

117TH CONGRESS
1ST SESSION

S. 3139

To ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 2, 2021

Mr. BRAUN (for himself and Ms. BALDWIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.

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 “Healthy Competition
5 for Better Care Act”.

6 **SEC. 2. BANNING ANTICOMPETITIVE TERMS IN FACILITY**
7 **AND INSURANCE CONTRACTS THAT LIMIT AC-**
8 **CESS TO HIGHER QUALITY, LOWER COST**
9 **CARE.**

10 (a) IN GENERAL.—

1 (1) PHSA.—Section 2799A–9 of the Public
2 Health Service Act (42 U.S.C. 300gg–119) is
3 amended by adding at the end the following:

4 “(b) PROTECTING HEALTH PLANS NETWORK DE-
5 SIGN FLEXIBILITY.—

6 “(1) IN GENERAL.—A group health plan or a
7 health insurance issuer offering group or individual
8 health insurance coverage shall not enter into an
9 agreement with a provider, network or association of
10 providers, or other service provider offering access to
11 a network of service providers if such agreement, di-
12 rectly or indirectly—

13 “(A) restricts the group health plan or
14 health insurance issuer from—

15 “(i) directing or steering enrollees to
16 other health care providers; or

17 “(ii) offering incentives to encourage
18 enrollees to utilize specific health care pro-
19 viders;

20 “(B) requires the group health plan or
21 health insurance issuer to enter into any addi-
22 tional contract with an affiliate of the provider
23 as a condition of entering into a contract with
24 such provider;

1 “(C) requires the group health plan or
2 health insurance issuer to agree to payment
3 rates or other terms for any affiliate not party
4 to the contract of the provider involved; or

5 “(D) restricts other group health plans or
6 health insurance issuers not party to the con-
7 tract, from paying a lower rate for items or
8 services than the contracting plan or issuer
9 pays for such items or services.

10 “(2) ADDITIONAL REQUIREMENT FOR SELF-IN-
11 SURED PLANS.—A self-insured group health plan
12 shall not enter into an agreement with a provider,
13 network or association of providers, third-party ad-
14 ministrator, or other service provider offering access
15 to a network of providers if such agreement directly
16 or indirectly requires the group health plan to cer-
17 tify, attest, or otherwise confirm in writing that the
18 group health plan is bound by restrictive contracting
19 terms between the service provider and a third-party
20 administrator that the group health plan is not
21 party to, without a disclosure that such terms exist.

22 “(3) EXCEPTION FOR CERTAIN GROUP MODEL
23 ISSUERS.—Paragraph (1)(A) shall not apply to a
24 group health plan or health insurance issuer offering

1 group or individual health insurance coverage with
2 respect to—

3 “(A) a health maintenance organization
4 (as defined in section 2791(b)(3)), if such
5 health maintenance organization operates pri-
6 marily through exclusive contracts with multi-
7 specialty physician groups, nor to any arrange-
8 ment between such a health maintenance orga-
9 nization and its affiliates; or

10 “(B) a value-based network arrangement,
11 such as an exclusive provider network, account-
12 able care organization or other alternative pay-
13 ment model, center of excellence, a provider
14 sponsored health insurance issuer that operates
15 primarily through aligned multi-specialty physi-
16 cian group practices or integrated health sys-
17 tems, or such other similar network arrange-
18 ments as determined by the Secretary through
19 rulemaking.

20 “(4) ATTESTATION.—A group health plan or
21 health insurance issuer offering group or individual
22 health insurance coverage shall annually submit to,
23 as applicable, the applicable authority described in
24 section 2723 or the Secretary of Labor, an attesta-

1 tion that such plan or issuer is in compliance with
2 the requirements of this subsection.

3 “(c) MAINTENANCE OF EXISTING HIPAA, GINA,
4 AND ADA PROTECTIONS.—Nothing in this section shall
5 modify, reduce, or eliminate the existing privacy protec-
6 tions and standards provided by reason of State and Fed-
7 eral law, including the requirements of parts 160 and 164
8 of title 45, Code of Federal Regulations (or any successor
9 regulations).

10 “(d) REGULATIONS.—The Secretary, in consultation
11 with the Secretary of Labor and the Secretary of the
12 Treasury, not later than 1 year after the date of enact-
13 ment of this section, shall promulgate regulations to carry
14 out this section.

15 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
16 tion shall be construed to limit network design or cost or
17 quality initiatives by a group health plan or health insur-
18 ance issuer, including accountable care organizations, ex-
19 clusive provider organizations, networks that tier providers
20 by cost or quality or steer enrollees to centers of excel-
21 lence, or other pay-for-performance programs.

22 “(f) CLARIFICATION WITH RESPECT TO ANTITRUST
23 LAWS.—Compliance with this section does not constitute
24 compliance with the antitrust laws, as defined in sub-

1 section (a) of the first section of the Clayton Act (15
2 U.S.C. 12(a)).”.

3 (2) ERISA.—Section 724 of the Employee Re-
4 tirement Income Security Act of 1974 (29 U.S.C.
5 1185m) is amended by adding at the end the fol-
6 lowing:

7 “(b) PROTECTING HEALTH PLANS NETWORK DE-
8 SIGN FLEXIBILITY.—

9 “(1) IN GENERAL.—A group health plan or a
10 health insurance issuer offering group health insur-
11 ance coverage shall not enter into an agreement with
12 a provider, network or association of providers, or
13 other service provider offering access to a network of
14 service providers if such agreement, directly or indi-
15 rectly—

16 “(A) restricts the group health plan or
17 health insurance issuer from—

18 “(i) directing or steering enrollees to
19 other health care providers; or

20 “(ii) offering incentives to encourage
21 enrollees to utilize specific health care pro-
22 viders;

23 “(B) requires the group health plan or
24 health insurance issuer to enter into any addi-
25 tional contract with an affiliate of the provider

1 as a condition of entering into a contract with
2 such provider;

3 “(C) requires the group health plan or
4 health insurance issuer to agree to payment
5 rates or other terms for any affiliate not party
6 to the contract of the provider involved; or

7 “(D) restricts other group health plans or
8 health insurance issuers not party to the con-
9 tract, from paying a lower rate for items or
10 services than the contracting plan or issuer
11 pays for such items or services.

12 “(2) ADDITIONAL REQUIREMENT FOR SELF-IN-
13 SURED PLANS.—A self-insured group health plan
14 shall not enter into an agreement with a provider,
15 network or association of providers, third-party ad-
16 ministrator, or other service provider offering access
17 to a network of providers if such agreement directly
18 or indirectly requires the group health plan to cer-
19 tify, attest, or otherwise confirm in writing that the
20 group health plan is bound by restrictive contracting
21 terms between the service provider and a third-party
22 administrator that the group health plan is not
23 party to, without a disclosure that such terms exist.

24 “(3) EXCEPTION FOR CERTAIN GROUP MODEL
25 ISSUERS.—Paragraph (1)(A) shall not apply to a

1 group health plan or health insurance issuer offering
2 group health insurance coverage with respect to—

3 “(A) a health maintenance organization
4 (as defined in section 733(b)(3)), if such health
5 maintenance organization operates primarily
6 through exclusive contracts with multi-specialty
7 physician groups, nor to any arrangement be-
8 tween such a health maintenance organization
9 and its affiliates; or

10 “(B) a value-based network arrangement,
11 such as an exclusive provider network, account-
12 able care organization or other alternative pay-
13 ment model, center of excellence, a provider
14 sponsored health insurance issuer that operates
15 primarily through aligned multi-specialty physi-
16 cian group practices or integrated health sys-
17 tems, or such other similar network arrange-
18 ments as determined by the Secretary through
19 rulemaking.

20 “(4) ATTESTATION.—A group health plan or
21 health insurance issuer offering group health insur-
22 ance coverage shall annually submit to the Secretary
23 of Labor an attestation that such plan or issuer is
24 in compliance with the requirements of this sub-
25 section.

1 “(c) MAINTENANCE OF EXISTING HIPAA, GINA,
2 AND ADA PROTECTIONS.—Nothing in this section shall
3 modify, reduce, or eliminate the existing privacy protec-
4 tions and standards provided by reason of State and Fed-
5 eral law, including the requirements of parts 160 and 164
6 of title 45, Code of Federal Regulations (or any successor
7 regulations).

8 “(d) REGULATIONS.—The Secretary, in consultation
9 with the Secretary of Health and Human Services and the
10 Secretary of the Treasury, not later than 1 year after the
11 date of enactment of this section, shall promulgate regula-
12 tions to carry out this section.

13 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
14 tion shall be construed to limit network design or cost or
15 quality initiatives by a group health plan or health insur-
16 ance issuer, including accountable care organizations, ex-
17 clusive provider organizations, networks that tier providers
18 by cost or quality or steer enrollees to centers of excel-
19 lence, or other pay-for-performance programs.

20 “(f) CLARIFICATION WITH RESPECT TO ANTITRUST
21 LAWS.—Compliance with this section does not constitute
22 compliance with the antitrust laws, as defined in sub-
23 section (a) of the first section of the Clayton Act (15
24 U.S.C. 12(a)).”.

1 (3) IRC.—Section 9824 of the Internal Rev-
2 enue Code of 1986 is amended by adding at the end
3 the following:

4 “(b) PROTECTING HEALTH PLANS NETWORK DE-
5 SIGN FLEXIBILITY.—

6 “(1) IN GENERAL.—A group health plan shall
7 not enter into an agreement with a provider, net-
8 work or association of providers, or other service
9 provider offering access to a network of service pro-
10 viders if such agreement, directly or indirectly—

11 “(A) restricts the group health plan
12 from—

13 “(i) directing or steering enrollees to
14 other health care providers; or

15 “(ii) offering incentives to encourage
16 enrollees to utilize specific health care pro-
17 viders;

18 “(B) requires the group health plan to
19 enter into any additional contract with an affil-
20 iate of the provider as a condition of entering
21 into a contract with such provider;

22 “(C) requires the group health plan to
23 agree to payment rates or other terms for any
24 affiliate not party to the contract of the pro-
25 vider involved; or

1 “(D) restricts other group health plans not
2 party to the contract, from paying a lower rate
3 for items or services than the contracting plan
4 pays for such items or services.

5 “(2) ADDITIONAL REQUIREMENT FOR SELF-IN-
6 SURED PLANS.—A self-insured group health plan
7 shall not enter into an agreement with a provider,
8 network or association of providers, third-party ad-
9 ministrator, or other service provider offering access
10 to a network of providers if such agreement directly
11 or indirectly requires the group health plan to cer-
12 tify, attest, or otherwise confirm in writing that the
13 group health plan is bound by restrictive contracting
14 terms between the service provider and a third-party
15 administrator that the group health plan is not
16 party to, without a disclosure that such terms exist.

17 “(3) EXCEPTION FOR CERTAIN GROUP MODEL
18 ISSUERS.—Paragraph (1)(A) shall not apply to a
19 group health plan with respect to—

20 “(A) a health maintenance organization
21 (as defined in section 9832(b)(3)), if such
22 health maintenance organization operates pri-
23 marily through exclusive contracts with multi-
24 specialty physician groups, nor to any arrange-

1 ment between such a health maintenance orga-
2 nization and its affiliates; or

3 “(B) a value-based network arrangement,
4 such as an exclusive provider network, account-
5 able care organization or other alternative pay-
6 ment model, center of excellence, a provider
7 sponsored health insurance issuer that operates
8 primarily through aligned multi-specialty physi-
9 cian group practices or integrated health sys-
10 tems, or such other similar network arrange-
11 ments as determined by the Secretary through
12 rulemaking.

13 “(4) ATTESTATION.—A group health plan shall
14 annually submit to the Secretary of Labor an attes-
15 tation that such plan is in compliance with the re-
16 quirements of this subsection.

17 “(c) MAINTENANCE OF EXISTING HIPAA, GINA,
18 AND ADA PROTECTIONS.—Nothing in this section shall
19 modify, reduce, or eliminate the existing privacy protec-
20 tions and standards provided by reason of State and Fed-
21 eral law, including the requirements of parts 160 and 164
22 of title 45, Code of Federal Regulations (or any successor
23 regulations).

24 “(d) REGULATIONS.—The Secretary, in consultation
25 with the Secretary of Health and Human Services and the

1 Secretary of Labor, not later than 1 year after the date
2 of enactment of this section, shall promulgate regulations
3 to carry out this section.

4 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion shall be construed to limit network design or cost or
6 quality initiatives by a group health plan, including ac-
7 countable care organizations, exclusive provider organiza-
8 tions, networks that tier providers by cost or quality or
9 steer enrollees to centers of excellence, or other pay-for-
10 performance programs.

11 “(f) CLARIFICATION WITH RESPECT TO ANTITRUST
12 LAWS.—Compliance with this section does not constitute
13 compliance with the antitrust laws, as defined in sub-
14 section (a) of the first section of the Clayton Act (15
15 U.S.C. 12(a)).”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall apply with respect to any contract en-
18 tered into on or after the date that is 18 months after
19 the date of enactment of this Act. With respect to an ap-
20 plicable contract that is in effect on the date of enactment
21 of this Act, such amendments shall apply on the earlier
22 of the date of renewal of such contract or 3 years after
23 such date of enactment.

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