPARTMENT OF A HOS-
3 PITAL.—The term ‘emergency department of a
4 hospital’ includes a hospital outpatient depart-
5 ment that provides emergency services.
6 “(B) EMERGENCY MEDICAL CONDITION.—
7 The term ‘emergency medical condition’ means
8 a medical condition manifesting itself by acute
9 symptoms of sufficient severity (including se-
10 vere pain) such that a prudent layperson, who
11 possesses an average knowledge of health and
12 medicine, could reasonably expect the absence
13 of immediate medical attention to result in a
14 condition described in clause (i), (ii), or (iii) of
15 section 1867(e)(1)(A) of the Social Security
16 Act.
17 “(C) EMERGENCY SERVICES.—
18 “(i) IN GENERAL.—The term ‘emer-
19 gency services’, with respect to an emer-
20 gency medical condition, means—
21 “(I) a medical screening exam-
22 ination (as required under section
23 1867 of the Social Security Act, or as
24 would be required under such section
25 if such section applied to an inde-

1 pendent freestanding emergency de-
2 partment) that is within the capability
3 of the emergency department of a hos-
4 pital or of an independent free-
5 standing emergency department, as
6 applicable, including ancillary services
7 routinely available to the emergency
8 department to evaluate such emer-
9 gency medical condition; and
10 "(II) within the capabilities of
11 the staff and facilities available at the
12 hospital or the independent free-
13 standing emergency department, as
14 applicable, such further medical exam-
15 ination and treatment as are required
16 under section 1867 of such Act, or as
17 would be required under such section
18 if such section applied to an inde-
19 pendent freestanding emergency de-
20 partment, to stabilize the patient.
21 "(ii) INCLUSION OF CERTAIN SERV-
22 ICES OUTSIDE OF EMERGENCY DEPART-
23 MENT.—
24 "(I) IN GENERAL.—For purposes
25 of this subsection and section 2799A–

1 1, in the case of an individual enrolled
2 in a group health plan or health in-
3 surance coverage offered by a health
4 insurance issuer in the group or indi-
5 vidual market who is furnished serv-
6 ices described in clause (i) by a par-
7 ticipating or nonparticipating provider
8 or a participating or nonparticipating
9 emergency facility to stabilize such in-
10 dividual with respect to an emergency
11 medical condition, the term 'emer-
12 gency services' shall include, unless
13 each of the conditions described in
14 subclause (II) are met, in addition to
15 the items and services described in
16 clause (i), items and services for
17 which benefits are provided or covered
18 under the plan or coverage, respec-
19 tively, furnished by a nonparticipating
20 provider or nonparticipating facility,
21 regardless of the department of the
22 hospital in which such individual is
23 furnished such items or services, if,
24 after such stabilization but during
25 such visit in which such individual is

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

4 "(II) CONDITIONS.—For pur-
5 poses of subclause (I), the conditions
6 described in this subclause, with re-
7 spect to an individual who is stabilized
8 and furnished additional items and
9 services described in subclause (I)
10 after such stabilization by a provider
11 or facility described in subclause (I),
12 are the following:

13 "(aa) Such a provider or fa-
14 cility determines such individual
15 is able to travel using nonmedical
16 transportation or nonemergency
17 medical transportation.

18 "(bb) Such provider fur-
19 nishing such additional items and
20 services satisfies the notice and
21 consent criteria of section
22 2799A–2(d) with respect to such
23 items and services.

24 "(cc) Such an individual is
25 in a condition to receive (as de-

1 termined in accordance with
2 guidance issued by the Secretary)
3 the information described in sec-
4 tion 2799A–2 and to provide in-
5 formed consent under such sec-
6 tion, in accordance with applica-
7 ble State law.
8 ‘‘(D) INDEPENDENT FREESTANDING
9 EMERGENCY DEPARTMENT.—The term ‘inde-
10 pendent freestanding emergency department’
11 means a facility that—
12 ‘‘(i) is geographically separate and
13 distinct and licensed separately from a hos-
14 pital under applicable State law; and
15 ‘‘(ii) provides any emergency services
16 (as defined in subparagraph (C)).
17 ‘‘(E) MEDIAN CONTRACTED RATE.—
18 ‘‘(i) IN GENERAL.—The term ‘median
19 contracted rate’ means, subject to clauses
20 (ii) and (iii), with respect to a sponsor of
21 a group health plan and health insurance
22 issuer offering health insurance coverage in
23 the group or individual market—
24 ‘‘(I) for an item or service fur-
25 nished during 2022, the median of the

1 contracted rates recognized by the
2 plan or issuer, respectively (deter-
3 mined with respect to all such plans
4 of such sponsor or all such coverage
5 offered by such issuer that are offered
6 within the same line of business as
7 the plan or coverage) as the total
8 maximum payment (including the
9 cost-sharing amount imposed for such
10 item or service and the amount to be
11 paid by the plan or issuer, respec-
12 tively) under such plans or coverage,
13 respectively, on January 31, 2019, for
14 the same or a similar item or service
15 that is provided by a provider in the
16 same or similar specialty and provided
17 in the geographic region in which the
18 item or service is furnished, consistent
19 with the methodology established by
20 the Secretary under paragraph
21 (2)(B), increased by the percentage
22 increase in the consumer price index
23 for all urban consumers (United
24 States city average) over 2019, such
25 percentage increase over 2020, and

1 such percentage increase over 2021;
2 and
3 "(II) for an item or service fur-
4 nished during 2023 or a subsequent
5 year, the median contracted rate de-
6 termined under this clause for such
7 an item or service furnished in the
8 previous year, increased by the per-
9 centage increase in the consumer price
10 index for all urban consumers (United
11 States city average) over such pre-
12 vious year.
13 "(ii) NEW PLANS AND COVERAGE.—
14 The term 'median contracted rate' means,
15 with respect to a sponsor of a group health
16 plan or health insurance issuer offering
17 health insurance coverage in the group or
18 individual market in a geographic region in
19 which such sponsor or issuer, respectively,
20 did not offer any group health plan or
21 health insurance coverage during 2019—
22 "(I) for the first year in which
23 such group health plan or health in-
24 surance coverage, respectively, is of-
25 fered in such region, a rate (deter-

1 mined in accordance with a method-
2 ology established by the Secretary) for
3 items and services that are covered by
4 such plan and furnished during such
5 first year; and
6 "(II) for each subsequent year
7 such group health plan or health in-
8 surance coverage, respectively, is of-
9 fered in such region, the median con-
10 tracted rate determined under this
11 clause for such items and services fur-
12 nished in the previous year, increased
13 by the percentage increase in the con-
14 sumer price index for all urban con-
15 sumers (United States city average)
16 over such previous year.
17 "(iii) INSUFFICIENT INFORMATION;
18 NEWLY COVERED ITEMS AND SERVICES.—
19 In the case of a sponsor of a group health
20 plan or health insurance issuer offering
21 health insurance coverage in the group or
22 individual market that does not have suffi-
23 cient information to calculate the median
24 of the contracted rates described in clause
25 (i)(I) in 2019 (or, in the case of a newly

1 covered item or service (as defined in
2 clause (iv)(III)), in the first coverage year
3 (as defined in clause (iv)(I)) for such item
4 or service with respect to such plan or cov-
5 erage) for an item or service (including
6 with respect to provider type, or amount,
7 of claims for items or services (as deter-
8 mined by the Secretary) provided in a par-
9 ticular geographic region (other than in a
10 case with respect to which clause (ii) ap-
11 plies)) the term 'median contracted rate'—
12 ''(I) for an item or service fur-
13 nished during 2022 (or, in the case of
14 a newly covered item or service, dur-
15 ing the first coverage year for such
16 item or service with respect to such
17 plan or coverage), means such rate for
18 such item or service determined by
19 the sponsor or issuer, respectively,
20 through use of any database that is
21 determined, in accordance with rule-
22 making described in paragraph
23 (2)(B), to not have any conflicts of in-
24 terest and to have sufficient informa-
25 tion reflecting allowed amounts paid

1 to a health care provider or facility for
2 relevant services furnished in the ap-
3 plicable geographic region (such as a
4 State all-payer claims database);
5 "(II) for an item or service fur-
6 nished in a subsequent year (before
7 the first sufficient information year
8 (as defined in clause (iv)(II)) for such
9 item or service with respect to such
10 plan or coverage), means the rate de-
11 termined under subclause (I) or this
12 subclause, as applicable, for such item
13 or service for the year previous to
14 such subsequent year, increased by
15 the percentage increase in the con-
16 sumer price index for all urban con-
17 sumers (United States city average)
18 over such previous year;
19 "(III) for an item or service fur-
20 nished in the first sufficient informa-
21 tion year for such item or service with
22 respect to such plan or coverage, has
23 the meaning given the term median
24 contracted rate in clause (i)(I), except
25 that in applying such clause to such

1 item or service, the reference to 'fur-
2 nished during 2022' shall be treated
3 as a reference to furnished during
4 such first sufficient information year,
5 the reference to 'in 2019' shall be
6 treated as a reference to such suffi-
7 cient information year, and the in-
8 crease described in such clause shall
9 not be applied; and

10 ''(IV) for an item or service fur-
11 nished in any year subsequent to the
12 first sufficient information year for
13 such item or service with respect to
14 such plan or coverage, has the mean-
15 ing given such term in clause (i)(II),
16 except that in applying such clause to
17 such item or service, the reference to
18 'furnished during 2023 or a subse-
19 quent year' shall be treated as a ref-
20 erence to furnished during the year
21 after such first sufficient information
22 year or a subsequent year.

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

1 "(I) FIRST COVERAGE YEAR.—
2 The term 'first coverage year' means,
3 with respect to a group health plan or
4 health insurance coverage offered by a
5 health insurance issuer in the group
6 or individual market and an item or
7 service for which coverage is not of-
8 fered in 2019 under such plan or cov-
9 erage, the first year after 2019 for
10 which coverage for such item or serv-
11 ice is offered under such plan or
12 health insurance coverage.
13 "(II) FIRST SUFFICIENT INFOR-
14 MATION YEAR.—The term 'first suffi-
15 cient information year' means, with
16 respect to a group health plan or
17 health insurance coverage offered by a
18 health insurance issuer in the group
19 or individual market—
20 "(aa) in the case of an item
21 or service for which the plan or
22 coverage does not have sufficient
23 information to calculate the me-
24 dian of the contracted rates de-
25 scribed in clause (i)(I) in 2019,

1 the first year subsequent to 2022
2 for which the sponsor or issuer
3 has such sufficient information to
4 calculate the median of such con-
5 tracted rates in the year previous
6 to such first subsequent year;
7 and

8 ‘‘(bb) in the case of a newly
9 covered item or service, the first
10 year subsequent to the first cov-
11 erage year for such item or serv-
12 ice with respect to such plan or
13 coverage for which the sponsor or
14 issuer has sufficient information
15 to calculate the median of the
16 contracted rates described in
17 clause (i)(I) in the year previous
18 to such first subsequent year.

19 ‘‘(III) NEWLY COVERED ITEM OR
20 SERVICE.—The term ‘newly covered
21 item or service’ means, with respect to
22 a group health plan or health insur-
23 ance issuer offering health insurance
24 coverage in the group or individual
25 market, an item or service for which

1 coverage was not offered in 2019
2 under such plan or coverage, but is
3 offered under such plan or coverage in
4 a year after 2019.
5 "(F) NONPARTICIPATING EMERGENCY FA-
6 CILITY; PARTICIPATING EMERGENCY FACIL-
7 ITY.—
8 "(i) NONPARTICIPATING EMERGENCY
9 FACILITY.—The term 'nonparticipating
10 emergency facility' means, with respect to
11 an item or service and a group health plan
12 or health insurance coverage offered by a
13 health insurance issuer in the group or in-
14 dividual market, an emergency department
15 of a hospital, or an independent free-
16 standing emergency department, that does
17 not have a contractual relationship directly
18 or indirectly with the plan or issuer, re-
19 spectively, for furnishing such item or serv-
20 ice under the plan or coverage, respec-
21 tively.
22 "(ii) PARTICIPATING EMERGENCY FA-
23 CILITY.—The term 'participating emer-
24 gency facility' means, with respect to an
25 item or service and a group health plan or

1 health insurance coverage offered by a
2 health insurance issuer in the group or in-
3 dividual market, an emergency department
4 of a hospital, or an independent free-
5 standing emergency department, that has
6 a contractual relationship directly or indi-
7 rectly with the plan or issuer, respectively,
8 with respect to the furnishing of such an
9 item or service at such facility.
10 ‘‘(G) NONPARTICIPATING PROVIDERS; PAR-
11 TICIPATING PROVIDERS.—
12 ‘‘(i) NONPARTICIPATING PROVIDER.—
13 The term ‘nonparticipating provider’
14 means, with respect to an item or service
15 and a group health plan or health insur-
16 ance coverage offered by a health insur-
17 ance issuer in the group or individual mar-
18 ket, a physician or other health care pro-
19 vider who is acting within the scope of
20 practice of that provider’s license or certifi-
21 cation under applicable State law and who
22 does not have a contractual relationship
23 with the plan or issuer, respectively, for
24 furnishing such item or service under the
25 plan or coverage, respectively.

1 "(ii) PARTICIPATING PROVIDER.—The
2 term 'participating provider' means, with
3 respect to an item or service and a group
4 health plan or health insurance coverage
5 offered by a health insurance issuer in the
6 group or individual market, a physician or
7 other health care provider who is acting
8 within the scope of practice of that pro-
9 vider's license or certification under appli-
10 cable State law and who has a contractual
11 relationship with the plan or issuer, respec-
12 tively, for furnishing such item or service
13 under the plan or coverage, respectively.
14 "(H) RECOGNIZED AMOUNT.—The term
15 'recognized amount' means, with respect to an
16 item or service furnished by a nonparticipating
17 provider or emergency facility during a year
18 and a group health plan or health insurance
19 coverage offered by a health insurance issuer in
20 the group or individual market—
21 "(i) subject to clause (iii), in the case
22 of such item or service furnished in a State
23 that has in effect a specified State law
24 with respect to such plan, coverage, or
25 issuer, respectively, such a nonpartici-

1 pating provider or emergency facility, and
2 such an item or service, the amount deter-
3 mined in accordance with such law;
4 "(ii) subject to clause (iii), in the case
5 of such item or service furnished in a State
6 that does not have in effect a specified
7 State law, with respect to such plan, cov-
8 erage, or issuer, respectively, such a non-
9 participating provider or emergency facil-
10 ity, and such an item or service, an
11 amount that is the median contracted rate
12 (as defined in subparagraph (E)) for such
13 year and determined in accordance with
14 rulemaking described in paragraph (2)(B))
15 for such item or service; or
16 "(iii) in the case of such item or serv-
17 ice furnished in a State with an All-Payer
18 Model Agreement under section 1115A of
19 the Social Security Act, the amount that
20 the State approves under such system for
21 such item or service so furnished.
22 "(I) SPECIFIED STATE LAW.—The term
23 'specified State law' means, with respect to a
24 State, an item or service furnished by a non-
25 participating provider or emergency facility dur-

1 ing a year and a group health plan or health in-
2 surance coverage offered by a health insurance
3 issuer in the group or individual market, a
4 State law that provides for a method for deter-
5 mining the amount of payment that is required
6 to be covered by such a plan, coverage, or
7 issuer, respectively (to the extent such State
8 law applies to such plan, coverage, or issuer,
9 subject to section 514 of the Employee Retire-
10 ment Income Security Act of 1974) in the case
11 of a participant, beneficiary, or enrollee covered
12 under such plan or coverage and receiving such
13 item or service from such a nonparticipating
14 provider or emergency facility.

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

20 (2) by adding at the end the following new sub-
21 sections:

22 ''(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
23 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
24 PARTICIPATING FACILITIES.—

1 "(1) IN GENERAL.—In the case of items or
2 services (other than emergency services to which
3 subsection (b) applies) for which any benefits are
4 provided or covered by a group health plan or health
5 insurance issuer offering health insurance coverage
6 in the group or individual market furnished to a
7 participant, beneficiary, or enrollee of such plan or
8 coverage by a nonparticipating provider (as defined
9 in subsection (b)(3)(G)(i)) (and who, with respect to
10 such items and services, has not satisfied the notice
11 and consent criteria of section 2799A–2(d)) with re-
12 spect to a visit (as defined by the Secretary in ac-
13 cordance with paragraph (2)(B)) at a participating
14 health care facility (as defined in paragraph (2)(A)),
15 with respect to such plan or coverage, respectively,
16 the plan or coverage, respectively—
17 "(A) shall not impose on such participant,
18 beneficiary, or enrollee a cost-sharing amount
19 (expressed as a copayment amount or coinsur-
20 ance rate) for such items and services so fur-
21 nished that is greater than the cost-sharing
22 amount that would apply under such plan or
23 coverage, respectively, had such items or serv-
24 ices been furnished by a participating provider
25 (as defined in subsection (b)(3)(G)(ii));

1 “(B) shall calculate such cost-sharing
2 amount as if the total amount that would have
3 been charged for such items and services by
4 such participating provider were equal to the
5 recognized amount (as defined in subsection
6 (b)(3)(H)) for such items and services, plan or
7 coverage, and year;
8 “(C) shall pay to such provider furnishing
9 such items and services to such participant,
10 beneficiary, or enrollee the amount by which the
11 recognized amount (as defined in subsection
12 (b)(3)(H)) for such items and services and year
13 involved exceeds the cost-sharing amount im-
14 posed under the plan or coverage, respectively,
15 for such items and services (as determined in
16 accordance with subparagraphs (A) and (B));
17 and
18 “(D) shall count toward any in-network
19 deductible and in-network out-of-pocket maxi-
20 mums (as applicable) applied under the plan or
21 coverage, respectively, any cost-sharing pay-
22 ments made by the participant, beneficiary, or
23 enrollee (and such in-network deductible and
24 out-of-pocket maximums shall be applied) with
25 respect to such items and services so furnished

1 in the same manner as if such cost-sharing pay-
2 ments were with respect to items and services
3 furnished by a participating provider.
4 ‘‘(2) DEFINITIONS.—In this section:
5 ‘‘(A) PARTICIPATING HEALTH CARE FACIL-
6 ITY.—
7 ‘‘(i) IN GENERAL.—The term ‘partici-
8 pating health care facility’ means, with re-
9 spect to an item or service and a group
10 health plan or health insurance issuer of-
11 fering health insurance coverage in the
12 group or individual market, a health care
13 facility described in clause (ii) that has a
14 contractual relationship with the plan or
15 issuer, respectively, with respect to the fur-
16 nishing of such an item or service at the
17 facility.
18 ‘‘(ii) HEALTH CARE FACILITY DE-
19 SCRIBED.—A health care facility described
20 in this clause, with respect to a group
21 health plan or health insurance coverage
22 offered in the group or individual market,
23 is each of the following:
24 ‘‘(I) A hospital (as defined in
25 1861(e) of the Social Security Act).

1 "(II) A hospital outpatient de-
2 partment.
3 "(III) A critical access hospital
4 (as defined in section 1861(mm) of
5 such Act).
6 "(IV) An ambulatory surgical
7 center (as defined in section
8 1833(i)(1)(A) of such Act).
9 "(V) Any other facility that pro-
10 vides items or services for which cov-
11 erage is provided under the plan or
12 coverage, respectively.
13 "(B) VISIT.—The term 'visit' shall, with
14 respect to items and services furnished to an in-
15 dividual at a participating health care facility,
16 include equipment and devices, telemedicine
17 services, imaging services, laboratory services,
18 and such other items and services as the Sec-
19 retary may specify, regardless of whether or not
20 the provider furnishing such items or services is
21 at the facility.
22 "(f) AIR AMBULANCE SERVICES.—
23 "(1) IN GENERAL.—In the case of a partici-
24 pant, beneficiary, or enrollee in a group health plan
25 or health insurance coverage offered in the group or

1 individual market who receives air ambulance serv-
2 ices from a nonparticipating provider (as defined in
3 subsection (b)(3)(G)) with respect to such plan or
4 coverage, if such services would be covered if pro-
5 vided by a participating provider (as defined in such
6 section) with respect to such plan or coverage—

7 "(A) the cost-sharing requirement (ex-
8 pressed as a copayment amount, coinsurance
9 rate, or deductible) with respect to such services
10 shall be the same requirement that would apply
11 if such services were provided by such a partici-
12 pating provider, and any coinsurance or deduct-
13 ible shall be based on rates that would apply for
14 such services if they were furnished by such a
15 participating provider;

16 "(B) such cost-sharing amounts shall be
17 counted toward the in-network deductible and
18 in-network out-of-pocket maximum amount
19 under the plan or coverage for the plan year
20 (and such in-network deductible shall be ap-
21 plied) with respect to such items and services so
22 furnished in the same manner as if such cost-
23 sharing payments were with respect to items
24 and services furnished by a participating pro-
25 vider; and

1 "(C) the plan or coverage shall pay to such
2 provider furnishing such services to such partic-
3 ipant, beneficiary, or enrollee the amount by
4 which the recognized amount (as defined in and
5 determined pursuant to subsection
6 (b)(3)(H)(ii)) for such services and year in-
7 volved exceeds the cost-sharing amount imposed
8 under the plan or coverage, respectively, for
9 such services (as determined in accordance with
10 subparagraphs (A) and (B)).
11 "(2) AIR AMBULANCE SERVICE DEFINED.—For
12 purposes of this section, the term 'air ambulance
13 service' means medical transport by helicopter or
14 airplane for patients.
15 "(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
16 BASES.—In the case of a sponsor of a group health plan
17 or health insurance issuer offering health insurance cov-
18 erage in the group or individual market that, pursuant to
19 subsection (b)(3)(E)(iii), uses a database described in
20 such subsection to determine a rate to apply under such
21 subsection for an item or service by reason of having insuf-
22 ficient information described in such subsection with re-
23 spect to such item or service, such sponsor or issuer shall
24 cover the cost for access to such database.".
25 (b) ERISA AMENDMENTS.—

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

5 **“SEC. 716. CONSUMER PROTECTIONS.**

6 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
7 a group health plan or health insurance issuer offering
8 group health insurance coverage requires or provides for
9 designation by a participant or beneficiary of a partici-
10 pating primary care provider, then the plan or issuer shall
11 permit each participant or beneficiary to designate any
12 participating primary care provider who is available to ac-
13 cept such individual.

14 “(b) COVERAGE OF EMERGENCY SERVICES.—

15 “(1) IN GENERAL.—If a group health plan, or
16 a health insurance issuer offering group health in-
17 surance coverage, provides or covers any benefits
18 with respect to services in an emergency department
19 of a hospital or with respect to emergency services
20 in an independent freestanding emergency depart-
21 ment (as defined in paragraph (3)(D)), the plan or
22 issuer shall cover emergency services (as defined in
23 paragraph (3)(C))—

24 “(A) without the need for any prior au-
25 thorization determination;

1 "(B) whether the health care provider fur-
2 nishing such services is a participating provider
3 or a participating emergency facility, as appli-
4 cable, with respect to such services;
5 "(C) in a manner so that, if such services
6 are provided to a participant or beneficiary by
7 a nonparticipating provider or a nonpartici-
8 pating emergency facility—
9 "(i) such services will be provided
10 without imposing any requirement under
11 the plan for prior authorization of services
12 or any limitation on coverage that is more
13 restrictive than the requirements or limita-
14 tions that apply to emergency services re-
15 ceived from participating providers and
16 participating emergency facilities with re-
17 spect to such plan or coverage, respec-
18 tively;
19 "(ii) the cost-sharing requirement (ex-
20 pressed as a copayment amount or coinsur-
21 ance rate) is not greater than the require-
22 ment that would apply if such services
23 were provided by a participating provider
24 or a participating emergency facility;

1 "(iii) such cost-sharing requirement is
2 calculated as if the total amount that
3 would have been charged for such services
4 by such participating provider or partici-
5 pating emergency facility were equal to the
6 recognized amount (as defined in para-
7 graph (3)(H)) for such services, plan or
8 coverage, and year;
9 "(iv) the group health plan or health
10 insurance issuer, respectively, pays to such
11 provider or facility, respectively, the
12 amount by which the recognized amount
13 for such services and year involved exceeds
14 the cost-sharing amount for such services
15 (as determined in accordance with clauses
16 (ii) and (iii)) and year; and
17 "(v) any cost-sharing payments made
18 by the participant or beneficiary with re-
19 spect to such emergency services so fur-
20 nished shall be counted toward any in-net-
21 work deductible or out-of-pocket maxi-
22 mums applied under the plan or coverage,
23 respectively (and such in-network deduct-
24 ible and out-of-pocket maximums shall be
25 applied) in the same manner as if such

1 cost-sharing payments were made with re-
2 spect to emergency services furnished by a
3 participating provider or a participating
4 emergency facility; 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 of this Act
11 and section 9815 of the Internal Revenue Code
12 of 1986, and other than applicable cost-shar-
13 ing).

14 "(2) AUDIT PROCESS AND REGULATIONS FOR
15 MEDIAN CONTRACTED RATES.—

16 "(A) AUDIT PROCESS.—

17 "(i) IN GENERAL.—Not later than
18 July 1, 2021, the Secretary, in consulta-
19 tion with appropriate State agencies and
20 the Secretary of Health and Human Serv-
21 ices and the Secretary of the Treasury,
22 shall establish through rulemaking a proc-
23 ess, in accordance with clause (ii), under
24 which group health plans and health insur-
25 ance issuers offering health insurance cov-

1 erage in the group market are audited by
2 the Secretary or applicable State authority
3 to ensure that—
4 "(I) such plans and coverage are
5 in compliance with the requirement of
6 applying a median contracted rate
7 under this section; and
8 "(II) such median contracted
9 rate so applied satisfies the definition
10 under paragraph (3)(E) with respect
11 to the year involved, including with re-
12 spect to a group health plan or health
13 insurance issuer described in clause
14 (ii) of such paragraph (3)(E).
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, with respect to
20 a year (beginning with 2022), of a
21 sample with respect to such year of
22 claims data from not more than 25
23 group health plans and health insur-
24 ance issuers offering health insurance
25 coverage in the group market; and

1 "(II) may audit any group health
2 plan or health insurance issuer offer-
3 ing health insurance coverage in the
4 group market if the Secretary has re-
5 ceived any complaint about such plan
6 or coverage, respectively, that involves
7 the compliance of the plan or cov-
8 erage, respectively, with either of the
9 requirements described in subclauses
10 (I) and (II) of such clause.
11 "(iii) REPORTS.—Beginning for 2022,
12 the Secretary shall annually submit to
13 Congress information on the number of
14 plans and issuers with respect to which au-
15 dits were conducted during such year pur-
16 suant to this subparagraph.
17 "(B) RULEMAKING.—Not later than July
18 1, 2021, the Secretary, in consultation with the
19 Secretary of the Treasury and the Secretary of
20 Health and Human Services, shall establish
21 through rulemaking—
22 "(i) the methodology the group health
23 plan or health insurance issuer offering
24 health insurance coverage in the group
25 market shall use to determine the median

1 contracted rate, differentiating by line of
2 business;
3 "(ii) the information such plan or
4 issuer, respectively, shall share with the
5 nonparticipating provider or nonpartici-
6 pating facility, as applicable, when making
7 such a determination;
8 "(iii) the geographic regions applied
9 for purposes of this subparagraph, taking
10 into account access to items and services in
11 rural and underserved areas, including
12 health professional shortage areas, as de-
13 fined in section 332 of the Public Health
14 Service Act; and
15 "(iv) a process to receive complaints
16 of violations of the requirements described
17 in subclauses (I) and (II) of paragraph
18 (2)(A)(i) by group health plans and health
19 insurance issuers offering health insurance
20 coverage in the group market.
21 Such rulemaking shall take into account pay-
22 ments that are made by such plan or issuer, re-
23 spectively, that are not on a fee-for-service
24 basis. Such methodology may account for rel-
25 evant payment adjustments that take into ac-

1 count quality or facility type (including higher
2 acuity settings and the case-mix of various fa-
3 cility types) that are otherwise taken into ac-
4 count for purposes of determining payment
5 amounts with respect to participating facilities.
6 In carrying out clause (iii), the Secretary shall
7 consult with the National Association of Insur-
8 ance Commissioners to establish the geographic
9 regions under such clause and shall periodically
10 update such regions, as appropriate.
11 ‘‘(3) DEFINITIONS.—In this section:
12 ‘‘(A) EMERGENCY DEPARTMENT OF A HOS-
13 PITAL.—The term ‘emergency department of a
14 hospital’ includes a hospital outpatient depart-
15 ment that provides emergency services.
16 ‘‘(B) EMERGENCY MEDICAL CONDITION.—
17 The term ‘emergency medical condition’ means
18 a medical condition manifesting itself by acute
19 symptoms of sufficient severity (including se-
20 vere pain) such that a prudent layperson, who
21 possesses an average knowledge of health and
22 medicine, could reasonably expect the absence
23 of immediate medical attention to result in a
24 condition described in clause (i), (ii), or (iii) of

1 section 1867(e)(1)(A) of the Social Security
2 Act.
3 ''(C) EMERGENCY SERVICES.—
4 ''(i) IN GENERAL.—The term 'emer-
5 gency services', with respect to an emer-
6 gency medical condition, means—
7 ''(I) a medical screening exam-
8 ination (as required under section
9 1867 of the Social Security Act, or as
10 would be required under such section
11 if such section applied to an inde-
12 pendent freestanding emergency de-
13 partment) that is within the capability
14 of the emergency department of a hos-
15 pital or of an independent free-
16 standing emergency department, as
17 applicable, including ancillary services
18 routinely available to the emergency
19 department to evaluate such emer-
20 gency medical condition; and
21 ''(II) within the capabilities of
22 the staff and facilities available at the
23 hospital or the independent free-
24 standing emergency department, as
25 applicable, such further medical exam-

1 ination and treatment as are required
2 under section 1867 of such Act, or as
3 would be required under such section
4 if such section applied to an inde-
5 pendent freestanding emergency de-
6 partment, to stabilize the patient.
7 ''(ii) INCLUSION OF CERTAIN SERV-
8 ICES OUTSIDE OF EMERGENCY DEPART-
9 MENT.—
10 ''(I) IN GENERAL.—For purposes
11 of this subsection and section 2799A–
12 1, in the case of an individual enrolled
13 in a group health plan or health in-
14 surance coverage offered by a health
15 insurance issuer in the group or indi-
16 vidual market who is furnished serv-
17 ices described in clause (i) by a par-
18 ticipating or nonparticipating provider
19 or a participating or nonparticipating
20 emergency facility to stabilize such in-
21 dividual with respect to an emergency
22 medical condition, the term 'emer-
23 gency services' shall include, unless
24 each of the conditions described in
25 subclause (II) are met, in addition to

1 the items and services described in
2 clause (i), items and services for
3 which benefits are provided or covered
4 under the plan or coverage, respec-
5 tively, furnished by a nonparticipating
6 provider or nonparticipating facility,
7 regardless of the department of the
8 hospital in which such individual is
9 furnished such items or services, if,
10 after such stabilization but during
11 such visit in which such individual is
12 so stabilized, the provider or facility
13 determines that such items or services
14 are needed.

15 "(II) CONDITIONS.—For pur-
16 poses of subclause (I), the conditions
17 described in this subclause, with re-
18 spect to an individual who is stabilized
19 and furnished additional items and
20 services described in subclause (I)
21 after such stabilization by a provider
22 or facility described in subclause (I),
23 are the following:

24 "(aa) Such a provider or fa-
25 cility determines such individual

1 is able to travel using nonmedical
2 transportation or nonemergency
3 medical transportation.
4 "(bb) Such provider fur-
5 nishing such additional items and
6 services satisfies the notice and
7 consent criteria of section
8 2799A–2(d) of the Public Health
9 Service Act with respect to such
10 items and services.
11 "(cc) Such an individual is
12 in a condition to receive (as de-
13 termined in accordance with
14 guidance issued by the Secretary)
15 the information described in sec-
16 tion 2799A–2 of the Public
17 Health Service Act and to pro-
18 vide informed consent under such
19 section, in accordance with appli-
20 cable State law.
21 "(D) INDEPENDENT FREESTANDING
22 EMERGENCY DEPARTMENT.—The term 'inde-
23 pendent freestanding emergency department'
24 means a facility that—

1 "(i) is geographically separate and
2 distinct and licensed separately from a hos-
3 pital under applicable State law; and
4 "(ii) provides any emergency services
5 (as defined in subparagraph (C)).
6 "(E) MEDIAN CONTRACTED RATE.—
7 "(i) IN GENERAL.—The term 'median
8 contracted rate' means, subject to clauses
9 (ii) and (iii), with respect to a sponsor of
10 a group health plan and health insurance
11 issuer offering health insurance coverage in
12 the group market—
13 "(I) for an item or service fur-
14 nished during 2022, the median of the
15 contracted rates recognized by the
16 plan or issuer, respectively (deter-
17 mined with respect to all such plans
18 of such sponsor or all such coverage
19 offered by such issuer that are offered
20 within the same line of business as
21 the plan or coverage) as the total
22 maximum payment (including the
23 cost-sharing amount imposed for such
24 item or service and the amount to be
25 paid by such plan or such issuer, re-

1 spectively) under such plans or cov-
2 erage, respectively, on January 31,
3 2019, for the same or a similar item
4 or service that is provided by a pro-
5 vider in the same or similar specialty
6 and provided in the geographic region
7 in which the item or service is fur-
8 nished, consistent with the method-
9 ology established by the Secretary
10 under paragraph (2)(B), increased by
11 the percentage increase in the con-
12 sumer price index for all urban con-
13 sumers (United States city average)
14 over 2019, such percentage increase
15 over 2020, and such percentage in-
16 crease over 2021; and

17 ''(II) for an item or service fur-
18 nished during 2023 or a subsequent
19 year, the median contracted rate de-
20 termined under this clause for such
21 an item or service furnished in the
22 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 pre-
2 vious year.
3 "(ii) NEW PLANS AND COVERAGE.—
4 The term 'median contracted rate' means,
5 with respect to a sponsor of a group health
6 plan or health insurance issuer offering
7 health insurance coverage in the group
8 market in a geographic region in which
9 such sponsor or issuer, respectively, did
10 not offer any group health plan or health
11 insurance coverage during 2019—
12 "(I) for the first year in which
13 such group health plan or health in-
14 surance coverage, respectively, is of-
15 fered in such region, a rate (deter-
16 mined in accordance with a method-
17 ology established by the Secretary) for
18 items and services that are covered by
19 such plan and furnished during such
20 first year; and
21 "(II) for each subsequent year
22 such group health plan or health in-
23 surance coverage, respectively, is of-
24 fered in such region, the median con-
25 tracted rate determined under this

1 clause for such items and services fur-
2 nished in the previous year, increased
3 by the percentage increase in the con-
4 sumer price index for all urban con-
5 sumers (United States city average)
6 over such previous year.
7 "(iii) INSUFFICIENT INFORMATION;
8 NEWLY COVERED ITEMS AND SERVICES.—
9 In the case of a sponsor of a group health
10 plan or health insurance issuer offering
11 health insurance coverage in the group
12 market that does not have sufficient infor-
13 mation to calculate the median of the con-
14 tracted rates described in clause (i)(I) in
15 2019 (or, in the case of a newly covered
16 item or service (as defined in clause
17 (iv)(III)), in the first coverage year (as de-
18 fined in clause (iv)(I)) for such item or
19 service with respect to such plan or cov-
20 erage) for an item or service (including
21 with respect to provider type, or amount,
22 of claims for items or services (as deter-
23 mined by the Secretary) provided in a par-
24 ticular geographic region (other than in a

1 case with respect to which clause (ii) ap-
2 plies)) the term 'median contracted rate'—
3 "(I) for an item or service fur-
4 nished during 2022 (or, in the case of
5 a newly covered item or service, dur-
6 ing the first coverage year for such
7 item or service with respect to such
8 plan or coverage), means such rate for
9 such item or service determined by
10 the sponsor or issuer, respectively,
11 through use of any database that is
12 determined, in accordance with rule-
13 making described in paragraph
14 (2)(B), to not have any conflicts of in-
15 terest and to have sufficient informa-
16 tion reflecting allowed amounts paid
17 to a health care provider or facility for
18 relevant services furnished in the ap-
19 plicable geographic region (such as a
20 State all-payer claims database);
21 "(II) for an item or service fur-
22 nished in a subsequent year (before
23 the first sufficient information year
24 (as defined in clause (iv)(II)) for such
25 item or service with respect to such

1 plan or coverage), means the rate de-
2 termined under subclause (I) or this
3 subclause, as applicable, for such item
4 or service for the year previous to
5 such subsequent year, increased by
6 the percentage increase in the con-
7 sumer price index for all urban con-
8 sumers (United States city average)
9 over such previous year;
10 ''(III) for an item or service fur-
11 nished in the first sufficient informa-
12 tion year for such item or service with
13 respect to such plan or coverage, has
14 the meaning given the term median
15 contracted rate in clause (i)(I), except
16 that in applying such clause to such
17 item or service, the reference to 'fur-
18 nished during 2022' shall be treated
19 as a reference to furnished during
20 such first sufficient information year,
21 the reference to 'in 2019' shall be
22 treated as a reference to such suffi-
23 cient information year, and the in-
24 crease described in such clause shall
25 not be applied; and

1 "(IV) for an item or service fur-
2 nished in any year subsequent to the
3 first sufficient information year for
4 such item or service with respect to
5 such plan or coverage, has the mean-
6 ing given such term in clause (i)(II),
7 except that in applying such clause to
8 such item or service, the reference to
9 'furnished during 2023 or a subse-
10 quent year' shall be treated as a ref-
11 erence to furnished during the year
12 after such first sufficient information
13 year or a subsequent year.
14 "(iv) DEFINITIONS.—For purposes of
15 this subparagraph:
16 "(I) FIRST COVERAGE YEAR.—
17 The term 'first coverage year' means,
18 with respect to a group health plan or
19 health insurance coverage offered by a
20 health insurance issuer in the group
21 market and an item or service for
22 which coverage is not offered in 2019
23 under such plan or coverage, the first
24 year after 2019 for which coverage for
25 such item or service is offered under

1 such plan or health insurance cov-
2 erage.
3 "(II) FIRST SUFFICIENT INFOR-
4 MATION YEAR.—The term 'first suffi-
5 cient information year' means, with
6 respect to a group health plan or
7 health insurance coverage offered by a
8 health insurance issuer in the group
9 market—
10 "(aa) in the case of an item
11 or service for which the plan or
12 coverage does not have sufficient
13 information to calculate the me-
14 dian of the contracted rates de-
15 scribed in clause (i)(I) in 2019,
16 the first year subsequent to 2022
17 for which such sponsor or issuer
18 has such sufficient information to
19 calculate the median of such con-
20 tracted rates in the year previous
21 to such first subsequent year;
22 and
23 "(bb) in the case of a newly
24 covered item or service, the first
25 year subsequent to the first cov-

1 erage year for such item or serv-
2 ice with respect to such plan or
3 coverage for which the sponsor or
4 issuer has sufficient information
5 to calculate the median of the
6 contracted rates described in
7 clause (i)(I) in the year previous
8 to such first subsequent year.

9 "(III) NEWLY COVERED ITEM OR
10 SERVICE.—The term 'newly covered
11 item or service' means, with respect to
12 a group health plan or health insur-
13 ance issuer offering health insurance
14 coverage in the group market, an item
15 or service for which coverage was not
16 offered in 2019 under such plan or
17 coverage, but is offered under such
18 plan or coverage in a year after 2019.

19 "(F) NONPARTICIPATING EMERGENCY FA-
20 CILITY; PARTICIPATING EMERGENCY FACIL-
21 ITY.—

22 "(i) NONPARTICIPATING EMERGENCY
23 FACILITY.—The term 'nonparticipating
24 emergency facility' means, with respect to
25 an item or service and a group health plan

1 or health insurance coverage offered by a
2 health insurance issuer in the group mar-
3 ket, an emergency department of a hos-
4 pital, or an independent freestanding emer-
5 gency department, that does not have a
6 contractual relationship directly or indi-
7 rectly with the plan or issuer, respectively,
8 for furnishing such item or service under
9 the plan or coverage, respectively.
10 "(ii) PARTICIPATING EMERGENCY FA-
11 CILITY.—The term 'participating emer-
12 gency facility' means, with respect to an
13 item or service and a group health plan or
14 health insurance coverage offered by a
15 health insurance issuer in the group mar-
16 ket, an emergency department of a hos-
17 pital, or an independent freestanding emer-
18 gency department, that has a contractual
19 relationship directly or indirectly with the
20 plan or issuer, respectively, with respect to
21 the furnishing of such an item or service at
22 such facility.
23 "(G) NONPARTICIPATING PROVIDERS; PAR-
24 TICIPATING PROVIDERS.—

1 "(i) NONPARTICIPATING PROVIDER.—
2 The term 'nonparticipating provider'
3 means, with respect to an item or service
4 and a group health plan or health insur-
5 ance coverage offered by a health insur-
6 ance issuer in the group market, a physi-
7 cian or other health care provider who is
8 acting within the scope of practice of that
9 provider's license or certification under ap-
10 plicable State law and who does not have
11 a contractual relationship with the plan or
12 issuer, respectively, for furnishing such
13 item or service under the plan or coverage,
14 respectively.
15 "(ii) PARTICIPATING PROVIDER.—The
16 term 'participating provider' means, with
17 respect to an item or service and a group
18 health plan or health insurance coverage
19 offered by a health insurance issuer in the
20 group market, a physician or other health
21 care provider who is acting within the
22 scope of practice of that provider's license
23 or certification under applicable State law
24 and who has a contractual relationship
25 with the plan or issuer, respectively, for

1 furnishing such item or service under the
2 plan or coverage, respectively.
3 "(H) RECOGNIZED AMOUNT.—The term
4 'recognized amount' means, with respect to an
5 item or service furnished by a nonparticipating
6 provider or emergency facility during a year
7 and a group health plan or health insurance
8 coverage offered by a health insurance issuer in
9 the group market—
10 "(i) subject to clause (iii), in the case
11 of such item or service furnished in a State
12 that has in effect a specified State law
13 with respect to such plan, coverage, or
14 issuer, respectively, such a nonpartici-
15 pating provider or emergency facility, and
16 such an item or service, the amount deter-
17 mined in accordance with such law;
18 "(ii) subject to clause (iii), in the case
19 of such item or service furnished in a State
20 that does not have in effect a specified
21 State law, with respect to such plan, cov-
22 erage, or issuer, respectively, such a non-
23 participating provider or emergency facil-
24 ity, and such an item or service, an
25 amount that is the median contracted rate

1 (as defined in subparagraph (E)) for such
2 year and determined in accordance with
3 rulemaking described in paragraph (2)(B))
4 for such item or service; or
5 ''(iii) in the case of such item or serv-
6 ice furnished in a State with an All-Payer
7 Model Agreement under section 1115A of
8 the Social Security Act, the amount that
9 the State approves under such system for
10 such item or service so furnished.
11 ''(I) SPECIFIED STATE LAW.—The term
12 'specified State law' means, with respect to a
13 State, an item or service furnished by a non-
14 participating provider or emergency facility dur-
15 ing a year and a group health plan or health in-
16 surance coverage offered by a health insurance
17 issuer in the group market, a State law that
18 provides for a method for determining the
19 amount of payment that is required to be cov-
20 ered by such a plan, coverage, or issuer, respec-
21 tively (to the extent such State law applies to
22 such plan, coverage, or issuer, subject to section
23 514) in the case of a participant or beneficiary
24 covered under such plan or coverage and receiv-

1 ing such item or service from such a nonpartici-
2 pating provider or emergency facility.
3 ''(J) STABILIZE.—The term 'to stabilize',
4 with respect to an emergency medical condition
5 (as defined in subparagraph (B)), has the
6 meaning give in section 1867(e)(3) of the Social
7 Security Act (42 U.S.C. 1395dd(e)(3)).
8 ''(c) ACCESS TO PEDIATRIC CARE.—
9 ''(1) PEDIATRIC CARE.—In the case of a person
10 who has a child who is a participant or beneficiary
11 under a group health plan, or health insurance cov-
12 erage offered by a health insurance issuer in the
13 group market, if the plan or issuer requires or pro-
14 vides for the designation of a participating primary
15 care provider for the child, the plan or issuer shall
16 permit such person to designate a physician
17 (allopathic or osteopathic) who specializes in pediat-
18 rics as the child's primary care provider if such pro-
19 vider participates in the network of the plan or
20 issuer.
21 ''(2) CONSTRUCTION.—Nothing in paragraph
22 (1) shall be construed to waive any exclusions of cov-
23 erage under the terms and conditions of the plan or
24 health insurance coverage with respect to coverage
25 of pediatric care.

1 "(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
2 COLOGICAL CARE.—
3 "(1) GENERAL RIGHTS.—
4 "(A) DIRECT ACCESS.—A group health
5 plan, or health insurance issuer offering group
6 health insurance coverage, described in para-
7 graph (2) may not require authorization or re-
8 ferral by the plan, issuer, or any person (includ-
9 ing a primary care provider described in para-
10 graph (2)(B)) in the case of a female partici-
11 pant or beneficiary who seeks coverage for ob-
12 stetrical or gynecological care provided by a
13 participating health care professional who spe-
14 cializes in obstetrics or gynecology. Such profes-
15 sional shall agree to otherwise adhere to such
16 plan's or issuer'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 or issuer.
21 "(B) OBSTETRICAL AND GYNECOLOGICAL
22 CARE.—A group health plan or health insur-
23 ance issuer described in paragraph (2) shall
24 treat the provision of obstetrical and gyneco-
25 logical care, and the ordering of related obstet-

1 rical and gynecological items and services, pur-
2 suant to the direct access described under sub-
3 paragraph (A), by a participating health care
4 professional who specializes in obstetrics or
5 gynecology as the authorization of the primary
6 care provider.
7 ‘‘(2) APPLICATION OF PARAGRAPH.—A group
8 health plan, or health insurance issuer offering
9 group health insurance coverage, described in this
10 paragraph is a group health plan or coverage that—
11 ‘‘(A) provides coverage for obstetric or
12 gynecologic care; and
13 ‘‘(B) requires the designation by a partici-
14 pant or beneficiary of a participating primary
15 care provider.
16 ‘‘(3) CONSTRUCTION.—Nothing in paragraph
17 (1) shall be construed to—
18 ‘‘(A) waive any exclusions of coverage
19 under the terms and conditions of the plan or
20 health insurance coverage with respect to cov-
21 erage of obstetrical or gynecological care; or
22 ‘‘(B) preclude the group health plan or
23 health insurance issuer involved from requiring
24 that the obstetrical or gynecological provider

1 notify the primary care health care professional
2 or the plan or issuer of treatment decisions.
3 ‘‘(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
4 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
5 PARTICIPATING FACILITIES.—
6 ‘‘(1) IN GENERAL.—In the case of items or
7 services (other than emergency services to which
8 subsection (b) applies) for which any benefits are
9 provided or covered by a group health plan or health
10 insurance issuer offering health insurance coverage
11 in the group market furnished to a participant or
12 beneficiary of such plan or coverage by a nonpartici-
13 pating provider (as defined in subsection
14 (b)(3)(G)(i)) (and who, with respect to such items
15 and services, has not satisfied the notice and consent
16 criteria of section 2799A–2(d) of the Public Health
17 Service Act) with respect to a visit (as defined by
18 the Secretary in accordance with paragraph (2)(B))
19 at a participating health care facility (as defined in
20 paragraph (2)(A)), with respect to such plan or cov-
21 erage, respectively, the plan or coverage, respec-
22 tively—
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 or coverage, re-
4 spectively, had such items or services been fur-
5 nished by a participating provider (as defined in
6 subsection (b)(3)(G)(ii));
7 "(B) shall calculate such cost-sharing
8 amount as if the total amount that would have
9 been charged for such items and services by
10 such participating provider were equal to the
11 recognized amount (as defined in subsection
12 (b)(3)(H)) for such items and services, plan or
13 coverage, and year;
14 "(C) shall pay to such provider furnishing
15 such items and services to such participant or
16 beneficiary the amount by which the recognized
17 amount (as defined in subsection (b)(3)(H)) for
18 such items and services and year involved ex-
19 ceeds the cost-sharing amount imposed under
20 the plan or coverage, respectively, for such
21 items and services (as determined in accordance
22 with subparagraphs (A) and (B)); and
23 "(D) shall count toward any in-network
24 deductible and in-network out-of-pocket maxi-
25 mums (as applicable) applied under the plan or

1 coverage, respectively, any cost-sharing pay-
2 ments made by the participant or beneficiary
3 (and such in-network deductible and out-of-
4 pocket maximums shall be applied) with respect
5 to such items and services so furnished in the
6 same manner as if such cost-sharing payments
7 were with respect to items and services fur-
8 nished by a participating provider.

9 ‘‘(2) DEFINITIONS.—In this section:

10 ‘‘(A) PARTICIPATING HEALTH CARE FACIL-
11 ITY.—

12 ‘‘(i) IN GENERAL.—The term ‘partici-
13 pating health care facility’ means, with re-
14 spect to an item or service and a group
15 health plan or health insurance issuer of-
16 fering health insurance coverage in the
17 group market, a health care facility de-
18 scribed in clause (ii) that has a contractual
19 relationship with the plan or issuer, respec-
20 tively, with respect to the furnishing of
21 such an item or service at the facility.

22 ‘‘(ii) HEALTH CARE FACILITY DE-
23 SCRIBED.—A health care facility described
24 in this clause, with respect to a group
25 health plan or health insurance coverage

1 offered in the group market, is each of the
2 following:
3 "(I) A hospital (as defined in
4 1861(e) of the Social Security Act).
5 "(II) A hospital outpatient de-
6 partment.
7 "(III) A critical access hospital
8 (as defined in section 1861(mm) of
9 such Act).
10 "(IV) An ambulatory surgical
11 center (as defined in section
12 1833(i)(1)(A) of such Act).
13 "(V) Any other facility that pro-
14 vides items or services for which cov-
15 erage is provided under the plan or
16 coverage, respectively.
17 "(B) VISIT.—The term 'visit' shall, with
18 respect to items and services furnished to an in-
19 dividual at a participating health care facility,
20 include equipment and devices, telemedicine
21 services, imaging services, laboratory services,
22 and such other items and services as the Sec-
23 retary may specify, regardless of whether or not
24 the provider furnishing such items or services is
25 at the facility.

1 ‘‘(f) AIR AMBULANCE SERVICES.—
2 ‘‘(1) IN GENERAL.—In the case of a participant
3 or beneficiary in a group health plan or health insur-
4 ance coverage offered in the group market who re-
5 ceives air ambulance services from a nonpartici-
6 pating provider (as defined in subsection (b)(3)(G))
7 with respect to such plan or coverage, if such serv-
8 ices would be covered if provided by a participating
9 provider (as defined in such subsection) with respect
10 to such plan or coverage—
11 ‘‘(A) the cost-sharing requirement (ex-
12 pressed as a copayment amount, coinsurance
13 rate, or deductible) with respect to such services
14 shall be the same requirement that would apply
15 if such services were provided by such a partici-
16 pating provider, and any coinsurance or deduct-
17 ible shall be based on rates that would apply for
18 such services if they were furnished by such a
19 participating provider;
20 ‘‘(B) such cost-sharing amounts shall be
21 counted toward the in-network deductible and
22 in-network out-of-pocket maximum amount
23 under the plan or coverage for the plan year
24 (and such in-network deductible shall be ap-
25 plied) with respect to such items and services so

1 furnished in the same manner as if such cost-
2 sharing payments were with respect to items
3 and services furnished by a participating pro-
4 vider; and
5 ''(C) the plan or coverage shall pay to such
6 provider furnishing such services to such partic-
7 ipant or beneficiary the amount by which the
8 recognized amount (as defined in and deter-
9 mined pursuant to subsection (b)(3)(H)(ii)) for
10 such services and year involved exceeds the
11 cost-sharing amount imposed under the plan or
12 coverage, respectively, for such services (as de-
13 termined in accordance with subparagraphs (A)
14 and (B)).
15 ''(2) AIR AMBULANCE SERVICE DEFINED.—For
16 purposes of this section, the term 'air ambulance
17 service' means medical transport by helicopter or
18 airplane for patients.
19 ''(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
20 BASES.—In the case of a sponsor of a group health plan
21 or health insurance issuer offering health insurance cov-
22 erage in the group market that, pursuant to subsection
23 (b)(3)(E)(iii), uses a database described in such sub-
24 section to determine a rate to apply under such subsection
25 for an item or service by reason of having insufficient in-

1 formation described in such subsection with respect to
2 such item or service, such sponsor or issuer shall cover
3 the cost for access to such database.''.
4 (2) CLERICAL AMENDMENT.—The table of con-
5 tents of the Employee Retirement Income Security
6 Act of 1974 is amended by inserting after the item
7 relating to section 714 the following:

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

8 (c) IRC AMENDMENTS.—
9 (1) IN GENERAL.—Subchapter B of chapter
10 100 of the Internal Revenue Code of 1986 is amend-
11 ed by adding at the end the following:

12 **''SEC. 9816. CONSUMER PROTECTIONS.**

13 ''(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
14 a group health plan requires or provides for designation
15 by a participant or beneficiary of a participating primary
16 care provider, then the plan shall permit each participant
17 or beneficiary to designate any participating primary care
18 provider who is available to accept such individual.
19 ''(b) COVERAGE OF EMERGENCY SERVICES.—
20 ''(1) IN GENERAL.—If a group health plan pro-
21 vides or covers any benefits with respect to services
22 in an emergency department of a hospital or with re-
23 spect to emergency services in an independent free-
24 standing emergency department (as defined in para-

1 graph (3)(D)), the plan shall cover emergency serv-
2 ices (as defined in paragraph (3)(C))—
3 ‘‘(A) without the need for any prior au-
4 thorization determination;
5 ‘‘(B) whether the health care provider fur-
6 nishing such services is a participating provider
7 or a participating emergency facility, as appli-
8 cable, with respect to such services;
9 ‘‘(C) in a manner so that, if such services
10 are provided to a participant or beneficiary by
11 a nonparticipating provider or a nonpartici-
12 pating emergency facility—
13 ‘‘(i) such services will be provided
14 without imposing any requirement under
15 the plan for prior authorization of services
16 or any limitation on coverage that is more
17 restrictive than the requirements or limita-
18 tions that apply to emergency services re-
19 ceived from participating providers and
20 participating emergency facilities with re-
21 spect to such plan;
22 ‘‘(ii) the cost-sharing requirement (ex-
23 pressed as a copayment amount or coinsur-
24 ance rate) is not greater than the require-
25 ment that would apply if such services

1 were provided by a participating provider
2 or a participating emergency facility;
3 “(iii) such cost-sharing requirement is
4 calculated as if the total amount that
5 would have been charged for such services
6 by such participating provider or partici-
7 pating emergency facility were equal to the
8 recognized amount (as defined in para-
9 graph (3)(H)) for such services, plan, and
10 year;
11 “(iv) the group health plan pays to
12 such provider or facility, respectively, the
13 amount by which the recognized amount
14 for such services and year involved exceeds
15 the cost-sharing amount for such services
16 (as determined in accordance with clauses
17 (ii) and (iii)) and year; and
18 “(v) any cost-sharing payments made
19 by the participant or beneficiary with re-
20 spect to such emergency services so fur-
21 nished shall be counted toward any in-net-
22 work deductible or out-of-pocket maxi-
23 mums applied under the plan (and such in-
24 network deductible and out-of-pocket maxi-
25 mums shall be applied) in the same man-

1 ner as if such cost-sharing payments were
2 made with respect to emergency services
3 furnished by a participating provider or a
4 participating emergency facility; 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 this Act, including as incorporated pursuant to
10 section 715 of the Employee Retirement Income
11 Security Act of 1974 and section 9815 of this
12 Act, and other than applicable cost-sharing).
13 "(2) AUDIT PROCESS AND REGULATIONS FOR
14 MEDIAN CONTRACTED RATES.—
15 "(A) AUDIT PROCESS.—
16 "(i) IN GENERAL.—Not later than
17 July 1, 2021, the Secretary, in consulta-
18 tion with appropriate State agencies and
19 the Secretary of Health and Human Serv-
20 ices and the Secretary of Labor, shall es-
21 tablish through rulemaking a process, in
22 accordance with clause (ii), under which
23 group health plans are audited by the Sec-
24 retary or applicable State authority to en-
25 sure 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) such median contracted
6 rate so applied satisfies the definition
7 under paragraph (3)(E) with respect
8 to the year involved, including with re-
9 spect to a group health plan described
10 in clause (ii) of such paragraph
11 (3)(E).
12 "(ii) AUDIT SAMPLES.—Under the
13 process established pursuant to clause (i),
14 the Secretary—
15 "(I) shall conduct audits de-
16 scribed in such clause, with respect to
17 a year (beginning with 2022), of a
18 sample with respect to such year of
19 claims data from not more than 25
20 group health plans; and
21 "(II) may audit any group health
22 plan if the Secretary has received any
23 complaint about such plan or cov-
24 erage, respectively, that involves the
25 compliance of the plan with either of

1 the requirements described in sub-
2 clauses (I) and (II) of such clause.
3 ''(iii) REPORTS.—Beginning for 2022,
4 the Secretary shall annually submit to
5 Congress a report on the number of plans
6 and issuers with respect to which audits
7 were conducted during such year pursuant
8 to this subparagraph.
9 ''(B) RULEMAKING.—Not later than July
10 1, 2021, the Secretary, in consultation with the
11 Secretary of Labor and the Secretary of Health
12 and Human Services, shall establish through
13 rulemaking—
14 ''(i) the methodology the group health
15 plan shall use to determine the median
16 contracted rate, differentiating by line of
17 business;
18 ''(ii) the information such plan or
19 issuer, respectively, shall share with the
20 nonparticipating provider or nonpartici-
21 pating facility, as applicable, when making
22 such a determination;
23 ''(iii) the geographic regions applied
24 for purposes of this subparagraph, taking
25 into account access to items and services in

1 rural and underserved areas, including
2 health professional shortage areas, as de-
3 fined in section 332 of the Public Health
4 Service Act; and
5 "(iv) a process to receive complaints
6 of violations of the requirements described
7 in subclauses (I) and (II) of paragraph
8 (2)(A)(i) by group health plans.
9 Such rulemaking shall take into account pay-
10 ments that are made by such plan that are not
11 on a fee-for-service basis. Such methodology
12 may account for relevant payment adjustments
13 that take into account quality or facility type
14 (including higher acuity settings and the case-
15 mix of various facility types) that are otherwise
16 taken into account for purposes of determining
17 payment amounts with respect to participating
18 facilities. In carrying out clause (iii), the Sec-
19 retary shall consult with the National Associa-
20 tion of Insurance Commissioners to establish
21 the geographic regions under such clause and
22 shall periodically update such regions, as appro-
23 priate.
24 "(3) DEFINITIONS.—In this section:

1 "(A) EMERGENCY DEPARTMENT OF A HOS-
2 PITAL.—The term 'emergency department of a
3 hospital' includes a hospital outpatient depart-
4 ment that provides emergency services.
5 "(B) EMERGENCY MEDICAL CONDITION.—
6 The term 'emergency medical condition' means
7 a medical condition manifesting itself by acute
8 symptoms of sufficient severity (including se-
9 vere pain) such that a prudent layperson, who
10 possesses an average knowledge of health and
11 medicine, could reasonably expect the absence
12 of immediate medical attention to result in a
13 condition described in clause (i), (ii), or (iii) of
14 section 1867(e)(1)(A) of the Social Security
15 Act.
16 "(C) EMERGENCY SERVICES.—
17 "(i) IN GENERAL.—The term 'emer-
18 gency services', with respect to an emer-
19 gency medical condition, means—
20 "(I) a medical screening exam-
21 ination (as required under section
22 1867 of the Social Security Act, or as
23 would be required under such section
24 if such section applied to an inde-
25 pendent freestanding emergency de-

1 partment) that is within the capability
2 of the emergency department of a hos-
3 pital or of an independent free-
4 standing emergency department, as
5 applicable, including ancillary services
6 routinely available to the emergency
7 department to evaluate such emer-
8 gency medical condition; and
9 "(II) within the capabilities of
10 the staff and facilities available at the
11 hospital or the independent free-
12 standing emergency department, as
13 applicable, such further medical exam-
14 ination and treatment as are required
15 under section 1867 of such Act, or as
16 would be required under such section
17 if such section applied to an inde-
18 pendent freestanding emergency de-
19 partment, to stabilize the patient.
20 "(ii) INCLUSION OF CERTAIN SERV-
21 ICES OUTSIDE OF EMERGENCY DEPART-
22 MENT.—
23 "(I) IN GENERAL.—For purposes
24 of this subsection and section 2799A–
25 1, in the case of an individual enrolled

1 in a group health plan or health in-
2 surance coverage offered by a health
3 insurance issuer in the group or indi-
4 vidual market who is furnished serv-
5 ices described in clause (i) by a par-
6 ticipating or nonparticipating provider
7 or a participating or nonparticipating
8 emergency facility to stabilize such in-
9 dividual with respect to an emergency
10 medical condition, the term 'emer-
11 gency services' shall include, unless
12 each of the conditions described in
13 subclause (II) are met, in addition to
14 the items and services described in
15 clause (i), items and services for
16 which benefits are provided or covered
17 under the plan or coverage, respec-
18 tively, furnished by a nonparticipating
19 provider or nonparticipating facility,
20 regardless of the department of the
21 hospital in which such individual is
22 furnished such items or services, if,
23 after such stabilization but during
24 such visit in which such individual is
25 so stabilized, the provider or facility

1 determines that such items or services
2 are needed.
3 "(II) CONDITIONS.—For pur-
4 poses of subclause (I), the conditions
5 described in this subclause, with re-
6 spect to an individual who is stabilized
7 and furnished additional items and
8 services described in subclause (I)
9 after such stabilization by a provider
10 or facility described in subclause (I),
11 are the following:
12 "(aa) Such a provider or fa-
13 cility determines such individual
14 is able to travel using nonmedical
15 transportation or nonemergency
16 medical transportation.
17 "(bb) Such provider fur-
18 nishing such additional items and
19 services satisfies the notice and
20 consent criteria of section
21 2799A–2(d) of the Public Health
22 Service Act with respect to such
23 items and services.
24 "(cc) Such an individual is
25 in a condition to receive (as de-

1 termined in accordance with
2 guidance issued by the Secretary)
3 the information described in sec-
4 tion 2799A–2 of the Public
5 Health Service Act and to pro-
6 vide informed consent under such
7 section, in accordance with appli-
8 cable State law.
9 ''(D) INDEPENDENT FREESTANDING
10 EMERGENCY DEPARTMENT.—The term 'inde-
11 pendent freestanding emergency department'
12 means a facility that—
13 ''(i) is geographically separate and
14 distinct and licensed separately from a hos-
15 pital under applicable State law; and
16 ''(ii) provides any emergency services
17 (as defined in subparagraph (C)).
18 ''(E) MEDIAN CONTRACTED RATE.—
19 ''(i) IN GENERAL.—The term 'median
20 contracted rate' means, subject to clauses
21 (ii) and (iii), with respect to a sponsor of
22 a group health plan—
23 ''(I) for an item or service fur-
24 nished during 2022, the median of the
25 contracted rates recognized by the

1 plan (determined with respect to all
2 such plans of such sponsor that are
3 offered within the same line of busi-
4 ness as the total maximum payment
5 (including the cost-sharing amount
6 imposed for such item or service and
7 the amount to be paid by the plan)
8 under such plans on January 31,
9 2019 for the same or a similar item
10 or service that is provided by a pro-
11 vider in the same or similar specialty
12 and provided in the geographic region
13 in which the item or service is fur-
14 nished, consistent with the method-
15 ology established by the Secretary
16 under paragraph (2)(B), increased by
17 the percentage increase in the con-
18 sumer price index for all urban con-
19 sumers (United States city average)
20 over 2019, such percentage increase
21 over 2020, and such percentage in-
22 crease over 2021; and
23 "(II) for an item or service fur-
24 nished during 2023 or a subsequent
25 year, the median contracted rate de-

1 termined under this clause for such
2 an item or service furnished in the
3 previous year, increased by the per-
4 centage increase in the consumer price
5 index for all urban consumers (United
6 States city average) over such pre-
7 vious year.
8 "(ii) NEW PLANS AND COVERAGE.—
9 The term 'median contracted rate' means,
10 with respect to a sponsor of a group health
11 plan in a geographic region in which such
12 sponsor, respectively, did not offer any
13 group health plan or health insurance cov-
14 erage during 2019—
15 "(I) for the first year in which
16 such group health plan is offered in
17 such region, a rate (determined in ac-
18 cordance with a methodology estab-
19 lished by the Secretary) for items and
20 services that are covered by such plan
21 and furnished during such first year;
22 and
23 "(II) for each subsequent year
24 such group health plan is offered in
25 such region, the median contracted

1 rate determined under this clause for
2 such items and services furnished in
3 the previous year, increased by the
4 percentage increase in the consumer
5 price index for all urban consumers
6 (United States city average) over such
7 previous year.

8 "(iii) INSUFFICIENT INFORMATION;
9 NEWLY COVERED ITEMS AND SERVICES.—
10 In the case of a sponsor of a group health
11 plan that does not have sufficient informa-
12 tion to calculate the median of the con-
13 tracted rates described in clause (i)(I) in
14 2019 (or, in the case of a newly covered
15 item or service (as defined in clause
16 (iv)(III)), in the first coverage year (as de-
17 fined in clause (iv)(I)) for such item or
18 service with respect to such plan) for an
19 item or service (including with respect to
20 provider type, or amount, of claims for
21 items or services (as determined by the
22 Secretary) provided in a particular geo-
23 graphic region (other than in a case with
24 respect to which clause (ii) applies)) the
25 term 'median contracted rate'—

1 "(I) for an item or service fur-
2 nished during 2022 (or, in the case of
3 a newly covered item or service, dur-
4 ing the first coverage year for such
5 item or service with respect to such
6 plan), means such rate for such item
7 or service determined by the sponsor
8 through use of any database that is
9 determined, in accordance with rule-
10 making described in paragraph
11 (2)(B), to not have any conflicts of in-
12 terest and to have sufficient informa-
13 tion reflecting allowed amounts paid
14 to a health care provider or facility for
15 relevant services furnished in the ap-
16 plicable geographic region (such as a
17 State all-payer claims database);
18 "(II) for an item or service fur-
19 nished in a subsequent year (before
20 the first sufficient information year
21 (as defined in clause (iv)(II)) for such
22 item or service with respect to such
23 plan), means the rate determined
24 under subclause (I) or this subclause,
25 as applicable, for such item or service

1 for the year previous to such subse-
2 quent year, increased by the percent-
3 age increase in the consumer price
4 index for all urban consumers (United
5 States city average) over such pre-
6 vious year;
7 ‘‘(III) for an item or service fur-
8 nished in the first sufficient informa-
9 tion year for such item or service with
10 respect to such plan, has the meaning
11 given the term median contracted rate
12 in clause (i)(I), except that in apply-
13 ing such clause to such item or serv-
14 ice, the reference to ‘furnished during
15 2022’ shall be treated as a reference
16 to furnished during such first suffi-
17 cient information year, the reference
18 to ‘on January 31, 2019’ shall be
19 treated as a reference to in such suffi-
20 cient information year, and the in-
21 crease described in such clause shall
22 not be applied; and
23 ‘‘(IV) for an item or service fur-
24 nished in any year subsequent to the
25 first sufficient information year for

1 such item or service with respect to
2 such plan, has the meaning given such
3 term in clause (i)(II), except that in
4 applying such clause to such item or
5 service, the reference to 'furnished
6 during 2023 or a subsequent year'
7 shall be treated as a reference to fur-
8 nished during the year after such first
9 sufficient information year or a subse-
10 quent year.

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

13 "(I) FIRST COVERAGE YEAR.—
14 The term 'first coverage year' means,
15 with respect to a group health plan
16 and an item or service for which cov-
17 erage is not offered in 2019 under
18 such plan or coverage, the first year
19 after 2019 for which coverage for
20 such item or service is offered under
21 such plan.

22 "(II) FIRST SUFFICIENT INFOR-
23 MATION YEAR.—The term 'first suffi-
24 cient information year' means, with
25 respect to a group health plan—

1 "(aa) in the case of an item
2 or service for which the plan does
3 not have sufficient information to
4 calculate the median of the con-
5 tracted rates described in clause
6 (i)(I) in 2019, the first year sub-
7 sequent to 2022 for which such
8 sponsor has such sufficient infor-
9 mation to calculate the median of
10 such contracted rates in the year
11 previous to such first subsequent
12 year; and

13 "(bb) in the case of a newly
14 covered item or service, the first
15 year subsequent to the first cov-
16 erage year for such item or serv-
17 ice with respect to such plan for
18 which the sponsor has sufficient
19 information to calculate the me-
20 dian of the contracted rates de-
21 scribed in clause (i)(I) in the
22 year previous to such first subse-
23 quent year.

24 "(III) NEWLY COVERED ITEM OR
25 SERVICE.—The term 'newly covered

1 item or service' means, with respect to
2 a group health plan, an item or serv-
3 ice for which coverage was not offered
4 in 2019 under such plan or coverage,
5 but is offered under such plan or cov-
6 erage in a year after 2019.

7 "(F) NONPARTICIPATING EMERGENCY FA-
8 CILITY; PARTICIPATING EMERGENCY FACIL-
9 ITY.—

10 "(i) NONPARTICIPATING EMERGENCY
11 FACILITY.—The term 'nonparticipating
12 emergency facility' means, with respect to
13 an item or service and a group health plan,
14 an emergency department of a hospital, or
15 an independent freestanding emergency de-
16 partment, that does not have a contractual
17 relationship directly or indirectly with the
18 plan for furnishing such item or service
19 under the plan.

20 "(ii) PARTICIPATING EMERGENCY FA-
21 CILITY.—The term 'participating emer-
22 gency facility' means, with respect to an
23 item or service and a group health plan, an
24 emergency department of a hospital, or an
25 independent freestanding emergency de-

1 partment, that has a contractual relation-
2 ship directly or indirectly with the plan,
3 with respect to the furnishing of such an
4 item or service at such facility.

5 "(G) NONPARTICIPATING PROVIDERS; PAR-
6 TICIPATING PROVIDERS.—

7 "(i) NONPARTICIPATING PROVIDER.—
8 The term 'nonparticipating provider'
9 means, with respect to an item or service
10 and a group health plan, a physician or
11 other health care provider who is acting
12 within the scope of practice of that pro-
13 vider's license or certification under appli-
14 cable State law and who does not have a
15 contractual relationship with the plan or
16 issuer, respectively, for furnishing such
17 item or service under the plan.

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

1 with the plan for furnishing such item or
2 service under the plan.
3 ''(H) RECOGNIZED AMOUNT.—The term
4 'recognized amount' means, with respect to an
5 item or service furnished by a nonparticipating
6 provider or emergency facility during a year
7 and a group health plan—
8 ''(i) subject to clause (iii), in the case
9 of such item or service furnished in a State
10 that has in effect a specified State law
11 with respect to such plan; such a non-
12 participating provider or emergency facil-
13 ity; and such an item or service, the
14 amount determined in accordance with
15 such law;
16 ''(ii) subject to clause (iii), in the case
17 of such item or service furnished in a State
18 that does not have in effect a specified
19 State law, with respect to such plan; such
20 a nonparticipating provider or emergency
21 facility; and such an item or service, an
22 amount that is the median contracted rate
23 (as defined in subparagraph (E)) for such
24 year and determined in accordance with

1 rulemaking described in paragraph (2)(B))
2 for such item or service; or
3 "(iii) in the case of such item or serv-
4 ice furnished in a State with an All-Payer
5 Model Agreement under section 1115A of
6 the Social Security Act, the amount that
7 the State approves under such system for
8 such item or service so furnished.
9 "(I) SPECIFIED STATE LAW.—The term
10 'specified State law' means, with respect to a
11 State, an item or service furnished by a non-
12 participating provider or emergency facility dur-
13 ing a year and a group health plan, a State law
14 that provides for a method for determining the
15 amount of payment that is required to be cov-
16 ered by such a plan (to the extent such State
17 law applies to such plan, subject to section 514
18 of the Employee Retirement Income Security
19 Act of 1974) in the case of a participant or
20 beneficiary covered under such plan and receiv-
21 ing such item or service from such a nonpartici-
22 pating provider or emergency facility.
23 "(J) STABILIZE.—The term 'to stabilize',
24 with respect to an emergency medical condition
25 (as defined in subparagraph (B)), has the

1 meaning give in section 1867(e)(3) of the Social
2 Security Act (42 U.S.C. 1395dd(e)(3)).
3 "(c) ACCESS TO PEDIATRIC CARE.—
4 "(1) PEDIATRIC CARE.—In the case of a person
5 who has a child who is a participant or beneficiary
6 under a group health plan, if the plan requires or
7 provides for the designation of a participating pri-
8 mary care provider for the child, the plan shall per-
9 mit such person to designate a physician (allopathic
10 or osteopathic) who specializes in pediatrics as the
11 child's primary care provider if such provider par-
12 ticipates in the network of the plan or issuer.
13 "(2) CONSTRUCTION.—Nothing in paragraph
14 (1) shall be construed to waive any exclusions of cov-
15 erage under the terms and conditions of the plan
16 with respect to coverage of pediatric care.
17 "(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
18 COLOGICAL CARE.—
19 "(1) GENERAL RIGHTS.—
20 "(A) DIRECT ACCESS.—A group health
21 plan described in paragraph (2) may not re-
22 quire authorization or referral by the plan or
23 any person (including a primary care provider
24 described in paragraph (2)(B)) in the case of a
25 female participant or beneficiary who seeks cov-

1 erage for obstetrical or gynecological care pro-
2 vided by a participating health care professional
3 who specializes in obstetrics or gynecology.
4 Such professional shall agree to otherwise ad-
5 here to such plan's policies and procedures, in-
6 cluding procedures regarding referrals and ob-
7 taining prior authorization and providing serv-
8 ices pursuant to a treatment plan (if any) ap-
9 proved by the plan.

10 "(B) OBSTETRICAL AND GYNECOLOGICAL
11 CARE.—A group health plan described in para-
12 graph (2) shall treat the provision of obstetrical
13 and gynecological care, and the ordering of re-
14 lated obstetrical and gynecological items and
15 services, pursuant to the direct access described
16 under subparagraph (A), by a participating
17 health care professional who specializes in ob-
18 stetrics or gynecology as the authorization of
19 the primary care provider.

20 "(2) APPLICATION OF PARAGRAPH.—A group
21 health plan described in this paragraph is a group
22 health plan that—

23 "(A) provides coverage for obstetric or
24 gynecologic care; and

1 "(B) requires the designation by a partici-
2 pant or beneficiary of a participating primary
3 care provider.
4 "(3) CONSTRUCTION.—Nothing in paragraph
5 (1) shall be construed to—
6 "(A) waive any exclusions of coverage
7 under the terms and conditions of the plan with
8 respect to coverage of obstetrical or gyneco-
9 logical care; or
10 "(B) preclude the group health plan in-
11 volved from requiring that the obstetrical or
12 gynecological provider notify the primary care
13 health care professional or the plan of treat-
14 ment decisions.
15 "(e) COVERAGE OF NON-EMERGENCY SERVICES PER-
16 FORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN
17 PARTICIPATING FACILITIES.—
18 "(1) IN GENERAL.—In the case of items or
19 services (other than emergency services to which
20 subsection (b) applies) for which any benefits are
21 provided or covered by a group health plan furnished
22 to a participant or beneficiary of such plan by a
23 nonparticipating provider (as defined in subsection
24 (b)(3)(G)(i)) (and who, with respect to such items
25 and services, has not satisfied the notice and consent

1 criteria of section 2799A–2(d) of the Public Health
2 Service Act) with respect to a visit (as defined by
3 the Secretary in accordance with paragraph (2)(B))
4 at a participating health care facility (as defined in
5 paragraph (2)(A)), with respect to such plan, the
6 plan—
7 ‘‘(A) shall not impose on such participant
8 or beneficiary a cost-sharing amount (expressed
9 as a copayment amount or coinsurance rate) for
10 such items and services so furnished that is
11 greater than the cost-sharing amount that
12 would apply under such plan had such items or
13 services been furnished by a participating pro-
14 vider (as defined in subsection (b)(3)(G)(ii));
15 ‘‘(B) shall calculate such cost-sharing
16 amount as if the total amount that would have
17 been charged for such items and services by
18 such participating provider were equal to the
19 recognized amount (as defined in subsection
20 (b)(3)(H)) for such items and services, plan,
21 and year;
22 ‘‘(C) shall pay to such provider furnishing
23 such items and services to such participant or
24 beneficiary the amount by which the recognized
25 amount (as defined in subsection (b)(3)(H)) for

1 such items and services and year involved ex-
2 ceeds the cost-sharing amount imposed under
3 the plan for such items and services (as deter-
4 mined in accordance with subparagraphs (A)
5 and (B)); and

6 "(D) shall count toward any in-network
7 deductible and in-network out-of-pocket maxi-
8 mums (as applicable) applied under the plan,
9 any cost-sharing payments made by the partici-
10 pant or beneficiary (and such in-network de-
11 ductible shall be applied) with respect to such
12 items and services so furnished in the same
13 manner as if such cost-sharing payments were
14 with respect to items and services furnished by
15 a participating provider.

16 "(2) DEFINITIONS.—In this section:

17 "(A) PARTICIPATING HEALTH CARE FACIL-
18 ITY.—

19 "(i) IN GENERAL.—The term 'partici-
20 pating health care facility' means, with re-
21 spect to an item or service and a group
22 health plan, a health care facility described
23 in clause (ii) that has a contractual rela-
24 tionship with the plan, with respect to the

1 furnishing of such an item or service at the
2 facility.
3 "(ii) HEALTH CARE FACILITY DE-
4 SCRIBED.—A health care facility described
5 in this clause, with respect to a group
6 health plan, is each of the following:
7 "(I) A hospital (as defined in
8 1861(e) of the Social Security Act).
9 "(II) A hospital outpatient de-
10 partment.
11 "(III) A critical access hospital
12 (as defined in section 1861(mm) of
13 such Act).
14 "(IV) An ambulatory surgical
15 center (as defined in section
16 1833(i)(1)(A) of such Act).
17 "(V) Any other facility that pro-
18 vides items or services for which cov-
19 erage is provided under the plan or
20 coverage, respectively.
21 "(B) VISIT.—The term 'visit' shall, with
22 respect to items and services furnished to an in-
23 dividual at a participating health care facility,
24 include equipment and devices, telemedicine
25 services, imaging services, laboratory services,

1 and such other items and services as the Sec-
2 retary may specify, regardless of whether or not
3 the provider furnishing such items or services is
4 at the facility.

5 ''(f) AIR AMBULANCE SERVICES.—

6 ''(1) IN GENERAL.—In the case of a participant
7 or beneficiary in a group health plan who receives
8 air ambulance services from a nonparticipating pro-
9 vider (as defined in subsection (b)(3)(G)) with re-
10 spect to such plan or coverage, if such services
11 would be covered if provided by a participating pro-
12 vider (as defined in such subsection) with respect to
13 such plan—

14 ''(A) the cost-sharing requirement (ex-
15 pressed as a copayment amount, coinsurance
16 rate, or deductible) with respect to such services
17 shall be the same requirement that would apply
18 if such services were provided by such a partici-
19 pating provider, and any coinsurance or deduct-
20 ible shall be based on rates that would apply for
21 such services if they were furnished by such a
22 participating provider;

23 ''(B) such cost-sharing amounts shall be
24 counted toward the in-network deductible and
25 in-network out-of-pocket maximum amount

1 under the plan for the plan year (and such in-
2 network deductible shall be applied) with re-
3 spect to such items and services so furnished in
4 the same manner as if such cost-sharing pay-
5 ments were with respect to items and services
6 furnished by a participating provider; and
7 "(C) the plan or coverage shall pay to such
8 provider furnishing such services to such partic-
9 ipant or beneficiary the amount by which the
10 recognized amount (as defined in and deter-
11 mined pursuant to subsection (b)(3)(H)(ii)) for
12 such services and year involved exceeds the
13 cost-sharing amount imposed under the plan for
14 such services (as determined in accordance with
15 subparagraphs (A) and (B)).
16 "(2) AIR AMBULANCE SERVICE DEFINED.—For
17 purposes of this section, the term 'air ambulance
18 service' means medical transport by helicopter or
19 airplane for patients.
20 "(g) CERTAIN ACCESS FEES TO CERTAIN DATA-
21 BASES.—In the case of a sponsor of a group health plan
22 that, pursuant to subsection (b)(3)(E)(iii), uses a data-
23 base described in such subsection to determine a rate to
24 apply under such subsection for an item or service by rea-
25 son of having insufficient information described in such

1 subsection with respect to such item or service, such spon-
2 sor shall cover the cost for access to such database.''.
3 (2) CLERICAL AMENDMENT.—The table of sec-
4 tions for subchapter B of chapter 100 of the Inter-
5 nal Revenue Code of 1986 is amended by adding at
6 the end the following new item:

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

7 (d) ADDITIONAL APPLICATION PROVISIONS.—
8 (1) APPLICATION TO FEHB.—
9 (A) IN GENERAL.—Section 8902 of title 5,
10 United States Code, is amended by adding at
11 the end the following new subsection:
12 ``(p) Each contract under this chapter shall require
13 the carrier to comply with requirements described in the
14 provisions of section 2719A of the Public Health Service
15 Act and sections 2730 and 2731 of such Act, sections 716,
16 717, and 718 of the Employee Retirement Income Secu-
17 rity Act of 1974, sections 9816, 9817, and 9818 of the
18 Internal Revenue Code of 1986 (as applicable), and sec-
19 tion 2(d) of the Ban Surprise Billing Act in the same man-
20 ner as such provisions apply to a group health plan or
21 health insurance issuer offering health insurance coverage,
22 as described in such sections. The provisions of sections
23 2799A–1, 2799A–2, 2799A–3, and 2799A–4 of the Public
24 Health Service Act shall apply to a health care provider

1 and facility and an air ambulance provider described in
2 such respective sections with respect to a participant, ben-
3 eficiary, or enrollee in a health benefits plan under this
4 chapter in the same manner as such provisions apply to
5 such a provider and facility with respect to an enrollee
6 in a group health plan or health insurance coverage of-
7 fered by a health insurance issuer in the group or indi-
8 vidual market, as described in such sections.''.

9 (B) EFFECTIVE DATE.—The amendment
10 made by this paragraph shall apply with respect
11 to contracts entered into or renewed for con-
12 tract years beginning on or after January 1,
13 2022.

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

18 ''(5) APPLICATION OF ADDITIONAL PROVI-
19 SIONS.—Subsections (b), (e), (f), (g), and (h) of sec-
20 tion 2719A of the Public Health Service Act shall
21 apply to grandfathered health plans for plan years
22 beginning on or after January 1, 2022.''.

23 (3) COORDINATION.—The Secretary of the
24 Treasury, the Secretary of Health and Human Serv-
25 ices, and the Secretary of Labor shall ensure,

1 through the execution of an interagency memo-
2 randum of understanding among such Secretaries,
3 that—
4 (A) regulations, rulings, and interpreta-
5 tions issued by such Secretaries relating to the
6 same matter over which 2 or more such Secre-
7 taries have responsibility under this title (and
8 the amendments made by this title) are admin-
9 istered so as to have the same effect at all
10 times; and
11 (B) coordination of policies relating to en-
12 forcing the same requirements through such
13 Secretaries in order to have a coordinated en-
14 forcement strategy that avoids duplication of
15 enforcement efforts and assigns priorities in en-
16 forcement.
17 (4) RULE OF CONSTRUCTION.—Nothing in this
18 title, including the amendments made by this title
19 may be construed as modifying, reducing, or elimi-
20 nating—
21 (A) the protections under section 222 of
22 the Indian Health Care Improvement Act (25
23 U.S.C. 1621u) and under subpart I of part 136
24 of title 42, Code of Federal Regulations (or any
25 successor regulation), against payment liability

1 for a patient who receives contract health serv-
2 ices that are authorized by the Indian Health
3 Service; or
4 (B) the requirements under section
5 1866(a)(1)(U) of the Social Security Act (42
6 U.S.C. 1395cc(a)(1)(U)).
7 (e) EFFECTIVE DATE.—The amendments made by
8 this section shall apply with respect to plan years begin-
9 ning on or after January 1, 2022.

10 **SEC. 3. PREVENTING CERTAIN CASES OF BALANCE BILL-**
11 **ING.**

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

15 **"PART D—HEALTH CARE PROVIDER**
16 **REQUIREMENTS**

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

19 "(a) IN GENERAL.—In the case of a participant, ben-
20 eficiary, or enrollee with benefits under a group health
21 plan or health insurance coverage offered by a health in-
22 surance issuer in the group or individual market who is
23 furnished during a plan year beginning on or after Janu-
24 ary 1, 2022, emergency services for which any benefit is
25 provided under such plan or coverage with respect to an

1 emergency medical condition with respect to a visit at an
2 emergency department of a hospital or an independent
3 freestanding emergency department—

4 "(1) in the case that the hospital or inde-
5 pendent freestanding emergency department is a
6 nonparticipating emergency facility, the emergency
7 department of a hospital or independent free-
8 standing emergency department shall not hold the
9 participant, beneficiary, or enrollee liable for a pay-
10 ment amount for such emergency services so fur-
11 nished that is more than the cost-sharing amount
12 for such services (as determined in accordance with
13 clauses (ii) and (iii) of section 2719A(b)(1)(C), sec-
14 tion 716(b)(1)(C) of the Employee Retirement In-
15 come Security Act of 1974, and section
16 9816(b)(1)(C) of the Internal Revenue Code of
17 1986, as applicable); and

18 "(2) in the case that such services are furnished
19 by a nonparticipating provider, the health care pro-
20 vider shall not hold such participant, beneficiary, or
21 enrollee liable for a payment amount for an emer-
22 gency service furnished to such individual by such
23 provider with respect to such emergency medical
24 condition and visit for which the individual receives
25 emergency services at the hospital or emergency de-

1 partment that is more than the cost-sharing amount
2 for such services furnished by the provider (as deter-
3 mined in accordance with clauses (ii) and (iii) of sec-
4 tion 2719A(b)(1)(C), section 716(b)(1)(C) of the
5 Employee Retirement Income Security Act of 1974,
6 and section 9816(b)(1)(C) of the Internal Revenue
7 Code of 1986, as applicable).

8 "(b) DEFINITION.—In this section, the term 'visit'
9 shall have such meaning as applied to such term for pur-
10 poses of section 2719A(e).

11 **"SEC. 2799A–2. BALANCE BILLING IN CASES OF NON-EMER-**
12 **GENCY SERVICES PERFORMED BY NON-**
13 **PARTICIPATING PROVIDERS AT CERTAIN**
14 **PARTICIPATING FACILITIES.**

15 "(a) IN GENERAL.—Subject to subsection (b), in the
16 case of a participant, beneficiary, or enrollee with benefits
17 under a group health plan or health insurance coverage
18 offered by a health insurance issuer in the group or indi-
19 vidual market who is furnished during a plan year begin-
20 ning on or after January 1, 2022, items or services (other
21 than emergency services to which section 2799A–1 ap-
22 plies) for which any benefit is provided under such plan
23 or coverage at a participating health care facility by a non-
24 participating provider, such provider shall not bill, and
25 shall not hold liable, such participant, beneficiary, or en-

1 rollee for a payment amount for such an item or service
2 furnished by such provider with respect to a visit at such
3 facility that is more than the cost-sharing amount for such
4 item or service (as determined in accordance with subpara-
5 graphs (A) and (B) of section 2719A(e)(1), section
6 716(e)(1) of the Employee Retirement Income Security
7 Act of 1974, and section 9816(e)(1) of the Internal Rev-
8 enue Code of 1986, as applicable).

9 ‘‘(b) EXCEPTION.—

10 ‘‘(1) IN GENERAL.—Subsection (a) shall not
11 apply with respect to items or services (other than
12 ancillary services described in paragraph (2)) fur-
13 nished by a nonparticipating provider to a partici-
14 pant, beneficiary, or enrollee of a group health plan
15 or health insurance coverage offered by a health in-
16 surance issuer in the group or individual market, if
17 the provider satisfies the notice and consent criteria
18 of subsection (d).

19 ‘‘(2) ANCILLARY SERVICES DESCRIBED.—For
20 purposes of paragraph (1), ancillary services de-
21 scribed in this paragraph are, with respect to a par-
22 ticipating health care facility—

23 ‘‘(A) subject to paragraph (3), items and
24 services related to emergency medicine, anesthe-
25 siology, pathology, radiology, and neonatology,

1 whether or not provided by a physician or non-
2 physician practitioner, and items and services
3 provided by assistant surgeons, hospitalists, and
4 intensivists;
5 "(B) subject to paragraph (3), diagnostic
6 services (including radiology and laboratory
7 services);
8 "(C) items and services provided by such
9 other specialty practitioners, as the Secretary
10 specifies through rulemaking; and
11 "(D) items and services provided by a non-
12 participating provider if there is no partici-
13 pating provider who can furnish such item or
14 service at such facility.
15 "(3) EXCEPTION.—The Secretary may, through
16 rulemaking, establish a list (and update such list) of
17 advanced diagnostic laboratory tests, which shall not
18 be included as an ancillary service described in para-
19 graph (2) and with respect to which subsection (a)
20 would apply.
21 "(c) CLARIFICATION.—In the case of a nonpartici-
22 pating provider that satisfies the notice and consent cri-
23 teria of subsection (d) with respect to an item or service
24 (referred to in this subsection as a 'covered item or serv-
25 ice'), such notice and consent criteria may not be con-

1 strued as applying with respect to any item or service that
2 is furnished as a result of unforeseen, urgent medical
3 needs that arise at the time such covered item or service
4 is furnished. For purposes of the previous sentence, a cov-
5 ered item or service shall not include an ancillary service
6 described in subsection (b)(2).

7 "(d) NOTICE AND CONSENT TO BE TREATED BY A
8 NONPARTICIPATING PROVIDER OR NONPARTICIPATING
9 FACILITY.—

10 "(1) IN GENERAL.—A nonparticipating provider
11 or nonparticipating facility satisfies the notice and
12 consent criteria of this subsection, with respect to
13 items or services furnished by the provider or facility
14 to a participant, beneficiary, or enrollee of a group
15 health plan or health insurance coverage offered by
16 a health insurance issuer in the group or individual
17 market, if the provider (or, if applicable, the partici-
18 pating health care facility on behalf of such pro-
19 vider) or nonparticipating facility—

20 "(A) provides to the participant, bene-
21 ficiary, or enrollee (or to an authorized rep-
22 resentative of the participant, beneficiary, or
23 enrollee) on the date on which the individual is
24 furnished such items or services and, in the
25 case that the participant, beneficiary, or en-

1 rollee makes an appointment to be furnished
2 such items or services, on such date the ap-
3 pointment is made—
4 "(i) an oral explanation of the written
5 notice described in clause (ii); and
6 "(ii) a written notice in paper or elec-
7 tronic form (and including electronic notifi-
8 cation, as practicable) specified by the Sec-
9 retary, not later than July 1, 2021,
10 through guidance (which shall be updated
11 as determined necessary by the Secretary)
12 that—
13 "(I) contains the information re-
14 quired under paragraph (2);
15 "(II) clearly states that consent
16 to receive such items and services
17 from such nonparticipating provider
18 or nonparticipating facility is optional
19 and that the participant, beneficiary,
20 or enrollee may instead seek care from
21 a participating provider or at a par-
22 ticipating facility, with respect to such
23 plan or coverage, as applicable, in
24 which case the cost-sharing responsi-
25 bility of the participant, beneficiary,

1 or enrollee would not exceed such re-
2 sponsibility that would apply with re-
3 spect to such an item or service that
4 is furnished by a participating pro-
5 vider or participating facility, as ap-
6 plicable with respect to such plan;

7 "(III) is available in the 15 most
8 common languages in the geographic
9 region of the applicable facility and, in
10 the case the primary language of the
11 beneficiary, participant, or enrollee,
12 respectively, is not one of such 15 lan-
13 guage, makes a good faith effort to
14 also provide such notice orally in such
15 primary language of the beneficiary,
16 participant, or enrollee; and

17 "(IV) is signed and dated by the
18 participant, beneficiary, or enrollee (or
19 by an authorized representative of the
20 participant, beneficiary, or enrollee)
21 and, with respect to items or services
22 to be furnished by such a provider
23 that are not poststabilization services
24 described in section
25 2719A(b)(3)(C)(ii), is so signed and

1 dated not less than 72 hours prior to
2 the participant, beneficiary, or en-
3 rollee being furnished such items or
4 services by such provider; and
5 “(B) obtains from the participant, bene-
6 ficiary, or enrollee (or from such an authorized
7 representative) the consent described in para-
8 graph (3) to be treated by a nonparticipating
9 provider or nonparticipating facility.
10 “(2) INFORMATION REQUIRED UNDER WRITTEN
11 NOTICE.—For purposes of paragraph (1)(A)(ii)(I),
12 the information described in this paragraph, with re-
13 spect to a nonparticipating provider or nonpartici-
14 pating facility and a participant, beneficiary, or en-
15 rollee of a group health plan or health insurance cov-
16 erage offered by a health insurance issuer in the
17 group or individual market, is each of the following:
18 “(A) Notification, as applicable, that the
19 health care provider is a nonparticipating pro-
20 vider with respect to the health plan or the
21 health care facility is a nonparticipating facility
22 with respect to the health plan.
23 “(B) Notification of the good faith esti-
24 mated amount that such provider or facility
25 may charge the participant, beneficiary, or en-

1 rollee for such items and services involved, in-
2 cluding a notification that the provision of such
3 estimate or consent to be treated under para-
4 graph (3) does not constitute a contract with
5 respect to the charges estimated for such items
6 and services.

7 "(C) In the case of a participating facility
8 and a nonparticipating provider, a list of any
9 participating providers at the facility who are
10 able to furnish such items and services involved
11 and notification that the participant, bene-
12 ficiary, or enrollee may be referred, at their op-
13 tion, to such a participating provider.

14 "(D) Information about whether prior au-
15 thorization or other care management limita-
16 tions may be required in advance of receiving
17 such items or services at the facility.

18 "(3) CONSENT DESCRIBED TO BE TREATED BY
19 A NONPARTICIPATING PROVIDER OR NONPARTICI-
20 PATING FACILITY.—For purposes of paragraph
21 (1)(B), the consent described in this paragraph, with
22 respect to a participant, beneficiary, or enrollee of a
23 group health plan or health insurance coverage of-
24 fered by a health insurance issuer in the group or
25 individual market who is to be furnished items or

1 services by a nonparticipating provider or nonpartici-
2 pating facility, is a document specified by the Sec-
3 retary through rulemaking, in consultation with the
4 Secretary of Labor, that—
5 "(A) acknowledges that the participant,
6 beneficiary, or enrollee has been—
7 "(i) provided with a written good faith
8 estimate and an oral explanation of the
9 charge that may be applied for the items
10 or services anticipated to be furnished by
11 such provider or facility; and
12 "(ii) informed that the payment of
13 such charge by the participant, beneficiary,
14 or enrollee may not accrue toward meeting
15 any limitation that the plan or coverage
16 places on cost-sharing, including an expla-
17 nation that such payment may not apply to
18 an in-network deductible applied under the
19 plan or coverage; and
20 "(B) documents the consent of the partici-
21 pant, beneficiary, or enrollee to be furnished
22 such item or services by such provider or facil-
23 ity.
24 "(4) RULE OF CONSTRUCTION.—The consent
25 described in paragraph (3), with respect to a partici-

1 pant, beneficiary, or enrollee of a group health plan
2 or health insurance coverage offered by a health in-
3 surance issuer in the group or individual market,
4 shall constitute only consent to the receipt of the in-
5 formation provided pursuant to this subsection and
6 shall not constitute a contractual agreement of the
7 participant, beneficiary, or enrollee to any estimated
8 charge or amount included in such information.
9 ''(e) RETENTION OF CERTAIN DOCUMENTS.—A non-
10 participating facility (with respect to such facility or any
11 nonparticipating provider at such facility) or a partici-
12 pating facility (with respect to nonparticipating providers
13 at such facility) that obtains from a participant, bene-
14 ficiary, or enrollee of a group health plan or health insur-
15 ance coverage offered by a health insurance issuer in the
16 group or individual market (or an authorized representa-
17 tive of such participant, beneficiary, or enrollee) a written
18 notice in accordance with subsection (d)(1)(A)(ii), with re-
19 spect to furnishing an item or service to such participant,
20 beneficiary, or enrollee, shall retain such notice for at least
21 a 2-year period after the date on which such item or serv-
22 ice is so furnished.
23 ''(f) DEFINITIONS.—In this section:
24 ''(1) The terms 'nonparticipating provider' and
25 'participating provider' have the meanings given

1 such terms, respectively, in subsection (b)(3) of sec-
2 tion 2719A.

3 ''(2) The term 'participating health care facil-
4 ity' has the meaning given such term in subsection
5 (e)(2) of section 2719A.

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

8 ''(A) with respect to emergency services (as
9 defined in section 2719A(b)(3)(C)(i)) and a
10 group health plan or health insurance coverage
11 offered by a health insurance issuer in the
12 group or individual market, an emergency de-
13 partment of a hospital, or an independent free-
14 standing emergency department, that does not
15 have a contractual relationship with the plan or
16 issuer, respectively, with respect to the fur-
17 nishing of such services under the plan or cov-
18 erage, respectively; and

19 ''(B) with respect to services described in
20 section 2719A(b)(3)(C)(ii) and a group health
21 plan or health insurance coverage offered by a
22 health insurance issuer in the group or indi-
23 vidual market, a hospital or an independent
24 freestanding emergency department, that does
25 not have a contractual relationship with the

1 plan or issuer, respectively, with respect to the
2 furnishing of such services under the plan or
3 coverage, respectively.
4 ‘‘(4) The term ‘participating facility’ means—
5 ‘‘(A) with respect to emergency services (as
6 defined in clause (i) of section 2719A(b)(3)(C))
7 that are not described in clause (ii) of such sec-
8 tion and a group health plan or health insur-
9 ance coverage offered by a health insurance
10 issuer in the group or individual market, an
11 emergency department of a hospital, or an inde-
12 pendent freestanding emergency department,
13 that has a contractual relationship with the
14 plan or issuer, respectively, with respect to the
15 furnishing of such services under the plan or
16 coverage, respectively; and
17 ‘‘(B) with respect to services that pursuant
18 to clause (ii) of section 2719A(b)(3)(C) are in-
19 cluded as emergency services (as defined in
20 clause (i) of such section) and a group health
21 plan or health insurance coverage offered by a
22 health insurance issuer in the group or indi-
23 vidual market, a hospital or an independent
24 freestanding emergency department, that has a
25 contractual relationship with the plan or cov-

1 erage, respectively, with respect to the fur-
2 nishing of such services under the plan or cov-
3 erage, respectively.

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

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

14 "(1) the requirements and prohibitions of such
15 provider or facility under sections 2799A–1, 2799A–
16 2, and 2799A–4 (relating to prohibitions on balance
17 billing in certain circumstances);

18 "(2) if provided for under applicable State law,
19 any other requirements on such provider or facility
20 regarding the amounts such provider or facility may,
21 with respect to an item or service, charge a partici-
22 pant, beneficiary, or enrollee of a group health plan
23 or health insurance coverage offered by a health in-
24 surance issuer in the group or individual market
25 with respect to which such provider or facility does

1 not have a contractual relationship for furnishing
2 such item or service under the plan or coverage, re-
3 spectively, after receiving payment from the plan or
4 coverage, respectively, for such item or service and
5 any applicable cost-sharing payment from such par-
6 ticipant, beneficiary, or enrollee; and
7 ''(3) information on contacting appropriate
8 State and Federal agencies in the case that an indi-
9 vidual believes that such provider or facility has vio-
10 lated any requirement described in paragraph (1) or
11 (2) with respect to such individual.
12 ''(b) GUIDANCE.—Not later than 6 months after the
13 date of the enactment of this section, the Secretary, in
14 consultation with the Secretary of Labor, shall issue guid-
15 ance on the requirements for the notice under this section.
16 **''SEC. 2799A–4. AIR AMBULANCE SERVICES.**
17 ''In the case of a participant, beneficiary, or enrollee
18 with benefits under a group health plan or health insur-
19 ance coverage offered by a health insurance issuer in the
20 group or individual market who is furnished on or after
21 January 1, 2022, air ambulance services from a non-
22 participating provider (as defined in section
23 2719A(b)(3)(G)) with respect to such plan or coverage,
24 such provider shall not bill, and shall not hold liable, such
25 participant, beneficiary, or enrollee for a payment amount

1 for such service furnished by such provider that is more
2 than the cost-sharing amount for such service (as deter-
3 mined in accordance with paragraphs (1) and (2) of sec-
4 tion 2719A(f), section 716(f) of the Employee Retirement
5 Income Security Act of 1974, or section 9816(f) of the
6 Internal Revenue Code of 1986, as applicable).

7 **"SEC. 2799A–5. ENFORCEMENT.**

8 "(a) STATE ENFORCEMENT.—

9 "(1) STATE AUTHORITY.—Each State may re-
10 quire a provider or health care facility (including a
11 provider of air ambulance services) subject to the re-
12 quirements of this part (except section 2799A–5) to
13 satisfy such requirements applicable to the provider
14 or facility.

15 "(2) FAILURE TO IMPLEMENT REQUIRE-
16 MENTS.—In the case of a determination by the Sec-
17 retary that a State has failed to substantially en-
18 force the requirements specified in paragraph (1)
19 with respect to applicable providers and facilities in
20 the State, the Secretary shall enforce such require-
21 ments under subsection (b) insofar as they relate to
22 violations of such requirements occurring in such
23 State.

24 "(3) NOTIFICATION OF SECRETARY OF
25 LABOR.—A State may notify the Secretary of Labor

1 of instances of violations of sections 2799A–1,
2 2799A–2, or 2799A–4 with respect to participants
3 or beneficiaries under a group health plan or health
4 insurance coverage offered by a health insurance
5 issuer in the group market and any enforcement ac-
6 tions taken against providers or facilities as a result
7 of such violations, including the disposition of any
8 such enforcement actions.

9 ‘‘(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

10 ‘‘(1) IN GENERAL.—If a provider or facility is
11 found to be in violation of a requirement specified in
12 subsection (a)(1) by the Secretary, the Secretary
13 may apply a civil monetary penalty with respect to
14 such provider or facility (including, as applicable, a
15 provider of air ambulance services) in an amount not
16 to exceed $10,000 per violation. The provisions of
17 subsections (c) (with the exception of the first sen-
18 tence of paragraph (1) of such subsection), (d), (e),
19 (g), (h), (k), and (l) of section 1128A of the Social
20 Security Act shall apply to a civil monetary penalty
21 or assessment under this subsection in the same
22 manner as such provisions apply to a penalty, as-
23 sessment, or proceeding under subsection (a) of such
24 section.

1 "(2) LIMITATION.—The provisions of para-
2 graph (1) shall apply to enforcement of a provision
3 (or provisions) specified in subsection (a)(1) only as
4 provided under subsection (a)(2).
5 "(3) COMPLAINT PROCESS.—The Secretary
6 shall, through rulemaking conducted in consultation
7 with the Secretary of Labor, establish a process to
8 receive consumer complaints of violations of such
9 provisions and resolve such complaints within 60
10 days of receipt of such complaints. Such process
11 shall provide that the Secretary of Labor be in-
12 formed of complaints by participants or beneficiaries
13 under a group health plan or health insurance cov-
14 erage offered by a health insurance issuer in the
15 group market and any enforcement actions against
16 providers resulting from such complaints, including
17 the disposition of any such enforcement actions.
18 "(4) EXCEPTION.—The Secretary may waive
19 the penalties described under paragraph (1) with re-
20 spect to a facility or provider (including a provider
21 of air ambulance services) who does not knowingly
22 violate, and should not have reasonably known it vio-
23 lated, sections 2799A–1, 2799A–2, or 2799A–4 with
24 respect to a participant, beneficiary, or enrollee, if
25 such facility or provider, within 30 days of the viola-

1 tion, withdraws the bill that was in violation of such
2 provision and reimburses the health plan or partici-
3 pant, beneficiary, or enrollee, as applicable, in an
4 amount equal to the difference between the amount
5 billed and the amount allowed to be billed under the
6 provision, plus interest, at an interest rate deter-
7 mined by the Secretary.

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

11 "(c) CONTINUED APPLICABILITY OF STATE LAW.—
12 The sections specified in subsection (a)(1) shall not be
13 construed to supersede any provision of State law which
14 establishes, implements, or continues in effect any require-
15 ment or prohibition except to the extent that such require-
16 ment or prohibition prevents the application of a require-
17 ment or prohibition of such a section.".

18 (b) SECRETARY OF LABOR INVESTIGATIVE AUTHOR-
19 ITY.—

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

1 **"SEC. 522. INVESTIGATIVE AUTHORITY REGARDING VIOLA-**
2 **TIONS OF CERTAIN HEALTH CARE PROVIDER**
3 **REQUIREMENTS; COMPLAINT PROCESS.**

4 "(a) INVESTIGATIVE AUTHORITY.—Upon receiving a
5 notice from a State or the Secretary of Health and Human
6 Services of violations of sections 2799A–1, 2799A–2, or
7 2799A–4 of the Public Health Service Act, the Secretary
8 of Labor shall have the power to conduct an investigation
9 to identify patterns of such violations with respect to par-
10 ticipants or beneficiaries under a group health plan or
11 health insurance coverage offered in connection with a
12 group health plan by a health insurance issuer in the
13 group market. The Secretary may assist States, the Sec-
14 retary of Health and Human Services, plans, or issuers
15 to ensure that appropriate measures have been taken to
16 correct such violations retrospectively and prospectively
17 with respect to participants or beneficiaries under a group
18 health plan or health insurance coverage offered in connec-
19 tion with a group health plan by a health insurance issuer
20 in the group market.

21 "(b) COMPLAINT PROCESS.—Not later than January
22 1, 2022, the Secretary shall establish a process under
23 which the Secretary—

24 "(1) may receive complaints from participants
25 and beneficiaries of group health plans or health in-
26 surance coverage offered in connection with such

1 plans relating to alleged violations of the sections
2 specified in subsection (a); and
3 "(2) transmits such complaints to States or the
4 Secretary of Health and Human Services (as deter-
5 mined appropriate by the Secretary) for potential
6 enforcement actions.".
7 (2) TECHNICAL AMENDMENT.—The table of
8 contents in section 1 of the Employee Retirement
9 Income Security Act of 1974 (29 U.S.C. 1001 et
10 seq.) is amended by inserting after the item relating
11 to section 521 the following new item:

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

12 (c) DISCLOSURE OF CERTAIN PROTECTIONS
13 AGAINST BALANCE BILLING.—Section 716 of the Em-
14 ployee Retirement Income Security Act of 1974, as added
15 by section 2, is further amended by adding at the end the
16 following new subsection:
17 "(h) DISCLOSURE OF CERTAIN PROTECTIONS
18 AGAINST BALANCE BILLING.—Each group health plan
19 and health insurance issuer offering group health insur-
20 ance coverage shall make publicly available, and (if appli-
21 cable) post on a public website of such plan or issuer—
22 "(1) information in plain language on—
23 "(A) the requirements and prohibitions ap-
24 plied under sections 2799A–1, 2799A–2 and

1 2799A–4 of the Public Health Service Act (re-
2 lating to prohibitions on balance billing in cer-
3 tain circumstances);

4 "(B) if provided for under applicable State
5 law, any other requirements on providers and
6 facilities regarding the amounts such providers
7 and facilities may, with respect to an item or
8 service, charge a participant, beneficiary, or en-
9 rollee of such plan or coverage with respect to
10 which such a provider or facility does not have
11 a contractual relationship for furnishing such
12 item or service under the plan or coverage after
13 receiving payment from the plan or coverage for
14 such item or service and any applicable cost-
15 sharing payment from such participant, bene-
16 ficiary, or enrollee; and

17 "(C) the requirements applied under sub-
18 sections (b), (e), and (f); and

19 "(2) information on contacting appropriate
20 State and Federal agencies in the case that an indi-
21 vidual believes that such a provider or facility has
22 violated any requirement described in paragraph (1)
23 with respect to such individual.".

24 **SEC. 4. INDEPENDENT DISPUTE RESOLUTION PROCESS.**

25 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this section, the Sec-
3 retary of Health and Human Services, the Secretary
4 of Labor, and the Secretary of the Treasury (in this
5 section referred to as the "Secretaries") shall jointly
6 establish by regulation an independent dispute reso-
7 lution process (in this section referred to as the
8 "IDR process") under which, with respect to a pay-
9 ment made by a group health plan or health insur-
10 ance issuer offering health insurance coverage in the
11 group or individual market pursuant to subsection
12 (b)(1), (e)(1), or (f)(1) of section 2719A of the Pub-
13 lic Health Service Act, section 716 of the Employee
14 Retirement Income Security Act of 1974, or section
15 9816 of the Internal Revenue Code of 1986 (as ap-
16 plicable) using the recognized amount (as defined in
17 and determined pursuant to section
18 2719A(b)(3)(H)(ii) of the Public Health Service Act
19 or subsection (b)(3)(H)(ii) of section 716 of the Em-
20 ployee Retirement Income Security Act of 1974 or
21 section 9816 of the Internal Revenue Code of 1986,
22 as applicable) to a nonparticipating provider (as de-
23 fined in subparagraph (G) of section 2719A(b)(3) of
24 the Public Health Service Act or subparagraph (G)
25 of subsection (b)(3) of section 716 of the Employee

1 Retirement Income Security Act of 1974 or section
2 9816 of the Internal Revenue Code of 1986, as ap-
3 plicable) or a nonparticipating emergency facility (as
4 defined in subparagraph (F) of such section
5 2719A(b)(3) or such subsection (b)(3) of such sec-
6 tion 716 or such section 9816, as applicable) with
7 respect to an item or service (or, in the case of pay-
8 ment made under section 2719A(f)(1) of the Public
9 Health Service Act or subsection (f)(1) of section
10 716 of the Employee Retirement Income Security
11 Act of 1974 or section 9816 of the Internal Revenue
12 Code of 1986, as applicable, with respect to air am-
13 bulance services) furnished by such provider or facil-
14 ity—

15 (A) subject to subparagraph (B), the non-
16 participating provider, nonparticipating emer-
17 gency facility, or group health plan or health in-
18 surance issuer, respectively, may, not later than
19 the date specified in paragraph (2), submit a
20 request that such payment should be increased
21 or decreased; and

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

1 ance with such paragraph an alternative pay-
2 ment to be applied, with respect to such re-
3 quest.
4 (2) DATE SPECIFIED.—For purposes of para-
5 graph (1)(A), the date specified in this paragraph
6 is—
7 (A) in the case of a request described in
8 such paragraph (1)(A) being submitted by a
9 nonparticipating provider or nonparticipating
10 emergency facility, with respect to items and
11 services (or air ambulance services) described in
12 paragraph (1), the date that is 30 days after
13 the applicable date described in subsection
14 (b)(2)(A)(ii); or
15 (B) in the case of such a request filed by
16 a group health plan or health insurance issuer,
17 the date that is 30 days after the date of the
18 submission of the notice described in subsection
19 (b)(1)(B)(ii).
20 (3) CLARIFICATION.—A nonparticipating pro-
21 vider may not, with respect to an item or service (or
22 air ambulance service) furnished by such provider,
23 submit a request under the IDR process if such pro-
24 vider is exempt from the requirement under sub-
25 section (a) of section 2799A–2 of the Public Health

1 Service Act with respect to such item or service pur-
2 suant to subsection (e) of such section.
3 (b) REQUIREMENTS FOR REQUESTS TO BE ELIGIBLE
4 FOR SUBMISSION UNDER IDR PROCESS.—
5 (1) TIMING REQUIREMENTS.—A request may
6 not be submitted under the IDR process, with re-
7 spect to items and services (or air ambulance serv-
8 ices) furnished by a nonparticipating provider or
9 nonparticipating emergency facility for which a
10 group health plan or health insurance issuer offering
11 health insurance coverage in the group or individual
12 market made a payment pursuant to subsection
13 (b)(1), (e)(1), or (f)(1) of section 2719A of the Pub-
14 lic Health Service Act or subsection (b)(1), (e)(1), or
15 (f)(1) of section 716 of the Employee Retirement In-
16 come Security Act of 1974 or section 9816 of the
17 Internal Revenue Code of 1986 (as applicable) un-
18 less—
19 (A) in the case such request is being sub-
20 mitted by the nonparticipating provider or non-
21 participating emergency facility—
22 (i) the provider or facility, respec-
23 tively, filed, not later than 30 days after
24 the date such payment is received by the
25 provider or facility, respectively, an appeal

1 under the appeals process of the group
2 health plan or health insurance issuer, the
3 subject of which includes the payment for
4 such items and services (or air ambulance
5 services); and
6 (ii) such request is not submitted be-
7 fore the sooner of the date on which such
8 appeal has been resolved or the date that
9 is 30 days after the date on which such ap-
10 peal is so filed; or
11 (B) in the case such request is being sub-
12 mitted by the group health plan or health insur-
13 ance issuer—
14 (i) the group health plan or health in-
15 surance issuer, respectively, not later than
16 30 days after such provider or facility, re-
17 spectively, receives such payment, submits
18 to such provider or facility, respectively, a
19 notice that such plan or issuer, respec-
20 tively, disputes the amount of such pay-
21 ment with respect to such items and serv-
22 ices (or air ambulance services); and
23 (ii) such request is not submitted be-
24 fore the date that is 30 days after the date
25 of the submission of such notice.

1 (2) MINIMUM MEDIAN CONTRACTED RATE.—A
2 request may not be submitted under the IDR proc-
3 ess, with respect to items and services (or air ambu-
4 lance services) furnished in a geographic area by a
5 nonparticipating provider or nonparticipating emer-
6 gency facility for which a group health plan or
7 health insurance issuer offering health insurance
8 coverage in the group or individual market made a
9 payment pursuant to subsection (b)(1), (e)(1), or
10 (f)(1) of section 2719A of the Public Health Service
11 Act or subsection (b)(1), (e)(1), or (f)(1) of section
12 716 of the Employee Retirement Income Security
13 Act of 1974 or section 9816 of the Internal Revenue
14 Code of 1986 (as applicable) unless—
15 (A) in the case such item or service is fur-
16 nished during 2022, the median contracted rate
17 (as defined in subsection (b)(3)(E) of section
18 2719A of the Public Health Service Act or sub-
19 section (b)(3)(E) of section 716 of the Em-
20 ployee Retirement Income Security Act of 1974
21 or section 9816 of the Internal Revenue Code
22 of 1986 (as applicable)) for such year under
23 such plan or such coverage with respect to each
24 such item or service furnished by such a pro-
25 vider or such a facility in such area is at least

1 $750 (or, in the case of air ambulance services,
2 is at least $25,000); or
3 (B) in the case such item or service (or air
4 ambulance services) is furnished during a sub-
5 sequent year, the median contracted rate (as so
6 defined) for such year under such plan or such
7 coverage with respect to each such item or serv-
8 ice furnished by such a provider or such a facil-
9 ity in such area is at least the amount applied
10 under this paragraph for the previous year, in-
11 creased by the percentage increase in the con-
12 sumer price index for all urban consumers
13 (United States city average) over such previous
14 year.
15 (3) LIMITATION ON BATCHING OF ITEMS AND
16 SERVICES IN A REQUEST.—A request may not be
17 submitted under the IDR process by a nonpartici-
18 pating provider, nonparticipating emergency facility,
19 or a group health plan or health insurance issuer of-
20 fering health insurance coverage in the group or in-
21 dividual market, with respect to multiple items and
22 services (or multiple air ambulance services), un-
23 less—

1 (A) all such items and services (or air am-
2 bulance services) included in such request are
3 furnished by the same provider or facility;
4 (B) payment for all such items and serv-
5 ices (or air ambulance services) made pursuant
6 to subsection (b)(1), (e)(1), or (f)(1) of section
7 2719A of the Public Health Service Act or sub-
8 section (b)(1), (e)(1), or (f)(1) of section 716 of
9 the Employee Retirement Income Security Act
10 of 1974 or section 9816 of the Internal Rev-
11 enue Code of 1986 (as applicable) was made by
12 a single group health plan or health insurance
13 coverage;
14 (C) all such items and services (or air am-
15 bulance services) are related to the treatment of
16 the same condition; and
17 (D) all such items and services were fur-
18 nished during the 30-day period following the
19 date on which the first item or service (or air
20 ambulance service) included in such request was
21 furnished.
22 (c) IDR ENTITIES.—
23 (1) PROCESS OF CERTIFICATION.—The process
24 described in subsection (a) shall include a certifi-

1 cation process under which eligible entities may be
2 certified to carry out the IDR process.
3 (2) CERTIFICATION.—
4 (A) IN GENERAL.—An entity wishing to
5 participate in the IDR process under this sec-
6 tion shall request certification from the Secre-
7 taries. The Secretaries shall determine whether
8 or not to certify applicant entities, taking into
9 consideration whether the entity is unbiased
10 and unaffiliated with health insurance issuers,
11 group health plans, health care facilities, and
12 health care providers and free of conflicts of in-
13 terest, in accordance with the Secretaries' rule-
14 making on determining criteria for conflicts of
15 interest.
16 (B) ELIGIBLE ENTITIES.—For purposes of
17 this section, an eligible entity is an entity that
18 is a nongovernmental entity and that agrees to
19 comply with the fee limitations described in
20 subparagraph (C).
21 (C) FEE LIMITATIONS.—For purposes of
22 subparagraph (B), the fee limitations described
23 in this subparagraph are limitations established
24 by the Secretaries for the amount a certified
25 IDR entity may charge a nonparticipating pro-

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

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

(d) PAYMENT DETERMINATION.—

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

1 (2), not later than 30 days after being so selected,
2 determine the alternative payment that should be
3 made for items and services (or air ambulance serv-
4 ices) included in such request in accordance with
5 paragraph (3).
6 (2) SETTLEMENT.—
7 (A) IN GENERAL.—If such entity deter-
8 mines that a settlement between the group
9 health plan or issuer, as applicable, and the
10 provider or facility, as applicable, is likely with
11 respect to a request under the IDR process, the
12 entity may direct the parties to attempt, for a
13 period not to exceed 10 days, a good faith nego-
14 tiation for a settlement of such request.
15 (B) TIMING.—The period for a settlement
16 described in subparagraph (A) shall accrue to-
17 ward the 30-day period described in paragraph
18 (1).
19 (3) DETERMINATION OF ALTERNATIVE PAY-
20 MENT.—
21 (A) IN GENERAL.—The group health plan
22 or health insurance issuer offering health insur-
23 ance coverage in the group or individual market
24 (as applicable) and the nonparticipating pro-
25 vider or nonparticipating emergency facility (as

1 applicable) involved shall, with respect to a re-
2 quest under the IDR process, each submit to
3 the certified IDR entity selected under sub-
4 section (c)(3) for such request a final offer to
5 be considered for the alternative payment to be
6 applied with respect to items and services (or
7 air ambulance services) which are the subject of
8 the request. Such entity shall determine, in ac-
9 cordance with subparagraph (B), which such
10 offer is the most reasonable and will be applied
11 as the alternative payment.
12 (B) CONSIDERATIONS IN DETERMINA-
13 TION.—
14 (i) IN GENERAL.—In determining
15 which final offer is the alternative payment
16 to be applied, the certified IDR entity se-
17 lected under subsection (c)(3) for such re-
18 quest shall consider—
19 (I) the median contracted rates
20 (as defined in subsection (b)(3)(E) of
21 section 2719A of the Public Health
22 Service Act or subsection (b)(3)(E) of
23 section 716 of the Employee Retire-
24 ment Income Security Act of 1974 or
25 section 9816 of the Internal Revenue

1 Code of 1986 (as applicable)) for the
2 applicable year for items or services
3 (or air ambulance services) that are
4 comparable to the items and services
5 (or air ambulance services) included
6 in the request and that are furnished
7 in the same geographic area (as de-
8 fined by the Secretaries for purposes
9 of such subsection) as such items and
10 services (or air ambulance services)
11 (not including any facility fees with
12 respect to such rates); and

13 (II) in the case of items and
14 services (other than air ambulances
15 services), each circumstance described
16 in clause (ii) with respect to which in-
17 formation is submitted by either party
18 or, in the case of air ambulance serv-
19 ices, each circumstance described in
20 clause (iii) with respect to which in-
21 formation is submitted by either
22 party.

23 (ii) ADDITIONAL CIRCUMSTANCES FOR
24 CERTAIN ITEMS AND SERVICES.—For pur-
25 poses of clause (i)(II), the circumstances

1 described in this clause are, with respect to
2 items and services (other than air ambu-
3 lance services) included in the request
4 under the IDR process of a nonpartici-
5 pating provider, nonparticipating emer-
6 gency facility, group health plan, or health
7 insurance issuer the following:

8 (I) The level of training, edu-
9 cation, experience, and quality and
10 outcomes measurements of the pro-
11 vider or facility that furnished such
12 items and services (such as those en-
13 dorsed by the consensus-based entity
14 authorized under section 1890 of the
15 Social Security Act).

16 (II) The market share held by
17 the provider or facility, or the plan or
18 issuer, in the geographic area in
19 which the item or service was pro-
20 vided.

21 (III) Any other extenuating cir-
22 cumstances with respect to the fur-
23 nishing of such items and services
24 that relate to the acuity of the indi-
25 vidual receiving such items and serv-

1 ices or the complexity of furnishing
2 such items and services to such indi-
3 vidual.

4 (iii) ADDITIONAL CIRCUMSTANCES
5 FOR AIR AMBULANCE SERVICES.—For pur-
6 poses of clause (i)(II), the circumstances
7 described in this clause are, with respect to
8 air ambulance services included in the re-
9 quest under the IDR process of a non-
10 participating provider, group health plan,
11 or health insurance issuer the following:

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

15 (II) Any other extenuating cir-
16 cumstances with respect to the fur-
17 nishing of such services that relate to
18 the acuity of the individual receiving
19 such services or the complexity of fur-
20 nishing such services to such indi-
21 vidual.

22 (III) The training, education, ex-
23 perience, and quality of the medical
24 personnel that furnished such serv-
25 ices.

1 (IV) Ambulance vehicle type, in-
2 cluding the clinical capability level of
3 such vehicle.
4 (V) Population density of the
5 pick up location (such as urban, sub-
6 urban, rural, or frontier).
7 (iv) PROHIBITION ON CONSIDERATION
8 OF BILLED CHARGES.—In determining
9 which final offer is the alternative payment
10 amount to be applied with respect to items
11 and services (or air ambulance services)
12 furnished by a provider or facility and in-
13 cluded in the request under the IDR proc-
14 ess, the certified IDR entity selected under
15 subsection (c)(3) with respect to such re-
16 quest shall not consider the amount that
17 would have been billed by such provider or
18 facility with respect to such items and
19 services had the provisions of section
20 2799A–1, 2799A–2, or 2799A–4 of the
21 Public Health Service Act (as applicable)
22 not applied.
23 (C) EFFECTS OF DETERMINATION.—

1 (i) IN GENERAL.—A determination of
2 a certified IDR entity under subparagraph
3 (A) shall be binding.
4 (ii) LIMITATION ON CERTAIN SUBSE-
5 QUENT IDR CLAIMS.—In the case of a de-
6 termination of a certified IDR entity under
7 subparagraph (A), with respect to a re-
8 quest submitted under subsection (a)(1)(A)
9 and the two parties involved with such re-
10 quest, the party that submitted such initial
11 request may not submit during the 90-day
12 period following such determination a sub-
13 sequent request under such subsection in-
14 volving the same other party to such re-
15 quest with respect to such an item or serv-
16 ice (or air ambulance service) that was the
17 subject of such initial request.
18 (D) COSTS OF INDEPENDENT DISPUTE
19 RESOLUTION PROCESS.—In the case of a re-
20 quest made by a nonparticipating provider, non-
21 participating emergency facility, group health
22 plan, or health insurance issuer offering health
23 insurance coverage in the group or individual
24 market and submitted to a certified IDR enti-
25 ty—

1 (i) if such entity makes a determina-
2 tion with respect to such request under
3 subparagraph (A), the party whose offer is
4 not chosen under such clause shall be re-
5 sponsible for paying all fees charged by
6 such entity; and
7 (ii) if the parties reach a settlement
8 with respect to such request prior to such
9 a determination, each party shall pay half
10 of all fees charged by such entity, unless
11 the parties otherwise agree.
12 (E) PAYMENT.—Not later than 30 days
13 after the date on which a determination de-
14 scribed in subparagraph (B) is made with re-
15 spect to a request under the IDR process of a
16 nonparticipating provider, nonparticipating
17 emergency facility, group health plan, or health
18 insurance issuer offering health insurance cov-
19 erage in the group or individual market—
20 (i) in the case that the alternative
21 payment determined to be applied is great-
22 er than the amount paid with respect to
23 such request, such plan or issuer (as appli-
24 cable) shall pay directly to the provider or
25 facility (as applicable) the difference be-

1 tween such alternative payment and the
2 amount so paid; and
3 (ii) in the case that the alternative
4 payment determined to be applied is less
5 than the amount paid with respect to such
6 request, such provider or facility (as appli-
7 cable) shall pay directly to the plan or
8 issuer (as applicable) the difference be-
9 tween the amount so paid and such alter-
10 native payment.
11 (e) PUBLICATION OF INFORMATION RELATING TO
12 DISPUTES.—
13 (1) PUBLICATION OF INFORMATION.—For 2022
14 and each subsequent year, the Secretaries shall
15 make available on the public website of the Depart-
16 ment of Health and Human Services, the Depart-
17 ment of Labor, and the Department of the Treas-
18 ury—
19 (A) the number of requests submitted
20 under the IDR process during such year;
21 (B) the practice size of the providers and
22 facilities submitting requests under the IDR
23 process during such year;

1 (C) the number of such requests with re-
2 spect to which a final determination was made
3 under subsection (d)(3)(A); and
4 (D) the information described in para-
5 graph (2) with respect to each request with re-
6 spect to which such a determination was so
7 made.
8 (2) INFORMATION WITH RESPECT TO RE-
9 QUESTS.—For purposes of paragraph (1), the infor-
10 mation described in this paragraph is, with respect
11 to a request under the IDR process of a nonpartici-
12 pating provider, nonparticipating emergency facility,
13 group health plan, or health insurance issuer offer-
14 ing health insurance coverage in the group or indi-
15 vidual market—
16 (A) a description of each item and service
17 (or air ambulance service) included in such re-
18 quest;
19 (B) the geography in which the items and
20 services (or air ambulance services) included in
21 such request were provided;
22 (C) the amount of the offer submitted
23 under subsection (d)(3)(A) by the group health
24 plan or health insurance issuer (as applicable)
25 and by the nonparticipating provider or non-

1 participating emergency facility (as applicable)
2 expressed as a percentage of the median con-
3 tracted rate;
4 (D) whether the offer selected by the cer-
5 tified IDR entity under such subsection to be
6 the alternative payment applied was the offer
7 submitted by such plan or issuer (as applicable)
8 or by such provider or facility (as applicable)
9 and the amount of such offer so selected ex-
10 pressed as a percentage of the median con-
11 tracted rate;
12 (E) the category and practice specialty of
13 each such provider or facility involved in fur-
14 nishing such items and services (or, in the case
15 of air ambulance services, the ambulance vehicle
16 type, including the clinical capability level of
17 such vehicle); and
18 (F) the identity of the group health plan or
19 health insurance issuer, provider, or facility,
20 with respect to the request.
21 (3) IDR ENTITY REQUIREMENTS.—For 2022
22 and each subsequent year, an IDR entity, as a con-
23 dition of certification as an IDR entity, shall submit
24 to the Secretaries such information as the Secre-

1 taries determines necessary for the Secretaries to
2 carry out the provisions of this subsection.
3 (f) ENFORCEMENT.—
4 (1) IN GENERAL.—Any health care provider,
5 health care facility, group health plan, or health in-
6 surance issuer offering group or individual health in-
7 surance coverage that violates a provision of this
8 section shall be subject to a civil monetary penalty
9 in an amount not to exceed $10,000 for each such
10 violation.
11 (2) APPLICATION.—The provisions of section
12 1128A of the Social Security Act (other than sub-
13 sections (a) and (b) and the first sentence of sub-
14 section (c)(1)) shall apply with respect to a civil
15 monetary penalty imposed under this subsection in
16 the same manner as such provisions apply with re-
17 spect to a penalty or proceeding under subsection
18 (a) of such section, except that any reference to ''the
19 Secretary'' in such provisions shall be treated as a
20 reference to ''the Secretaries''.
21 (g) DEFINITIONS.—In this subsection, terms ''group
22 health plan'', ''group market'', ''health insurance issuer'',
23 ''health insurance coverage'', ''individual health insurance
24 coverage'', ''group health insurance coverage'', and ''indi-
25 vidual market'' have the meanings given such terms, re-

1 spectively, in section 2791 of the Public Health Service
2 Act.

3 **SEC. 5. ADVISORY COMMITTEE ON GROUND AMBULANCE**
4 **AND PATIENT BILLING.**

5 (a) IN GENERAL.—Not later than 60 days after the
6 date of enactment of this Act, the Secretary of Labor, Sec-
7 retary of Health and Human Services, and the Secretary
8 of the Treasury (the Secretaries) shall jointly establish an
9 advisory committee for the purpose of reviewing options
10 to improve the disclosure of charges and fees for ground
11 ambulance services, better inform consumers of insurance
12 options for such services, and protect consumers from bal-
13 ance billing.

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

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

19 (2) The Secretary of Health and Human Serv-
20 ices, or the Secretary's designee.

21 (3) The Secretary of the Treasury, or the Sec-
22 retary's designee.

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

1 (A) Each relevant Federal agency, as de-
2 termined by the Secretaries.
3 (B) State insurance regulators.
4 (C) Health insurance providers or trade or-
5 ganization.
6 (D) Patient advocacy groups.
7 (E) Consumer advocacy groups.
8 (F) State and local governments.
9 (G) Physician specializing in emergency,
10 trauma, cardiac, or stroke.
11 (5) Three representatives, to be appointed joint-
12 ly by the Secretaries, to represent the various seg-
13 ments of the ground ambulance industry.
14 (6) Up to an additional three representatives
15 otherwise not described in paragraphs (1) through
16 (5), as determined necessary and appropriate by the
17 Secretaries.
18 (c) CONSULTATION.—The advisory committee shall,
19 as appropriate, consult with relevant experts and stake-
20 holders, including those not otherwise included under sub-
21 section (b), while conducting the review described in sub-
22 section (a).
23 (d) RECOMMENDATIONS.—The advisory committee
24 shall make recommendations with respect to disclosure of
25 charges and fees for ground ambulance services and insur-

1 ance coverage, consumer protection and enforcement au-
2 thorities of the Departments of Labor, Health and Human
3 Services, and the Treasury and State authorities, and the
4 prevention of balance billing to consumers. The rec-
5 ommendations shall address, at a minimum—

6 (1) options, best practices, and identified stand-
7 ards to prevent instances of balance billing;

8 (2) steps that can be taken by State legisla-
9 tures, State insurance regulators, State attorneys
10 general, and other State officials as appropriate,
11 consistent with current legal authorities regarding
12 consumer protection; and

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

15 (e) REPORT.—Not later than 180 days after the date
16 of the first meeting of the advisory committee, the advi-
17 sory committee shall submit to the Secretaries, and the
18 Committees on Education and Labor, Energy and Com-
19 merce, and Ways and Means of the House of Representa-
20 tives and the Committees on Finance and Health, Edu-
21 cation, Labor, and Pensions a report containing the rec-
22 ommendations made under subsection (d).

23 (f) RULEMAKING.—Upon receipt of the report under
24 subsection (e), the Secretaries shall consider the rec-
25 ommendations of the advisory committee and issue regula-

tions or other guidance as deemed necessary to provide consumer protections for patients of ground ambulance providers.

SEC. 6. IMPROVING PROVIDER DIRECTORIES.

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

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

"(a) NETWORK STATUS OF PROVIDERS.—

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

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

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

"(I) through a written electronic communication from the plan or

1 issuer to the enrollee, as soon as prac-
2 ticable and not later than 1 business
3 day after such inquiry is made by
4 such participant, beneficiary, or en-
5 rollee for such information;
6 "(II) through an oral commu-
7 nication from the plan or issuer to the
8 enrollee, as soon as practicable and
9 not later than 1 business day after
10 such inquiry is made by such enrollee
11 for such information, which commu-
12 nication shall be documented by such
13 plan or issuer, and such documenta-
14 tion shall be kept in the enrollee's file
15 for a minimum of 2 years; and
16 "(ii) in real-time through an online
17 health care provider directory search tool
18 maintained by the plan or issuer; and
19 "(B) include in any print directory—
20 "(i) a disclosure that the information
21 included in the directory is accurate as of
22 the date of the last data update and that
23 enrollees or prospective enrollees should
24 consult the group health plan's or issuer's
25 electronic provider directory on its website

1 or call a specified customer service tele-
2 phone number to obtain the most current
3 provider directory information; and
4 "(ii) a list of the categories of pro-
5 viders of ancillary services for which the
6 plan or coverage has no in-network pro-
7 viders.
8 "(2) GROUP HEALTH PLAN AND HEALTH IN-
9 SURANCE ISSUER BUSINESS PROCESSES.—Beginning
10 on the date that is one year after the date of the en-
11 actment of this section, a group health plan or a
12 health insurance issuer offering group or individual
13 health insurance coverage shall establish business
14 processes to—
15 "(A) verify and update, at least once every
16 90 days, the provider directory information for
17 all providers included in the online health care
18 provider directory search tool described in para-
19 graph (1)(A)(ii); and
20 "(B) remove any provider from such online
21 directory search tool if such provider has not
22 verified the directory information within the
23 previous 6 months or the plan or issuer has
24 been unable to verify the provider's network
25 participation.

1 "(b) COST-SHARING LIMITATIONS.—A group health
2 plan or a health insurance issuer offering group or indi-
3 vidual health insurance coverage shall not apply, and shall
4 ensure that no provider applies, cost-sharing to an enrollee
5 for treatment or services provided by a health care pro-
6 vider in excess of the normal cost-sharing applied for such
7 treatment or services provided in-network (including any
8 balance bill issued by the health care provider involved),
9 if such enrollee, or health care provider referring such en-
10 rollee, demonstrates (based on the electronic, written in-
11 formation described in subsection (a)(1)(A)(i)(I), the oral
12 confirmation described in subsection (a)(1)(A)(i)(II) re-
13 ceived by the enrollee not more than 30 days before the
14 date the treatment or services were received, or a copy
15 of the online provider directory described in subsection
16 (a)(1)(A)(ii) on a date not more than 30 days before the
17 date the treatment or services were received), that the en-
18 rollee relied on the information described in subsection
19 (a)(1) for which such enrollee provides such documenta-
20 tion, that indicated that the provider is an in-network pro-
21 vider, if the provider was out-of-network at the time the
22 treatment or service involved was received.
23 "(c) DEFINITION.—For purposes of this section, the
24 term 'provider directory information' includes the names,
25 addresses, specialty, and telephone numbers of individual

1 health care providers, and the names, addresses, and tele-
2 phone numbers of each medical group, clinic, or facility
3 contracted to participate in any of the networks of the
4 group health plan or health insurance coverage involved.
5 ''(d) RULE OF CONSTRUCTION.—Nothing in this sec-
6 tion shall be construed to preempt any provision of State
7 law relating to health care provider directories.''.
8 (b) ERISA.—Subpart B of part 7 of subtitle B of
9 title I of the Employee Retirement Income Security Act
10 of 1974 (29 U.S.C. 1185 et seq.), as amended by section
11 2, is further amended by adding at the end the following:
12 **''SEC. 717. PROTECTING PATIENTS AND IMPROVING THE**
13 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
14 **MATION.**
15 ''(a) NETWORK STATUS OF PROVIDERS.—
16 ''(1) IN GENERAL.—Beginning on the date that
17 is one year after the date of enactment of this sec-
18 tion, a group health plan (or health insurance cov-
19 erage offered in connection with such a plan) shall—
20 ''(A) establish business processes to ensure
21 that all participants and beneficiaries in such
22 plan or coverage receive proof of a health care
23 provider's network status, based on what a plan
24 or issuer of such coverage knows or should
25 know—

1 "(i) upon a telephone inquiry by a
2 participant or beneficiary—
3 "(I) through a written electronic
4 communication from the plan or
5 issuer to the participant or bene-
6 ficiary, as soon as practicable and not
7 later than 1 business day after such
8 inquiry is made by such participant or
9 beneficiary for such information;
10 "(II) through an oral commu-
11 nication from the plan or issuer to the
12 participant or beneficiary, as soon as
13 practicable and not later than 1 busi-
14 ness day after such inquiry is made by
15 such participant or beneficiary for
16 such information, which communica-
17 tion shall be documented by such plan
18 or issuer, and such documentation
19 shall be kept in the participant's or
20 beneficiary's file for a minimum of 2
21 years; and
22 "(ii) in real-time through an online
23 health care provider directory search tool
24 maintained by the plan or issuer; and
25 "(B) include in any print directory—

1 "(i) a disclosure that the information
2 included in the directory is accurate as of
3 the date of the last data update and that
4 participants or beneficiaries or prospective
5 participants or beneficiaries should consult
6 the group health plan's or issuer's elec-
7 tronic provider directory on its website or
8 call a specified customer service telephone
9 number to obtain the most current pro-
10 vider directory information; and

11 "(ii) a list of the categories of pro-
12 viders of ancillary services for which the
13 plan or coverage has no in-network pro-
14 viders.

15 "(2) GROUP HEALTH PLAN AND HEALTH IN-
16 SURANCE ISSUER BUSINESS PROCESSES.—Beginning
17 on the date that is one year after the date of enact-
18 ment of this section, a group health plan (or health
19 insurance coverage offered in connection with such a
20 plan) shall establish business processes to—

21 "(A) verify and update, at least once every
22 90 days, the provider directory information for
23 all providers included in the online health care
24 provider directory search tool described in para-
25 graph (1)(A)(ii); and

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

7 "(b) COST-SHARING LIMITATIONS.—A group health
8 plan (or health insurance coverage offered in connection
9 with such a plan) shall not apply, and shall ensure that
10 no provider applies, cost-sharing to a participant or bene-
11 ficiary for treatment or services provided by a health care
12 provider in excess of the normal cost-sharing applied for
13 such treatment or services provided in-network (including
14 any balance bill issued by the health care provider in-
15 volved), if such participant or beneficiary, or health care
16 provider referring such participant or beneficiary, dem-
17 onstrates (based on the electronic, written information de-
18 scribed in subsection (a)(1)(A)(i)(I), the oral confirmation
19 described in subsection (a)(1)(A)(i)(II) received by the
20 participant or beneficiary not more than 30 days before
21 the date the treatment or services were received, or a copy
22 of the online provider directory described in subsection
23 (a)(1)(A)(ii) on a date not more than 30 days before the
24 date the treatment or services were received), that the par-
25 ticipant or beneficiary relied on the information described

1 in subsection (a)(1) for which such participant or bene-
2 ficiary provides such documentation, that indicated that
3 the provider is an in-network provider, if the provider was
4 out-of-network at the time the treatment or service in-
5 volved was received.

6 ‘‘(c) DEFINITION.—For purposes of this section, the
7 term ‘provider directory information’ includes the names,
8 addresses, specialty, and telephone numbers of individual
9 health care providers, and the names, addresses, and tele-
10 phone numbers of each medical group, clinic, or facility
11 contracted to participate in any of the networks of the
12 group health plan or health insurance coverage involved.’’.

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

16 **‘‘SEC. 9817. PROTECTING PATIENTS AND IMPROVING THE**
17 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
18 **MATION.**

19 ‘‘(a) NETWORK STATUS OF PROVIDERS.—

20 ‘‘(1) IN GENERAL.—Beginning on the date that
21 is one year after the date of enactment of this sec-
22 tion, a group health plan shall—

23 ‘‘(A) establish business processes to ensure
24 that all participants or beneficiaries in such
25 plan receive proof of a health care provider’s

1 network status, based on what a plan or issuer
2 knows or should know—
3 ‘‘(i) upon a telephone inquiry by a
4 participant or beneficiary—
5 ‘‘(I) through a written electronic
6 communication from the plan to the
7 participant or beneficiary, as soon as
8 practicable and not later than 1 busi-
9 ness day after such inquiry is made by
10 such participant or beneficiary for
11 such information;
12 ‘‘(II) through an oral commu-
13 nication from the plan to the partici-
14 pant or beneficiary, as soon as prac-
15 ticable and not later than 1 business
16 day after such inquiry is made by
17 such participant or beneficiary for
18 such information, which communica-
19 tion shall be documented by such
20 plan, and such documentation shall be
21 kept in the participant’s or bene-
22 ficiary’s file for a minimum of 2
23 years; and

1 "(ii) in real-time through an online
2 health care provider directory search tool
3 maintained by the plan; and
4 "(B) include in any print directory—
5 "(i) a disclosure that the information
6 included in the directory is accurate as of
7 the date of the last data update and that
8 participants or beneficiaries or prospective
9 participants or beneficiaries should consult
10 the group health plan's electronic provider
11 directory on its website or call a specified
12 customer service telephone number to ob-
13 tain the most current provider directory in-
14 formation; and
15 "(ii) a list of the categories of pro-
16 viders of ancillary services for which the
17 plan or coverage has no in-network pro-
18 viders.
19 "(2) GROUP HEALTH PLAN BUSINESS PROC-
20 ESSES.—Beginning on the date that is one year
21 after the date of enactment of this section, a group
22 health plan shall establish business processes to—
23 "(A) verify and update, at least once every
24 90 days, the provider directory information for
25 all providers included in the online health care

1 provider directory search tool described in para-
2 graph (1)(A)(ii); and
3 ‘‘(B) remove any provider from such online
4 directory search tool if such provider has not
5 verified the directory information within the
6 previous 6 months or the plan or issuer has
7 been unable to verify the provider's network
8 participation.
9 ‘‘(b) COST-SHARING LIMITATIONS.—A group health
10 plan shall not apply, and shall ensure that no provider
11 applies, cost-sharing to a participant or beneficiary for
12 treatment or services provided by a health care provider
13 in excess of the normal cost-sharing applied for such treat-
14 ment or services provided in-network (including any bal-
15 ance bill issued by the health care provider involved), if
16 such participant or beneficiary, or health care provider re-
17 ferring such participant or beneficiary, demonstrates
18 (based on the electronic, written information described in
19 subsection (a)(1)(A)(i)(I), the oral confirmation described
20 in subsection (a)(1)(A)(i)(II) received by the participant
21 or beneficiary not more than 30 days before the date the
22 treatment or services were received, or a copy of the online
23 provider directory described in subsection (a)(1)(A)(ii) on
24 a date not more than 30 days before the date the treat-
25 ment or services were received), that the participant or

1 beneficiary relied on the information described in sub-
2 section (a)(1) for which such participant or beneficiary
3 provides such documentation, that indicated that the pro-
4 vider is an in-network provider, if the provider was out-
5 of-network at the time the treatment or service involved
6 was received.

7 "(c) DEFINITION.—For purposes of this section, the
8 term 'provider directory information' includes the names,
9 addresses, specialty, and telephone numbers of individual
10 health care providers, and the names, addresses, and tele-
11 phone numbers of each medical group, clinic, or facility
12 contracted to participate in any of the networks of the
13 group health plan involved.

14 "(d) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed to preempt any provision of State
16 law relating to health care provider directories.".

17 (d) CLERICAL AMENDMENTS.—

18 (1) ERISA.—The table of contents in section 1
19 of the Employee Retirement Income Security Act of
20 1974 (29 U.S.C. 1001 et seq.), as amended by sec-
21 tion 2, is further amended by inserting after the
22 item relating to section 716 the following new item:

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

23 (2) IRC.—The table of sections for subchapter
24 B of chapter 100 of the Internal Revenue Code of

1 1986, as amended by section 2, is further amended
2 by adding at the end the following new item:

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

3 (e) PROVIDER REQUIREMENTS.—Part D of title
4 XXVII of the Public Health Service Act (42 U.S.C. 300gg
5 et seq.), as added by section 3, is amended—
6 (1) by redesignating section 2799A–5 as section
7 2799A–7; and
8 (2) by inserting after section 2799A–4 the fol-
9 lowing new section:

10 **"SEC. 2799A–5. PROVIDER REQUIREMENTS TO PROTECT PA-**
11 **TIENTS AND IMPROVE THE ACCURACY OF**
12 **PROVIDER DIRECTORY INFORMATION.**

13 "(a) PROVIDER BUSINESS PROCESSES.—A health
14 care provider shall have in place business processes to en-
15 sure the timely provision of provider directory information
16 to a group health plan or a health insurance issuer offer-
17 ing group or individual health insurance coverage to sup-
18 port compliance by such plans or issuers with section
19 2730(a)(1), section 717(a)(1) of the Employee Retirement
20 Income Security Act of 1974, or section 9817(a)(1) of the
21 Internal Revenue Code of 1986 (as applicable). Such pro-
22 viders shall submit provider directory information to a
23 plan or issuers, at a minimum—

1 "(1) when the provider begins a network agree-
2 ment with a plan or with an issuer with respect to
3 certain coverage;
4 "(2) when the provider terminates a network
5 agreement with a plan or with an issuer with respect
6 to certain coverage;
7 "(3) when there are material changes to the
8 content of provider directory information described
9 in section 2730(a)(1), section 717(a)(1) of the Em-
10 ployee Retirement Income Security Act of 1974, or
11 section 9817(a)(1) of the Internal Revenue Code of
12 1986 (as applicable); and
13 "(4) every 90 days throughout the duration of
14 the network agreement with a plan or issuer.
15 "(b) ENFORCEMENT.—
16 "(1) CIVIL PENALTIES.—
17 "(A) IN GENERAL.—Subject to paragraph
18 (2), a health care provider that violates a re-
19 quirement under subsection (a) or takes actions
20 that prevent a group health plan or health in-
21 surance issuer from complying with subsection
22 (a)(1) or (b) of sections 2730, 717 of the Em-
23 ployee Retirement Income Security Act of 1974,
24 or 9817 of the Internal Revenue Code of 1986
25 (as applicable) shall be subject to a civil mone-

1 tary penalty of not more than $10,000 for each
2 act constituting such violation.
3 "(B) SAFE HARBOR.—The Secretary may
4 waive the penalty described under paragraph
5 (1) with respect to a health care provider that
6 unknowingly violates section 2730(b)(1), section
7 717(b)(1) of the Employee Retirement Income
8 Security Act of 1974, or section 9817(b)(1) of
9 the Internal Revenue Code of 1986 (as applica-
10 ble) with respect to an enrollee if such provider
11 rescinds the bill involved and, if applicable, re-
12 imburses the enrollee within 30 days of the date
13 on which the provider billed the enrollee in vio-
14 lation of such subsection.
15 "(C) PROCEDURE.—The provisions of sec-
16 tion 1128A of the Social Security Act, other
17 than subsections (a) and (b) and the first sen-
18 tence of subsection (c)(1) of such section, shall
19 apply to civil money penalties under this sub-
20 section in the same manner as such provisions
21 apply to a penalty or proceeding under section
22 1128A of the Social Security Act.
23 "(2) REFUNDS TO ENROLLEES.—If a health
24 care provider submits a bill to an enrollee based on
25 cost-sharing for treatment or services provided by

1 the health care provider that is in excess of the nor-
2 mal cost-sharing applied for such treatment or serv-
3 ices provided in-network, as prohibited under section
4 2730(b), section 717(b) of the Employee Retirement
5 Income Security Act of 1974, or section 9817(b) of
6 the Internal Revenue Code of 1986 (as applicable)
7 and the enrollee pays such bill, the provider shall re-
8 imburse the enrollee for the full amount paid by the
9 enrollee in excess of the in-network cost-sharing
10 amount for the treatment or services involved, plus
11 interest, at an interest rate determined by the Sec-
12 retary.
13 "(c) LIMITATION.—Nothing in this section shall pro-
14 hibit a provider from requiring in the terms of a contract,
15 or contract termination, with a group health plan or health
16 insurance issuer—
17 "(1) that the plan or issuer remove, at the time
18 of termination of such contract, the provider from a
19 directory of the plan or issuer described in section
20 2730(a)(1), section 717(a)(1) of the Employee Re-
21 tirement Income Security Act of 1974, or section
22 9817(a)(1) of the Internal Revenue Code of 1986
23 (as applicable); or
24 "(2) that the plan or issuer bear financial re-
25 sponsibility, including under section 2730(b), section

1 717(b) of the Employee Retirement Income Security
2 Act of 1974, or section 9817(b) of the Internal Rev-
3 enue Code of 1986 (as applicable) for providing in-
4 accurate network status information to an enrollee.

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

12 "(e) RULE OF CONSTRUCTION.—Nothing in this sec-
13 tion shall be construed to preempt any provision of State
14 law relating to health care provider directories.".

15 **SEC. 7. INCREASING TRANSPARENCY IN HEALTH COV-**
16 **ERAGE.**

17 (a) DISCLOSURE OF DIRECT AND INDIRECT COM-
18 PENSATION FOR BROKERS AND CONSULTANTS TO EM-
19 PLOYER-SPONSORED HEALTH PLANS AND ENROLLEES IN
20 PLANS ON THE INDIVIDUAL MARKET.—

21 (1) GROUP HEALTH PLANS.—Section 408(b)(2)
22 of the Employee Retirement Income Security Act of
23 1974 (29 U.S.C. 1108(b)(2)) is amended—

1 (A) by striking ''(2) Contracting or mak-
2 ing'' and inserting ''(2)(A) Contracting or mak-
3 ing''; and
4 (B) by adding at the end the following:
5 ''(B)(i) No contract or arrangement for services
6 between a covered plan and a covered service pro-
7 vider, and no extension or renewal of such a contract
8 or arrangement, is reasonable within the meaning of
9 this paragraph unless the requirements of this sub-
10 paragraph are met.
11 ''(ii)(I) For purposes of this subparagraph:
12 ''(aa) The term 'covered plan' means a
13 group health plan as defined section 733(a).
14 ''(bb) The term 'covered service provider'
15 means a service provider that enters into a con-
16 tract or arrangement with the covered plan and
17 reasonably expects $1,000 (or such amount as
18 the Secretary may establish in regulations to
19 account for inflation since the date of the enact-
20 ment of the Ban Surprise Billing Act, as appro-
21 priate) or more in compensation, direct or indi-
22 rect, to be received in connection with providing
23 one or more of the following services, pursuant
24 to the contract or arrangement, regardless of
25 whether such services will be performed, or such

1 compensation received, by the covered service
2 provider, an affiliate, or a subcontractor:
3 "(AA) Brokerage services, for which
4 the covered service provider, an affiliate, or
5 a subcontractor reasonably expects to re-
6 ceive indirect compensation or direct com-
7 pensation described in item (dd), provided
8 to a covered plan with respect to selection
9 of insurance products (including vision and
10 dental), recordkeeping services, medical
11 management vendor, benefits administra-
12 tion (including vision and dental), stop-loss
13 insurance, pharmacy benefit management
14 services, wellness services, transparency
15 tools and vendors, group purchasing orga-
16 nization preferred vendor panels, disease
17 management vendors and products, compli-
18 ance services, employee assistance pro-
19 grams, or third party administration serv-
20 ices.
21 "(BB) Consulting, for which the cov-
22 ered service provider, an affiliate, or a sub-
23 contractor reasonably expects to receive in-
24 direct compensation or direct compensation
25 described in item (dd), related to the devel-

1 opment or implementation of plan design,
2 insurance or insurance product selection
3 (including vision and dental), record-
4 keeping, medical management, benefits ad-
5 ministration selection (including vision and
6 dental), stop-loss insurance, pharmacy ben-
7 efit management services, wellness design
8 and management services, transparency
9 tools, group purchasing organization agree-
10 ments and services, participation in and
11 services from preferred vendor panels, dis-
12 ease management, compliance services, em-
13 ployee assistance programs, or third party
14 administration services.

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

22 ''(dd)(AA) The term 'compensation' means
23 anything of monetary value, but does not in-
24 clude non-monetary compensation valued at
25 $250 (or such amount as the Secretary may es-

1 tablish in regulations to account for inflation
2 since the date of enactment of the Ban Surprise
3 Billing Act, as appropriate) or less, in the ag-
4 gregate, during the term of the contract or ar-
5 rangement.

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

9 "(CC) The term 'indirect compensation'
10 means compensation received from any source
11 other than the covered plan, the plan sponsor,
12 the covered service provider, or an affiliate.
13 Compensation received from a subcontractor is
14 indirect compensation, unless it is received in
15 connection with services performed under a con-
16 tract or arrangement with a subcontractor.

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

21 "(ff) The term 'subcontractor' means any
22 person or entity (or an affiliate of such person
23 or entity) that is not an affiliate of the covered
24 service provider and that, pursuant to a con-
25 tract or arrangement with the covered service

1 provider or an affiliate, reasonably expects to
2 receive $1,000 (or such amount as the Sec-
3 retary may establish in regulations to account
4 for inflation since the date of enactment of the
5 Ban Surprise Billing Act, as appropriate) or
6 more in compensation for performing one or
7 more services described in item (bb) under a
8 contract or arrangement with the covered plan.
9 ''(II) For purposes of this subparagraph, a de-
10 scription of compensation or cost may be expressed
11 as a monetary amount, formula, or a per capita
12 charge for each enrollee or, if the compensation or
13 cost cannot reasonably be expressed in such terms,
14 by any other reasonable method, including a disclo-
15 sure that additional compensation may be earned
16 but may not be calculated at the time of contract if
17 such a disclosure includes a description of the cir-
18 cumstances under which the additional compensation
19 may be earned and a reasonable and good faith esti-
20 mate if the covered service provider cannot otherwise
21 readily describe compensation or cost and explains
22 the methodology and assumptions used to prepare
23 such estimate. Any such description shall contain
24 sufficient information to permit evaluation of the
25 reasonableness of the compensation or cost.

1 "(III) No person or entity is a 'covered service
2 provider' within the meaning of subclause (I)(bb)
3 solely on the basis of providing services as an affil-
4 iate or a subcontractor that is performing one or
5 more of the services described in subitem (AA) or
6 (BB) of such subclause under the contract or ar-
7 rangement with the covered plan.

8 "(iii) A covered service provider shall disclose to
9 a responsible plan fiduciary, in writing, the fol-
10 lowing:

11 "(I) A description of the services to be pro-
12 vided to the covered plan pursuant to the con-
13 tract or arrangement.

14 "(II) If applicable, a statement that the
15 covered service provider, an affiliate, or a sub-
16 contractor will provide, or reasonably expects to
17 provide, services pursuant to the contract or ar-
18 rangement directly to the covered plan as a fi-
19 duciary (within the meaning of section 3(21)).

20 "(III) A description of all direct compensa-
21 tion, either in the aggregate or by service, that
22 the covered service provider, an affiliate, or a
23 subcontractor reasonably expects to receive in
24 connection with the services described in sub-
25 clause (I).

1 "(IV)(aa) A description of all indirect com-
2 pensation that the covered service provider, an
3 affiliate, or a subcontractor reasonably expects
4 to receive in connection with the services de-
5 scribed in subclause (I)—
6 "(AA) including compensation from a
7 vendor to a brokerage firm based on a
8 structure of incentives not solely related to
9 the contract with the covered plan; and
10 "(BB) not including compensation re-
11 ceived by an employee from an employer
12 on account of work performed by the em-
13 ployee.
14 "(bb) A description of the arrangement be-
15 tween the payer and the covered service pro-
16 vider, an affiliate, or a subcontractor, as appli-
17 cable, pursuant to which such indirect com-
18 pensation is paid.
19 "(cc) Identification of the services for
20 which the indirect compensation will be re-
21 ceived, if applicable.
22 "(dd) Identification of the payer of the in-
23 direct compensation.
24 "(V) A description of any compensation
25 that will be paid among the covered service pro-

1 vider, an affiliate, or a subcontractor, in con-
2 nection with the services described in subclause
3 (I) if such compensation is set on a transaction
4 basis (such as commissions, finder's fees, or
5 other similar incentive compensation based on
6 business placed or retained), including identi-
7 fication of the services for which such com-
8 pensation will be paid and identification of the
9 payers and recipients of such compensation (in-
10 cluding the status of a payer or recipient as an
11 affiliate or a subcontractor), regardless of
12 whether such compensation also is disclosed
13 pursuant to subclause (III) or (IV).

14 "(VI) A description of any compensation
15 that the covered service provider, an affiliate, or
16 a subcontractor reasonably expects to receive in
17 connection with termination of the contract or
18 arrangement, and how any prepaid amounts
19 will be calculated and refunded upon such ter-
20 mination.

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

1 "(v)(I) A covered service provider shall disclose
2 the information required under clauses (iii) and (iv)
3 to the responsible plan fiduciary not later than the
4 date that is reasonably in advance of the date on
5 which the contract or arrangement is entered into,
6 and extended or renewed.

7 "(II) A covered service provider shall disclose
8 any change to the information required under clause
9 (iii) and (iv) as soon as practicable, but not later
10 than 60 days from the date on which the covered
11 service provider is informed of such change, unless
12 such disclosure is precluded due to extraordinary cir-
13 cumstances beyond the covered service provider's
14 control, in which case the information shall be dis-
15 closed as soon as practicable.

16 "(vi)(I) Upon the written request of the respon-
17 sible plan fiduciary or covered plan administrator, a
18 covered service provider shall furnish any other in-
19 formation relating to the compensation received in
20 connection with the contract or arrangement that is
21 required for the covered plan to comply with the re-
22 porting and disclosure requirements under this Act.

23 "(II) The covered service provider shall disclose
24 the information required under clause (iii)(I) reason-
25 ably in advance of the date upon which such respon-

1 sible plan fiduciary or covered plan administrator
2 states that it is required to comply with the applica-
3 ble reporting or disclosure requirement, unless such
4 disclosure is precluded due to extraordinary cir-
5 cumstances beyond the covered service provider's
6 control, in which case the information shall be dis-
7 closed as soon as practicable.
8 "(vii) No contract or arrangement will fail to be
9 reasonable under this subparagraph solely because
10 the covered service provider, acting in good faith and
11 with reasonable diligence, makes an error or omis-
12 sion in disclosing the information required pursuant
13 to clause (iii) (or a change to such information dis-
14 closed pursuant to clause (v)(II)) or clause (vi), pro-
15 vided that the covered service provider discloses the
16 correct information to the responsible plan fiduciary
17 as soon as practicable, but not later than 30 days
18 from the date on which the covered service provider
19 knows of such error or omission.
20 "(viii)(I) Pursuant to subsection (a), subpara-
21 graphs (C) and (D) of section 406(a)(1) shall not
22 apply to a responsible plan fiduciary, notwith-
23 standing any failure by a covered service provider to
24 disclose information required under clause (iii), if
25 the following conditions are met:

1 "(aa) The responsible plan fiduciary did
2 not know that the covered service provider
3 failed or would fail to make required disclosures
4 and reasonably believed that the covered service
5 provider disclosed the information required to
6 be disclosed.

7 "(bb) The responsible plan fiduciary, upon
8 discovering that the covered service provider
9 failed to disclose the required information, re-
10 quests in writing that the covered service pro-
11 vider furnish such information.

12 "(cc) If the covered service provider fails
13 to comply with a written request described in
14 subclause (II) within 90 days of the request,
15 the responsible plan fiduciary notifies the Sec-
16 retary of the covered service provider's failure,
17 in accordance with subclauses (II) and (III).

18 "(II) A notice described in subclause (I)(cc)
19 shall contain—

20 "(aa) the name of the covered plan;

21 "(bb) the plan number used for the annual
22 report on the covered plan;

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

1 "(dd) the name, address, and telephone
2 number of the responsible plan fiduciary;
3 "(ee) the name, address, phone number,
4 and, if known, employer identification number
5 of the covered service provider;
6 "(ff) a description of the services provided
7 to the covered plan;
8 "(gg) a description of the information that
9 the covered service provider failed to disclose;
10 "(hh) the date on which such information
11 was requested in writing from the covered serv-
12 ice provider; and
13 "(ii) a statement as to whether the covered
14 service provider continues to provide services to
15 the plan.
16 "(III) A notice described in subclause (I)(cc)
17 shall be filed with the Department not later than 30
18 days following the earlier of—
19 "(aa) The covered service provider's re-
20 fusal to furnish the information requested by
21 the written request described in subclause
22 (I)(bb); or
23 "(bb) 90 days after the written request re-
24 ferred to in subclause (I)(cc) is made.

1 "(IV) If the covered service provider fails to
2 comply with the written request under subclause
3 (I)(bb) within 90 days of such request, the respon-
4 sible plan fiduciary shall determine whether to ter-
5 minate or continue the contract or arrangement
6 under section 404. If the requested information re-
7 lates to future services and is not disclosed promptly
8 after the end of the 90-day period, the responsible
9 plan fiduciary shall terminate the contract or ar-
10 rangement as expeditiously as possible, consistent
11 with such duty of prudence.

12 "(ix) Nothing in this subparagraph shall be
13 construed to supersede any provision of State law
14 that governs disclosures by parties that provide the
15 services described in this section, except to the ex-
16 tent that such law prevents the application of a re-
17 quirement of this section.".

18 (2) APPLICABILITY OF EXISTING REGULA-
19 TIONS.—Nothing in the amendments made by para-
20 graph (1) shall be construed to affect the applica-
21 bility of section 2550.408b–2 of title 29, Code of
22 Federal Regulations (or any successor regulations),
23 with respect to any applicable entity other than a
24 covered plan or a covered service provider (as de-
25 fined in section 408(b)(2)(B)(ii) of the Employee

1 Retirement Income Security Act of 1974, as amend-
2 ed by paragraph (1)).
3 (3) INDIVIDUAL MARKET COVERAGE.—Subpart
4 1 of part B of title XXVII of the Public Health
5 Service Act (42 U.S.C. 300gg–41 et seq.) is amend-
6 ed by adding at the end the following:

7 **"SEC. 2746. DISCLOSURE TO ENROLLEES OF INDIVIDUAL**
8 **MARKET COVERAGE.**

9 ''(a) IN GENERAL.—A health insurance issuer offer-
10 ing individual health insurance coverage shall make disclo-
11 sures to enrollees in such coverage, as described in sub-
12 section (b), and reports to the Secretary, as described in
13 subsection (c), regarding direct or indirect compensation
14 provided to an agent or broker associated with enrolling
15 individuals in such coverage.

16 ''(b) DISCLOSURE.—A health insurance issuer de-
17 scribed in subsection (a) shall disclose to an enrollee the
18 amount of direct or indirect compensation provided to an
19 agent or broker for services provided by such agent or
20 broker associated with plan selection and enrollment. Such
21 disclosure shall be—
22 ''(1) made prior to the individual finalizing plan
23 selection; and
24 ''(2) included on any documentation confirming
25 the individual's enrollment.

1 "(c) REPORTING.—A health insurance issuer de-
2 scribed in subsection (a) shall annually report to the Sec-
3 retary, prior to the beginning of open enrollment, any di-
4 rect or indirect compensation provided to an agent or
5 broker associated with enrolling individuals in such cov-
6 erage.

7 "(d) RULEMAKING.—Not later than 1 year after the
8 date of enactment of the Ban Surprise Billing Act, the
9 Secretary shall finalize, through notice-and-comment rule-
10 making, the form and manner in which issuers described
11 in subsection (a) are required to make the disclosures de-
12 scribed in subsection (b) and the reports described in sub-
13 section (c). Such rulemaking may also include adjustments
14 to notice requirements to reflect the different processes
15 for plan renewals, in order to provide enrollees with full,
16 timely information.".

17 (4) TRANSITION RULE.—No contract executed
18 prior to the effective date described in paragraph (5)
19 by a group health plan subject to the requirements
20 of section 408(b)(2)(B) of the Employee Retirement
21 Income Security Act of 1974 (as amended by para-
22 graph (1)) or by a health insurance issuer subject to
23 the requirements of section 2746 of the Public
24 Health Service Act (as added by paragraph (3))

1 shall be subject to the requirements of such section
2 408(b)(2)(B) or such section 2746, as applicable.
3 (5) EFFECTIVE DATE.—The amendments made
4 by paragraphs (1) and (3) shall apply beginning one
5 year after the date of enactment of this Act.
6 (b) STANDARDIZED REPORTING FORMAT.—Section
7 716 of the Employee Retirement Income Security Act of
8 1974, as added by section 2 and amended by section 3(c),
9 is further amended by adding at the end the following new
10 subsection:
11 ''(i) STANDARDIZED REPORTING FORMAT.—
12 ''(1) IN GENERAL.—Not later than 1 year after
13 the date of enactment of this subsection, the Sec-
14 retary shall establish a standardized reporting for-
15 mat for the reporting, by group health plans (or
16 health insurance coverage offered in connection with
17 such a plan) to State All Payer Claims Databases,
18 of medical claims, pharmacy claims, dental claims,
19 and eligibility and provider files that are collected
20 from private and public payers, and shall provide
21 guidance to States on the process by which States
22 may collect such data from such plans or coverage
23 in the standardized reporting format.
24 ''(2) DEFINITION.—In this subsection, the term
25 'State All Payer Claims Database' means, with re-

1 spect to a State, a database that may include med-
2 ical claims, pharmacy claims, dental claims, and eli-
3 gibility and provider files, which are collected from
4 private and public payers.''.

5 **SEC. 8. ACCESS TO COST-SHARING INFORMATION.**

6 (a) INSURER AND PLAN REQUIREMENTS.—
7 (1) PHSA.—Part A of title XXVII of the Pub-
8 lic Health Service Act (42 U.S.C. 300gg–11 et seq.),
9 as amended by section 6(a), is further amended by
10 inserting after section 2730 the following:

11 **''SEC. 2731. PROVISION OF COST-SHARING INFORMATION.**

12 ''A group health plan or a health insurance issuer of-
13 fering group or individual health insurance coverage shall
14 provide a participant, beneficiary, or enrollee in the plan
15 or coverage with a good faith estimate of the enrollee's
16 cost-sharing (including deductibles, copayments, and coin-
17 surance) for which the participant, beneficiary, or enrollee
18 may be responsible for paying with respect to a specific
19 health care service (including any service that is reason-
20 ably expected to be provided in conjunction with such spe-
21 cific service), as soon as practicable and not later than
22 2 business days after a request for such information by
23 a participant, beneficiary, or enrollee.''.

24 (2) ERISA.—Subpart B of part 7 of subtitle B
25 of title I of the Employee Retirement Income Secu-

1 rity Act of 1974 (29 U.S.C. 1185 et seq.), as
2 amended by section 6(b), is further amended by add-
3 ing at the end the following:

4 **“SEC. 718. PROVISION OF COST-SHARING INFORMATION.**

5 ‘‘A group health plan (or health insurance coverage
6 offered in connection with such a plan) shall provide a par-
7 ticipant or beneficiary in the plan or coverage with a good
8 faith estimate of the participant’s or beneficiary’s cost-
9 sharing (including deductibles, copayments, and coinsur-
10 ance) for which the participant or beneficiary may be re-
11 sponsible for paying with respect to a specific health care
12 service (including any service that is reasonably expected
13 to be provided in conjunction with such specific service),
14 as soon as practicable and not later than 2 business days
15 after a request for such information by a participant or
16 beneficiary.’’.

17 (3) IRC.—Subchapter B of chapter 100 of the
18 Internal Revenue Code of 1986, as amended by sec-
19 tion 6(c), is further amended by adding at the end
20 the following:

21 **“SEC. 9818. PROVISION OF COST-SHARING INFORMATION.**

22 ‘‘A group health plan shall provide a participant or
23 beneficiary in the plan with a good faith estimate of the
24 participant’s or beneficiary’s cost-sharing (including
25 deductibles, copayments, and coinsurance) for which the

1 participant or beneficiary may be responsible for paying
2 with respect to a specific health care service (including any
3 service that is reasonably expected to be provided in con-
4 junction with such specific service), as soon as practicable
5 and not later than 2 business days after a request for such
6 information by a participant or beneficiary.''.

7 (4) CLERICAL AMENDMENTS.—

8 (A) ERISA.—The table of contents in sec-
9 tion 1 of the Employee Retirement Income Se-
10 curity Act of 1974 (29 U.S.C. 1001 et seq.), as
11 amended by section 8(b)(4), is further amended
12 by inserting after the item relating to section
13 717 the following new item:

``Sec. 718. Provision of cost-sharing information.''.

14 (B) IRC.—The table of sections for sub-
15 chapter B of chapter 100 of the Internal Rev-
16 enue Code of 1986, as amended by section
17 8(b)(4), is further amended by adding at the
18 end the following new item:

``Sec. 9818. Provision of cost-sharing information.''.

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

1 **"SEC. 2799A–6. PROVISION OF COST-SHARING INFORMA-
2 TION.**

3 "A provider that is in-network with respect to a
4 group health plan or a health insurance issuer offering
5 group or individual health insurance coverage shall, upon
6 request by a participant, beneficiary, or enrollee, provide
7 to a participant, beneficiary, or enrollee in the plan or cov-
8 erage the following information, together with accurate
9 and complete information about the participant's, bene-
10 ficiary's, or enrollee's coverage under the applicable plan
11 or coverage:

12 "(1) As soon as practicable and not later than
13 2 business days after the participant, beneficiary, or
14 enrollee requests such information, a good faith esti-
15 mate of the expected participant, beneficiary, or en-
16 rollee cost-sharing for the provision of a particular
17 health care service (including any service that is rea-
18 sonably expected to be provided in conjunction with
19 such specific service).

20 "(2) As soon as practicable and not later than
21 2 business days after a participant, beneficiary, or
22 enrollee requests such information, the contact infor-
23 mation for any ancillary providers for a scheduled
24 health care service.".

25 (c) EFFECTIVE DATE.—The amendments made by
26 subsections (a) and (b) shall apply with respect to plan

1 years beginning on or after the date that is 18 months
2 after the date of enactment of this Act.

3 **SEC. 9. TRANSPARENCY REGARDING IN-NETWORK AND**
4 **OUT-OF-NETWORK DEDUCTIBLES AND OUT-**
5 **OF-POCKET LIMITATIONS.**

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

9 "(g) TRANSPARENCY REGARDING IN-NETWORK AND
10 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
11 LIMITATIONS.—

12 "(1) IN GENERAL.—A group health plan or a
13 health insurance issuer offering group or individual
14 health insurance coverage and providing or covering
15 any benefit with respect to items or services shall in-
16 clude, in clear writing, on any plan or insurance
17 identification card issued to enrollees in the plan or
18 coverage the amount of the in-network and out-of-
19 network deductibles and the in-network and out-of-
20 network out-of-pocket maximum limitation that
21 apply to such plan or coverage.

22 "(2) GUIDANCE.—The Secretary, in consulta-
23 tion with the Secretary of Labor and Secretary of
24 the Treasury, shall issue guidance to implement
25 paragraph (1).".

1 (b) ERISA.—Section 716 of the Employee Retire-
2 ment Income Security Act of 1974, as added by section
3 2 and as amended by sections 3(c) and 7(b), is further
4 amended by adding at the end the following new sub-
5 section:

6 "(j) TRANSPARENCY REGARDING IN-NETWORK AND
7 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
8 LIMITATIONS.—

9 "(1) IN GENERAL.—A group health plan or a
10 health insurance issuer offering group health insur-
11 ance coverage and providing or covering any benefit
12 with respect to items or services shall include, in
13 clear writing, on any plan or insurance identification
14 card issued to participants or beneficiaries in the
15 plan or coverage the amount of the in-network and
16 out-of-network deductibles and the in-network and
17 out-of-network out-of-pocket maximum limitation
18 that apply to such plan or coverage.

19 "(2) GUIDANCE.—The Secretary, in consulta-
20 tion with the Secretary of Health and Human Serv-
21 ices and Secretary of the Treasury, shall issue guid-
22 ance to implement paragraph (1).".

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

1 "(h) TRANSPARENCY REGARDING IN-NETWORK AND
2 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
3 LIMITATIONS.—
4 "(1) IN GENERAL.—A group health plan pro-
5 viding or covering any benefit with respect to items
6 or services shall include, in clear writing, on any
7 plan or insurance identification card issued to par-
8 ticipants or beneficiaries in the plan the amount of
9 the in-network and out-of-network deductibles and
10 the in-network and out-of-network out-of-pocket
11 maximum limitation that apply to such plan.
12 "(2) GUIDANCE.—The Secretary, in consulta-
13 tion with the Secretary of Health and Human Serv-
14 ices and Secretary of Labor, shall issue guidance to
15 implement paragraph (1).".
16 (d) EFFECTIVE DATE.—The amendments made by
17 this subsection shall apply with respect to plan years be-
18 ginning on or after January 1, 2022.