

**AMENDMENT TO THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 5800
OFFERED BY MR. MORELLE OF NEW YORK**

In lieu of the matter proposed to be inserted, insert
the following:

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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

1 **SEC. 2. CONSUMER PROTECTIONS THROUGH REQUIRE-**
2 **MENTS ON HEALTH PLANS TO PREVENT SUR-**
3 **PRISE MEDICAL BILLS FOR EMERGENCY**
4 **SERVICES.**

5 (a) PHSA AMENDMENTS.—

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

9 (A) in subsection (b)—

10 (i) in the heading, by striking “COV-
11 ERAGE” and inserting “COST-SHARING
12 AND PAYMENT”;

13 (ii) in paragraph (1)—

14 (I) in the matter preceding sub-
15 paragraph (A)—

16 (aa) by striking “a group
17 health plan, or a health insurance
18 issuer offering group or indi-
19 vidual health insurance issuer,”
20 and inserting “a health plan”;

21 (bb) by inserting “or, for
22 plan year 2022 or a subsequent
23 plan year, with respect to emer-
24 gency services in an independent
25 freestanding emergency depart-

1 ment” after “emergency depart-
2 ment of a hospital”;

3 (cc) by striking “the plan or
4 issuer” and inserting “the plan”;
5 and

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

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

16 (III) in subparagraph (C)—

17 (aa) in the matter preceding
18 clause (i), by inserting “by a
19 nonparticipating provider or a
20 nonparticipating facility that is
21 an emergency department of a
22 hospital or an independent free-
23 standing emergency department”
24 after “enrollee”;

25 (bb) by striking clause (i);

1 (cc) by striking “(ii)(I) such
2 services” and inserting “(i) such
3 services”;

4 (dd) by striking “where the
5 provider of services does not have
6 a contractual relationship with
7 the plan for the providing of
8 services”;

9 (ee) by striking “emergency
10 department services received
11 from providers who do have such
12 a contractual relationship with
13 the plan; and” and inserting
14 “emergency services received
15 from participating providers and
16 participating emergency facilities
17 with respect to such plan;”;

18 (ff) by striking “(II) if such
19 services” and all that follows
20 through “were provided in-net-
21 work” and inserting the fol-
22 lowing:

23 “(ii) the cost-sharing requirement (ex-
24 pressed as a copayment amount or coinsur-
25 ance rate) is not greater than the require-

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

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

5 “(A) AUDIT PROCESS.—

6 “(i) IN GENERAL.—Not later than
7 July 1, 2021, the Secretary, in coordina-
8 tion with the Secretary of the Treasury
9 and the Secretary of Labor and in con-
10 sultation with the National Association of
11 Insurance Commissioners, shall establish
12 through rulemaking a process, in accord-
13 ance with clause (ii), under which health
14 plans are audited by the Secretary to en-
15 sure that—

16 “(I) such plans are in compliance
17 with the requirement of applying a
18 median contracted rate under this sec-
19 tion; and

20 “(II) that such median con-
21 tracted rate so applied satisfies the
22 definition under subsection (k)(8)
23 with respect to the year involved.

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

4 “(I) shall conduct audits de-
5 scribed in such clause of a sample of
6 health plans; and

7 “(II) may audit any health plan
8 if the Secretary has received any com-
9 plaint about such plan that involves
10 the compliance of the plan with the
11 requirement described in such clause.

12 “(B) RULEMAKING.—Not later than July
13 1, 2021, the Secretary, in coordination with the
14 Secretary of Labor and the Secretary of the
15 Treasury, shall establish through rulemaking—

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

24 “(ii) the information such sponsor or
25 issuer shall share with the nonparticipating

1 provider involved when making such a de-
2 termination.”; and

3 (B) by adding at the end the following new
4 subsection:

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

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

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

23 “(3) EMERGENCY DEPARTMENT OF A HOS-
24 PITAL.—The term ‘emergency department of a hos-

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

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

13 “(5) EMERGENCY SERVICES.—

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

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

1 lary services routinely available to the
2 emergency department to evaluate such
3 emergency medical condition; and

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

17 “(B) INCLUSION OF ADDITIONAL RELATED
18 SERVICES.—In the case of an individual en-
19 rolled in a health plan who is furnished services
20 described in subparagraph (A) by a provider or
21 hospital or independent freestanding emergency
22 department to stabilize such individual with re-
23 spect to an emergency medical condition, the
24 term ‘emergency services’ shall include, in addi-
25 tion to those described in subparagraph (A),

1 items and services furnished as part of out-
2 patient observation or an inpatient or out-
3 patient stay during a visit in which such indi-
4 vidual is so stabilized if such items and services
5 would otherwise be covered under such plan if
6 furnished by a participating provider or partici-
7 pating facility that is an emergency department
8 of a hospital or an independent freestanding
9 emergency department, unless each of the fol-
10 lowing conditions are met:

11 “(i) Such a provider or hospital or
12 independent freestanding emergency de-
13 partment determines such individual is
14 able to travel using nonmedical transpor-
15 tation or nonemergency medical transpor-
16 tation.

17 “(ii) The criteria described in sub-
18 paragraph (C) are satisfied with respect to
19 such provider or hospital or independent
20 freestanding emergency department, indi-
21 vidual, and items and services.

22 “(C) SIGNED NOTICE CRITERIA.—For pur-
23 poses of subparagraph (B)(ii), the criteria de-
24 scribed in this subparagraph, with respect to an
25 individual described in subparagraph (B), any

1 item or service that may be considered needed
2 to be furnished (after stabilization but during
3 the visit in which the individual is stabilized, as
4 described in the matter preceding clause (i) of
5 such subparagraph), and the hospital or inde-
6 pendent freestanding emergency department
7 furnishing such items or services, are the fol-
8 lowing:

9 “(i) A written notice (as specified by
10 the Secretary) is provided by the hospital
11 or independent freestanding emergency de-
12 partment to such individual, not later than
13 24 hours after the time of such stabiliza-
14 tion of such individual, that includes the
15 following information:

16 “(I) In the case the hospital or
17 independent freestanding emergency
18 department is a nonparticipating facil-
19 ity, with respect to the health plan of
20 such individual, that the hospital or
21 independent freestanding emergency
22 department is a nonparticipating facil-
23 ity (or, in the case the hospital or
24 independent freestanding emergency
25 department is a participating facility,

1 that potentially a provider that may
2 furnish such an item or service during
3 such visit, may be a nonparticipating
4 provider with respect to such health
5 plan).

6 “(II) To the extent practicable,
7 the estimated amount that such non-
8 participating facility or such a non-
9 participating provider may charge the
10 individual for such an item or service.

11 “(III) A statement that the indi-
12 vidual may seek such an item or serv-
13 ice from a provider that is a partici-
14 pating provider or a hospital or inde-
15 pendent freestanding emergency de-
16 partment that is a participating facil-
17 ity.

18 “(ii) Before the end of such 24 hours,
19 the individual signs and dates such notice
20 confirming receipt of the notice.

21 “(iii) The health plan of such indi-
22 vidual and the hospital or independent
23 freestanding emergency department ar-
24 range for such continued care as nec-
25 essary, similar to the process relating to

1 promoting efficient and timely coordination
2 of appropriate maintenance and post-sta-
3 bilization care under section 1852(d)(2) of
4 the Social Security Act.

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

11 “(7) INDEPENDENT FREESTANDING EMER-
12 GENCY DEPARTMENT.—The term ‘independent free-
13 standing emergency department’ means a health
14 care facility that—

15 “(A) is geographically separate and dis-
16 tinct and licensed separately from a hospital
17 under applicable State law; and

18 “(B) provides emergency services.

19 “(8) MEDIAN CONTRACTED RATE.—

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

23 “(i) for an item or service furnished
24 during 2022, the median of the contracted
25 rates recognized by the sponsor or issuer

1 of such plan (determined with respect to
2 all such plans of such sponsor or such
3 issuer that are within the same line of
4 business (as specified in subparagraph (C))
5 as the plan involved) as the total maximum
6 payment under such plans in 2019 for the
7 same or a similar item or service that is
8 provided by a provider or facility in the
9 same or similar specialty and provided in
10 the geographic region (established (and up-
11 dated, as appropriate) by the Secretary, in
12 consultation with the National Association
13 of Insurance Commissioners) in which the
14 item or service is furnished, consistent with
15 the methodology established by the Sec-
16 retary under subsection (b)(2)(B), in-
17 creased by the percentage increase in the
18 consumer price index for all urban con-
19 sumers (United States city average) over
20 2019, 2020, and 2021;

21 “(ii) for an item or service furnished
22 during 2023 or a subsequent year through
23 2026, the median contracted rate for the
24 previous year, increased by the percentage
25 increase in the consumer price index for all

1 urban consumers (United States city aver-
2 age) over such previous year;

3 “(iii) for an item or service furnished
4 during a rebasing year (as defined in sub-
5 paragraph (D)), the median of the con-
6 tracted rates recognized by the sponsor or
7 issuer of such plan (determined with re-
8 spect to all such plans of such sponsor or
9 such issuer that are within the same line
10 of business (as specified in subparagraph
11 (C)) as the plan involved) as the total max-
12 imum payment under such plans in such
13 year for the same or a similar item or serv-
14 ice that is provided by a provider or facility
15 in the same or similar specialty and pro-
16 vided in the geographic region (as estab-
17 lished pursuant to clause (i)) in which the
18 item or service is furnished, consistent with
19 the methodology established by the Sec-
20 retary under subsection (b)(2)(B); and

21 “(iv) for an item or service furnished
22 during any of the 4 years following a re-
23 basing year, the median contracted rate for
24 the previous year, increased by the per-
25 centage increase in the consumer price

1 index for all urban consumers (United
2 States city average) over such previous
3 year.

4 “(B) USE OF SUBSTITUTE RATE IN CASE
5 OF INSUFFICIENT DATA.—

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

22 “(ii) SUBSTITUTE RATE.—For pur-
23 poses of clause (i), the term ‘substitute
24 rate’ means, with respect to an item or
25 service furnished by a provider or facility

1 in a geographic region (established pursu-
2 ant to subparagraph (A)(i)) during a year
3 for which a health plan is required to make
4 payment pursuant to subsection (b)(1),
5 (e)(1), or (i)(1)—

6 “(I) if sufficient information (as
7 specified by the Secretary) exists to
8 determine the median of the con-
9 tracted rates recognized by all health
10 plans offered in the same line of busi-
11 ness (as specified in subparagraph
12 (C)) by any group health plan or
13 health insurance issuer for such an
14 item or service furnished in such re-
15 gion by such a provider or facility
16 during such year using a database or
17 other source of information deter-
18 mined appropriate by the Secretary,
19 such median; and

20 “(II) if such sufficient informa-
21 tion does not exist, the median of the
22 contracted rates recognized by all
23 health plans offered in the same line
24 of business (as specified in subpara-
25 graph (C)) by any group health plan

1 or health insurance issuer for such an
2 item or service furnished in a simi-
3 larly situated geographic region (as
4 determined by the Secretary) with
5 such sufficient information by such a
6 provider or facility during such year
7 using such a database or such other
8 source of information.

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

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

20 “(i) The individual market.

21 “(ii) The small group market.

22 “(iii) The large group market.

23 “(iv) In the case of a self-insured
24 group health plan, other self-insured group
25 health plans.

1 “(D) REBASING YEAR DEFINED.—For pur-
2 poses of subparagraph (A), the term ‘rebasings
3 year’ means 2027 and every 5 years thereafter.

4 “(9) NONPARTICIPATING FACILITY; PARTICI-
5 PATING FACILITY.—

6 “(A) NONPARTICIPATING FACILITY.—The
7 term ‘nonparticipating facility’ means, with re-
8 spect to an item or service and a health plan,
9 a health care facility described in subparagraph
10 (B)(ii) that does not have a contractual rela-
11 tionship with the plan for furnishing such item
12 or service.

13 “(B) PARTICIPATING FACILITY.—

14 “(i) IN GENERAL.—The term ‘partici-
15 pating facility’ means, with respect to an
16 item or service and a health plan, a health
17 care facility described in clause (ii) that
18 has a contractual relationship with the
19 plan for furnishing such item or service.

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

23 “(I) A hospital (as defined in
24 1861(e) of the Social Security Act),

1 including an emergency department of
2 a hospital.

3 “(II) A critical access hospital
4 (as defined in section 1861(mm) of
5 such Act).

6 “(III) An ambulatory surgical
7 center (as defined in section
8 1833(i)(1)(A) of such Act).

9 “(IV) A laboratory.

10 “(V) A radiology facility or imag-
11 ing center.

12 “(VI) An independent free-
13 standing emergency department.

14 “(VII) Any other facility speci-
15 fied by the Secretary.

16 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
17 PATING PROVIDERS.—

18 “(A) NONPARTICIPATING PROVIDER.—The
19 term ‘nonparticipating provider’ means, with re-
20 spect to an item or service and a health plan,
21 a physician or other health care provider who
22 does not have a contractual relationship with
23 the plan for furnishing such item or service
24 under the plan.

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

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

13 “(A) subject to subparagraphs (C) and
14 (D), in the case such State has in effect a State
15 law that provides for a method for determining
16 the amount payable (by the plan and the partici-
17 pant, beneficiary, or enrollee) under such
18 health plan regulated by such State with re-
19 spect to such item or service furnished by such
20 provider or facility, such amount (including
21 cost-sharing) determined in accordance with
22 such law;

23 “(B) subject to subparagraphs (C) and
24 (D),, in the case such State does not have in ef-

1 fect such a law with respect to such item or
2 service, plan, and provider or facility—

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

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

19 “(C) subject to subparagraph (D), in the
20 case such State has an All-Payer Model Agree-
21 ment under section 1115A of the Social Secu-
22 rity Act, the amount (including cost-sharing)
23 that the State approves under such system for
24 such item or service so furnished; or

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

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

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

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

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

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

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

1 meaning give in section 1867(e)(3) of the Social Se-
2 curity Act).”.

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

6 (b) IRC AMENDMENTS.—

7 (1) IN GENERAL.—Subchapter B of chapter
8 100 of the Internal Revenue Code of 1986 is amend-
9 ed by adding at the end the following new section:

10 **“SEC. 9816. PATIENT PROTECTIONS.**

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

17 “(b) COST-SHARING AND PAYMENT OF EMERGENCY
18 SERVICES.—

19 “(1) IN GENERAL.—If a health plan provides or
20 covers any benefits with respect to services in an
21 emergency department of a hospital or, for plan year
22 2022 or a subsequent plan year, with respect to
23 emergency services in an independent freestanding
24 emergency department, the plan shall cover emer-
25 gency services—

1 “(A) without the need for any prior au-
2 thorization determination;

3 “(B) whether the health care provider fur-
4 nishing such services is a participating provider
5 or a participating facility that is an emergency
6 department of a hospital or an independent
7 freestanding emergency department (in this
8 subsection referred to as a ‘participating emer-
9 gency facility’) with respect to such services;

10 “(C) in a manner so that, if such services
11 are provided to a participant or beneficiary by
12 a nonparticipating provider or a nonpartici-
13 pating facility that is an emergency department
14 of a hospital or an independent freestanding
15 emergency department—

16 “(i) such services will be provided
17 without imposing any requirement under
18 the plan for prior authorization of services
19 or any limitation on coverage that is more
20 restrictive than the requirements or limita-
21 tions that apply to emergency services re-
22 ceived from participating providers and
23 participating emergency facilities with re-
24 spect to such plan;

1 “(ii) the cost-sharing requirement (ex-
2 pressed as a copayment amount or coinsur-
3 ance rate) is not greater than the require-
4 ment that would apply if such services
5 were furnished by a participating provider
6 or a participating emergency facility, as
7 applicable;

8 “(iii) such cost-sharing requirement is
9 calculated as if the contracted rate for
10 such services if furnished by a partici-
11 pating provider or a participating emer-
12 gency facility were equal to the recognized
13 amount for such services;

14 “(iv) the health plan pays to such pro-
15 vider or facility, respectively, the amount
16 by which the out-of-network rate for such
17 services exceeds the cost-sharing amount
18 for such services (as determined in accord-
19 ance with clauses (ii) and (iii)); and

20 “(v) any deductible or out-of-pocket
21 maximum that would apply if such services
22 were furnished by a participating provider
23 or a participating emergency facility shall
24 be the deductible or out-of-pocket max-
25 imum that applies; and

1 “(D) without regard to any other term or
2 condition of such coverage (other than exclusion
3 or coordination of benefits, or an affiliation or
4 waiting period, permitted under section 2704 of
5 the Public Health Service Act, including as in-
6 corporated pursuant to section 715 of the Em-
7 ployee Retirement Income Security Act of 1974
8 and section 9815, and other than applicable
9 cost-sharing).

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

12 “(A) AUDIT PROCESS.—

13 “(i) IN GENERAL.—Not later than
14 July 1, 2021, the Secretary, in coordina-
15 tion with the Secretary of Health and
16 Human Services and the Secretary of
17 Labor and in consultation with the Na-
18 tional Association of Insurance Commis-
19 sioners, shall establish through rulemaking
20 a process, in accordance with clause (ii),
21 under which health plans are audited by
22 the Secretary to ensure that—

23 “(I) such plans are in compliance
24 with the requirement of applying a

1 median contracted rate under this sec-
2 tion; and

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

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

10 “(I) shall conduct audits de-
11 scribed in such clause of a sample of
12 health plans; and

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

18 “(B) RULEMAKING.—Not later than July
19 1, 2021, the Secretary, in coordination with the
20 Secretary of Labor and the Secretary of Health
21 and Human Services, shall establish through
22 rulemaking—

23 “(i) the methodology the sponsor of a
24 health plan shall use to determine the me-
25 dian contracted rate, which shall account

1 for relevant payment adjustments that
2 take into account facility type that are oth-
3 erwise taken into account for purposes of
4 determining payment amounts with respect
5 to participating facilities; and

6 “(ii) the information such sponsor
7 shall share with the nonparticipating pro-
8 vider involved when making such a deter-
9 mination.

10 “(c) ACCESS TO PEDIATRIC CARE.—

11 “(1) PEDIATRIC CARE.—In the case of a person
12 who has a child who is a participant or beneficiary
13 under a health plan, if the plan requires or provides
14 for the designation of a participating primary care
15 provider for the child, the plan shall permit such
16 person to designate a physician (allopathic or osteo-
17 pathic) who specializes in pediatrics as the child’s
18 primary care provider if such provider participates
19 in the network of the plan.

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

24 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
25 COLOGICAL CARE.—

1 “(1) GENERAL RIGHTS.—

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

17 “(B) OBSTETRICAL AND GYNECOLOGICAL
18 CARE.—A health plan described in paragraph
19 (2) shall treat the provision of obstetrical and
20 gynecological care, and the ordering of related
21 obstetrical and gynecological items and services,
22 pursuant to the direct access described under
23 subparagraph (A), by a participating health
24 care professional who specializes in obstetrics or

1 gynecology as the authorization of the primary
2 care provider.

3 “(2) APPLICATION OF PARAGRAPH.—A health
4 plan described in this paragraph is a health plan
5 that—

6 “(A) provides coverage for obstetric or
7 gynecologic care; and

8 “(B) requires the designation by a partici-
9 pant or beneficiary of a participating primary
10 care provider.

11 “(3) CONSTRUCTION.—Nothing in paragraph
12 (1) shall be construed to—

13 “(A) waive any exclusions of coverage
14 under the terms and conditions of the plan with
15 respect to coverage of obstetrical or gynecolo-
16 gical care; or

17 “(B) preclude the health plan involved
18 from requiring that the obstetrical or gynecolo-
19 gical provider notify the primary care health
20 care professional or the plan of treatment deci-
21 sions.

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

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

1 nishing an item or service to a beneficiary or partici-
2 pant of such plan, the agreed upon total payment
3 amount (inclusive of any cost-sharing) to such pro-
4 vider or facility for such item or service.

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

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

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

1 result in a condition described in clause (i), (ii), or
2 (iii) of section 1867(e)(1)(A) of the Social Security
3 Act.

4 “(5) EMERGENCY SERVICES.—

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

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

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

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

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

1 emergency department, unless each of the fol-
2 lowing conditions are met:

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

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

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

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

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

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

1 participating provider may charge the
2 individual for such an item or service.

3 “(III) A statement that the indi-
4 vidual may seek such an item or serv-
5 ice from a provider that is a partici-
6 pating provider or a hospital or inde-
7 pendent freestanding emergency de-
8 partment that is a participating facil-
9 ity.

10 “(ii) Before the end of such 24 hours,
11 the individual signs and dates such notice
12 confirming receipt of the notice.

13 “(iii) The health plan of such indi-
14 vidual and the hospital or independent
15 freestanding emergency department ar-
16 range for such continued care as nec-
17 essary, similar to the process relating to
18 promoting efficient and timely coordination
19 of appropriate maintenance and post-sta-
20 bilization care under section 1852(d)(2) of
21 the Social Security Act.

22 “(6) HEALTH PLAN.—The term ‘health plan’
23 means a group health plan, including any group
24 health plan that is a grandfathered health plan (as

1 defined in section 1251(e) of the Patient Protection
2 and Affordable Care Act).

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

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

10 “(B) provides emergency services.

11 “(8) MEDIAN CONTRACTED RATE.—

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

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

1 provided in the geographic region (estab-
2 lished (and updated, as appropriate) by the
3 Secretary, in consultation with the Na-
4 tional Association of Insurance Commis-
5 sioners) in which the item or service is fur-
6 nished, consistent with the methodology es-
7 tablished by the Secretary under sub-
8 section (b)(2)(B), increased by the percent-
9 age increase in the consumer price index
10 for all urban consumers (United States
11 city average) over 2019, 2020, and 2021;

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

19 “(iii) for an item or service furnished
20 during a rebasing year (as defined in sub-
21 paragraph (D)), the median of the con-
22 tracted rates recognized by the sponsor of
23 such plan (determined with respect to all
24 such plans of such sponsor that are within
25 the same line of business (as specified in

1 subparagraph (C)) as the plan involved) as
2 the total maximum payment under such
3 plans in such year for the same or a simi-
4 lar item or service that is provided by a
5 provider or facility in the same or similar
6 specialty and provided in the geographic
7 region (as established pursuant to clause
8 (i)) in which the item or service is fur-
9 nished, consistent with the methodology es-
10 tablished by the Secretary under sub-
11 section (b)(2)(B); and

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

20 “(B) USE OF SUBSTITUTE RATE IN CASE
21 OF INSUFFICIENT DATA.—

22 “(i) IN GENERAL.—In the case the
23 sponsor of a health plan has insufficient
24 information (as specified by the Secretary)
25 to calculate the median of the contracted

1 rates in accordance with subparagraph (A)
2 for a year for an item or service furnished
3 in a particular geographic region (as estab-
4 lished pursuant to subparagraph (A)(i)) by
5 a type of provider or facility, the substitute
6 rate (as defined in clause (ii)) for such
7 item or service shall be deemed to be the
8 median contracted rate for such item or
9 service furnished in such region during
10 such year by such a provider or facility for
11 such year under such subparagraph (A) for
12 such plan.

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

22 “(I) if sufficient information (as
23 specified by the Secretary) exists to
24 determine the median of the con-
25 tracted rates recognized by all health

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

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

23 The Secretary shall develop a methodology
24 for determining a substitute rate based on
25 a similarly situated health plan that is not

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

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

9 “(i) The small group market.

10 “(ii) The large group market.

11 “(iii) In the case of a self-insured
12 group health plan, other self-insured group
13 health plans.

14 “(D) REBASING YEAR DEFINED.—For pur-
15 poses of subparagraph (A), the term ‘rebasings
16 year’ means 2027 and every 5 years thereafter.

17 “(9) NONPARTICIPATING FACILITY; PARTICI-
18 PATING FACILITY.—

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

1 “(B) PARTICIPATING FACILITY.—

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

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

11 “(I) A hospital (as defined in
12 1861(e) of the Social Security Act),
13 including an emergency department of
14 a hospital.

15 “(II) A critical access hospital
16 (as defined in section 1861(mm) of
17 such Act).

18 “(III) An ambulatory surgical
19 center (as defined in section
20 1833(i)(1)(A) of such Act).

21 “(IV) A laboratory.

22 “(V) A radiology facility or imag-
23 ing center.

24 “(VI) An independent free-
25 standing emergency department.

1 “(VII) Any other facility speci-
2 fied by the Secretary.

3 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
4 PATING PROVIDERS.—

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

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

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

24 “(A) subject to subparagraphs (C) and
25 (D), in the case such State has in effect a State

1 law that provides for a method for determining
2 the amount payable (by the plan and the partic-
3 ipant or beneficiary) under such health plan
4 regulated by such State with respect to such
5 item or service furnished by such provider or
6 facility, such amount (including cost-sharing)
7 determined in accordance with such law;

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

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

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

1 such item or service under such subsection,
2 the amount of such determination;

3 “(C) subject to subparagraph (D), in the
4 case such State has an All-Payer Model Agree-
5 ment under section 1115A of the Social Secu-
6 rity Act, the amount (including cost-sharing)
7 that the State approves under such system for
8 such item or service so furnished; or

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

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

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

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

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

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

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

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

9 (2) CONFORMING AMENDMENTS.—

10 (A) APPLICATION PROVISIONS.—Section
11 9815(a) of the Internal Revenue Code of 1986
12 is amended—

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

19 (ii) in paragraph (2), by inserting
20 “(other than, with respect to a plan year
21 beginning on or after January 1, 2022, the
22 provisions of section 2719A of such Act)”
23 after “such part A”.

24 (B) APPLICATION TO RETIREE-ONLY
25 PLANS.—Section 9831(a) of the Internal Rev-

1 enue Code of 1986 is amended by inserting
2 “(other than, with respect to a group health
3 plan described in paragraph (2), the require-
4 ments of section 9816)” before “shall not
5 apply”.

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

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

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

12 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT
13 OF 1974 AMENDMENTS.—

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

19 **“SEC. 716. PATIENT PROTECTIONS.**

20 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
21 a health plan requires or provides for designation by a par-
22 ticipant or beneficiary of a participating primary care pro-
23 vider, then the plan shall permit each participant or bene-

1 ficiary to designate any participating primary care pro-
2 vider who is available to accept such individual.

3 “(b) COST-SHARING AND PAYMENT OF EMERGENCY
4 SERVICES.—

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

12 “(A) without the need for any prior au-
13 thorization determination;

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

21 “(C) in a manner so that, if such services
22 are provided to a participant or beneficiary by
23 a nonparticipating provider or a nonpartici-
24 pating facility that is an emergency department

1 of a hospital or an independent freestanding
2 emergency department—

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

12 “(ii) the cost-sharing requirement (ex-
13 pressed as a copayment amount or coinsur-
14 ance rate) is not greater than the require-
15 ment that would apply if such services
16 were furnished by a participating provider
17 or a participating emergency facility, as
18 applicable;

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

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

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

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

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

23 “(A) AUDIT PROCESS.—

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

1 tion with the Secretary of Health and
2 Human Services and the Secretary of the
3 Treasury and in consultation with the Na-
4 tional Association of Insurance Commis-
5 sioners, shall establish through rulemaking
6 a process, in accordance with clause (ii),
7 under which health plans are audited by
8 the Secretary to ensure that—

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

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

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

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

23 “(II) may audit any health plan
24 if the Secretary has received any com-
25 plaint about such plan that involves

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

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

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

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

20 “(c) ACCESS TO PEDIATRIC CARE.—

21 “(1) PEDIATRIC CARE.—In the case of a person
22 who has a child who is a participant or beneficiary
23 under a health plan, if the plan requires or provides
24 for the designation of a participating primary care
25 provider for the child, the plan shall permit such

1 person to designate a physician (allopathic or osteo-
2 pathic) who specializes in pediatrics as the child's
3 primary care provider if such provider participates
4 in the network of the plan.

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

9 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
10 COLOGICAL CARE.—

11 “(1) GENERAL RIGHTS.—

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

1 ices pursuant to a treatment plan (if any) ap-
2 proved by the plan.

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

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

16 “(A) provides coverage for obstetric or
17 gynecologic care; and

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

21 “(3) CONSTRUCTION.—Nothing in paragraph
22 (1) shall be construed to—

23 “(A) waive any exclusions of coverage
24 under the terms and conditions of the plan with

1 respect to coverage of obstetrical or gynecological care; or

2
3 “(B) preclude the health plan involved
4 from requiring that the obstetrical or gynecological provider notify the primary care health
5 care professional or the plan of treatment decisions.
6
7

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

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

16 “(2) DURING A VISIT.—The term ‘during a visit’ shall, with respect to an individual who is furnished items and services at a participating facility,
17 include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and
18 services as the Secretary may specify furnished to such individual, regardless of whether or not the provider furnishing such items or services is at the
19 facility.
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1 “(3) EMERGENCY DEPARTMENT OF A HOS-
2 PITAL.—The term ‘emergency department of a hos-
3 pital’ includes a hospital outpatient department that
4 provides emergency services.

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

15 “(5) EMERGENCY SERVICES.—

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

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

1 of an independent freestanding emergency
2 department, as applicable, including ancil-
3 lary services routinely available to the
4 emergency department to evaluate such
5 emergency medical condition; and

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

19 “(B) INCLUSION OF ADDITIONAL RELATED
20 SERVICES.—In the case of an individual en-
21 rolled in a health plan who is furnished services
22 described in subparagraph (A) by a provider or
23 hospital or independent freestanding emergency
24 department to stabilize such individual with re-
25 spect to an emergency medical condition, the

1 term ‘emergency services’ shall include, in addi-
2 tion to those described in subparagraph (A),
3 items and services furnished as part of out-
4 patient observation or an inpatient or out-
5 patient stay during a visit in which such indi-
6 vidual is so stabilized if such items and services
7 would otherwise be covered under such plan if
8 furnished by a participating provider or partici-
9 pating facility that is an emergency department
10 of a hospital or an independent freestanding
11 emergency department, unless each of the fol-
12 lowing conditions are met:

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

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

24 “(C) SIGNED NOTICE CRITERIA.—For pur-
25 poses of subparagraph (B)(ii), the criteria de-

1 scribed in this subparagraph, with respect to an
2 individual described in subparagraph (B), any
3 item or service that may be considered needed
4 to be furnished (after stabilization but during
5 the visit in which the individual is stabilized, as
6 described in the matter preceding clause (i) of
7 such subparagraph), and the hospital or inde-
8 pendent freestanding emergency department
9 furnishing such items or services, are the fol-
10 lowing:

11 “(i) A written notice (as specified by
12 the Secretary) is provided by the hospital
13 or independent freestanding emergency de-
14 partment to such individual, not later than
15 24 hours after the time of such stabiliza-
16 tion of such individual, that includes the
17 following information:

18 “(I) In the case the hospital or
19 independent freestanding emergency
20 department is a nonparticipating facil-
21 ity, with respect to the health plan of
22 such individual, that the hospital or
23 independent freestanding emergency
24 department is a nonparticipating facil-
25 ity (or, in the case the hospital or

1 independent freestanding emergency
2 department is a participating facility,
3 that potentially a provider that may
4 furnish such an item or service during
5 such visit, may be a nonparticipating
6 provider with respect to such health
7 plan).

8 “(II) To the extent practicable,
9 the estimated amount that such non-
10 participating facility or such a non-
11 participating provider may charge the
12 individual for such an item or service.

13 “(III) A statement that the indi-
14 vidual may seek such an item or serv-
15 ice from a provider that is a partici-
16 pating provider or a hospital or inde-
17 pendent freestanding emergency de-
18 partment that is a participating facil-
19 ity.

20 “(ii) Before the end of such 24 hours,
21 the individual signs and dates such notice
22 confirming receipt of the notice.

23 “(iii) The health plan of such indi-
24 vidual and the hospital or independent
25 freestanding emergency department ar-

1 range for such continued care as nec-
2 essary, similar to the process relating to
3 promoting efficient and timely coordination
4 of appropriate maintenance and post-sta-
5 bilization care under section 1852(d)(2) of
6 the Social Security Act.

7 “(6) HEALTH PLAN.—The term ‘health plan’
8 means a group health plan and health insurance cov-
9 erage offered by a health insurance issuer in the
10 group market and includes a grandfathered health
11 plan (as defined in section 1251(e) of the Patient
12 Protection and Affordable Care Act) that is such a
13 plan or coverage.

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

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

21 “(B) provides emergency services.

22 “(8) MEDIAN CONTRACTED RATE.—

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

1 “(i) for an item or service furnished
2 during 2022, the median of the contracted
3 rates recognized by the sponsor or issuer
4 of such plan (determined with respect to
5 all such plans of such sponsor or such
6 issuer that are within the same line of
7 business (as specified in subparagraph (C))
8 as the plan involved) as the total maximum
9 payment under such plans in 2019 for the
10 same or a similar item or service that is
11 provided by a provider or facility in the
12 same or similar specialty and provided in
13 the geographic region (established (and up-
14 dated, as appropriate) by the Secretary, in
15 consultation with the National Association
16 of Insurance Commissioners) in which the
17 item or service is furnished, consistent with
18 the methodology established by the Sec-
19 retary under subsection (b)(2)(B), in-
20 creased by the percentage increase in the
21 consumer price index for all urban con-
22 sumers (United States city average) over
23 2019, 2020, and 2021;

24 “(ii) for an item or service furnished
25 during 2023 or a subsequent year through

1 2026, the median contracted rate for the
2 previous year, increased by the percentage
3 increase in the consumer price index for all
4 urban consumers (United States city aver-
5 age) over such previous year;

6 “(iii) for an item or service furnished
7 during a rebasing year (as defined in sub-
8 paragraph (D)), the median of the con-
9 tracted rates recognized by the sponsor or
10 issuer of such plan (determined with re-
11 spect to all such plans of such sponsor or
12 issuer that are within the same line of
13 business (as specified in subparagraph (C))
14 as the plan involved) as the total maximum
15 payment under such plans in such year for
16 the same or a similar item or service that
17 is provided by a provider or facility in the
18 same or similar specialty and provided in
19 the geographic region (as established pur-
20 suant to clause (i)) in which the item or
21 service is furnished, consistent with the
22 methodology established by the Secretary
23 under subsection (b)(2)(B); and

24 “(iv) for an item or service furnished
25 during any of the 4 years following a re-

1 basing year, the median contracted rate for
2 the previous year, increased by the per-
3 centage increase in the consumer price
4 index for all urban consumers (United
5 States city average) over such previous
6 year.

7 “(B) USE OF SUBSTITUTE RATE IN CASE
8 OF INSUFFICIENT DATA.—

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

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

10 “(I) if sufficient information (as
11 specified by the Secretary) exists to
12 determine the median of the con-
13 tracted rates recognized by all health
14 plans offered in the same line of busi-
15 ness (as specified in subparagraph
16 (C)) by any group health plan for
17 such an item or service furnished in
18 such region by such a provider or fa-
19 cility during such year using a data-
20 base or other source of information
21 determined appropriate by the Sec-
22 retary, such median; and

23 “(II) if such sufficient informa-
24 tion does not exist, the median of the
25 contracted rates recognized by all

1 health plans offered in the same line
2 of business (as specified in subpara-
3 graph (C)) by any group health plan
4 for such an item or service furnished
5 in a similarly situated geographic re-
6 gion (as determined by the Secretary)
7 with such sufficient information by
8 such a provider or facility during such
9 year using such a database or such
10 other source of information.

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

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

22 “(i) The small group market.

23 “(ii) The large group market.

1 “(iii) In the case of a self-insured
2 group health plan, other self-insured group
3 health plans.

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

7 “(9) NONPARTICIPATING FACILITY; PARTICI-
8 PATING FACILITY.—

9 “(A) NONPARTICIPATING FACILITY.—The
10 term ‘nonparticipating facility’ means, with re-
11 spect to an item or service and a health plan,
12 a health care facility described in subparagraph
13 (B)(ii) that does not have a contractual rela-
14 tionship with the plan for furnishing such item
15 or service.

16 “(B) PARTICIPATING FACILITY.—

17 “(i) IN GENERAL.—The term ‘partici-
18 pating facility’ means, with respect to an
19 item or service and a health plan, a health
20 care facility described in clause (ii) that
21 has a contractual relationship with the
22 plan for furnishing such item or service.

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

1 “(I) A hospital (as defined in
2 1861(e) of the Social Security Act),
3 including an emergency department of
4 a hospital.

5 “(II) A critical access hospital
6 (as defined in section 1861(mm) of
7 such Act).

8 “(III) An ambulatory surgical
9 center (as defined in section
10 1833(i)(1)(A) of such Act).

11 “(IV) A laboratory.

12 “(V) A radiology facility or imag-
13 ing center.

14 “(VI) An independent free-
15 standing emergency department.

16 “(VII) Any other facility speci-
17 fied by the Secretary.

18 “(10) NONPARTICIPATING PROVIDERS; PARTICI-
19 PATING PROVIDERS.—

20 “(A) NONPARTICIPATING PROVIDER.—The
21 term ‘nonparticipating provider’ means, with re-
22 spect to an item or service and a health plan,
23 a physician or other health care provider who
24 does not have a contractual relationship with

1 the plan for furnishing such item or service
2 under the plan.

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

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

15 “(A) subject to subparagraphs (C) and
16 (D), in the case such State has in effect a State
17 law that provides for a method for determining
18 the amount payable (by the plan and the partic-
19 ipant or beneficiary) under such health plan
20 regulated by such State with respect to such
21 item or service furnished by such provider or
22 facility, such amount (including cost-sharing)
23 determined in accordance with such law;

24 “(B) subject to subparagraphs (C) and
25 (D),, in the case such State does not have in ef-

1 fect such a law with respect to such item or
2 service, plan, and provider or facility—

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

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

19 “(C) subject to subparagraph (D), in the
20 case such State has an All-Payer Model Agree-
21 ment under section 1115A of the Social Secu-
22 rity Act, the amount (including cost-sharing)
23 that the State approves under such system for
24 such item or service so furnished; or

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

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

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

24 “(B) subject to subparagraphs (C) and
25 (D), in the case such State does not have in ef-

1 fect such a law, an amount that is the median
2 contracted rate for such item or service for such
3 year;

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

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

22 “(13) STABILIZE.—The term ‘to stabilize’, with
23 respect to an emergency medical condition, has the
24 meaning give in section 1867(e)(3) of the Social Se-
25 curity Act).”.

1 (2) CONFORMING AMENDMENT.—

2 (A) APPLICATION PROVISIONS.—Section
3 715(a) of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1185d(a)) is
5 amended—

6 (i) in paragraph (1), by striking “(as
7 amended by the Patient Protection and Af-
8 fordable Care Act)” and inserting “(other
9 than, with respect to a plan year beginning
10 on or after January 1, 2022, the provisions
11 of section 2719A of such Act)”; and

12 (ii) in paragraph (2), by inserting
13 “(other than, with respect to a plan year
14 beginning on or after January 1, 2022, the
15 provisions of section 2719A of such Act)”
16 after “such part A”.

17 (B) APPLICATION TO RETIREE-ONLY
18 PLANS.—Section 732(a) of the Employee Re-
19 tirement Income Security Act of 1974 (29
20 U.S.C. 1191a(a)) is amended by striking “sec-
21 tion 711” and inserting “sections 711 and
22 716”.

23 (3) CLERICAL AMENDMENT.—The table of con-
24 tents in section 1 of the Employee Retirement In-
25 come Security Act of 1974 is amended by inserting

1 after the item relating to section 714 the following
2 new items:

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

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

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

12 (a) **PHSA AMENDMENTS.**—

13 (1) **IN GENERAL.**—Section 2719A of the Public
14 Health Service Act (42 U.S.C. 300gg–19a), as
15 amended by section 2(a), is further amended by in-
16 serting before subsection (k) the following new sub-
17 section:

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

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

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

8 “(A) shall not impose on such participant,
9 beneficiary, or enrollee a cost-sharing amount
10 (expressed as a copayment amount or coinsur-
11 ance rate) for such items and services so fur-
12 nished that is greater than the cost-sharing
13 amount that would apply under such plan had
14 such items or services been furnished by a par-
15 ticipating provider;

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

21 “(C) shall pay to such provider furnishing
22 such items and services to such participant,
23 beneficiary, or enrollee the amount by which the
24 out-of-network rate for such items and services
25 exceeds the cost-sharing amount imposed under

1 the plan for such items and services (as deter-
2 mined in accordance with subparagraphs (A)
3 and (B)); and

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

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

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

22 (b) IRC AMENDMENTS.—

23 (1) IN GENERAL.—Section 9816 of the Internal
24 Revenue Code of 1986, as added by section 2(b), is

1 amended by inserting before subsection (k) the fol-
2 lowing new subsection:

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

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

17 “(A) shall not impose on such participant
18 or beneficiary a cost-sharing amount (expressed
19 as a copayment amount or coinsurance rate) for
20 such items and services so furnished that is
21 greater than the cost-sharing amount that
22 would apply under such plan had such items or
23 services been furnished by a participating pro-
24 vider;

1 “(B) shall calculate such cost-sharing
2 amount as if the contracted rate for such serv-
3 ices if furnished by a participating provider
4 were equal to the recognized amount for such
5 items and services;

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

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

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

1 apply with respect to such provider and such items
2 and services due to the application of paragraph (2)
3 of such section.”.

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

7 (c) ERISA AMENDMENTS.—

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

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

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

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

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

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

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

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

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

15 **SEC. 4. CONSUMER PROTECTIONS THROUGH APPLICATION**
16 **OF HEALTH PLAN EXTERNAL REVIEW IN**
17 **CASES OF CERTAIN SURPRISE MEDICAL**
18 **BILLS.**

19 Section 2719(b)(1) of the Public Health Service Act
20 (42 U.S.C. 300gg–19(b)(1)) is amended—

21 (1) by striking “at a minimum, includes” and
22 inserting “at a minimum—

23 “(A) includes”;

24 (2) by striking at the end “or” and inserting
25 “and”; and

1 (3) by adding at the end the following new sub-
2 paragraph:

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

13 **SEC. 5. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
14 **TRANSPARENCY REQUIREMENTS.**

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

20 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

23 “(A) establish the verification process de-
24 scribed in paragraph (2);

1 “(B) establish the response protocol de-
2 scribed in paragraph (3);

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

5 “(D) include in any directory (other than
6 the database described in subparagraph (C))
7 containing provider directory information with
8 respect to such plan the information described
9 in paragraph (5).

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

13 “(A) under which such plan verifies and
14 updates the provider directory information in-
15 cluded on the database described in paragraph
16 (4) of such plan of—

17 “(i) not less frequently than once
18 every 90 days, a random sample of at least
19 10 percent of health care providers and
20 health care facilities included in such data-
21 base; and

22 “(ii) any such provider or such facility
23 included in such database that has not
24 submitted any claim to such plan during a
25 12-month period;

1 “(B) that establishes a procedure for the
2 removal from such database of such a provider
3 or facility with respect to which such plan has
4 been unable to verify such information during a
5 period specified by the plan; and

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

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

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

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

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

8 “(A) a list of each health care provider and
9 health care facility with which such plan has a
10 contractual relationship for furnishing items
11 and services under such plan; and

12 “(B) provider directory information with
13 respect to each such provider and facility.

14 “(5) INFORMATION.—The information de-
15 scribed in this paragraph is, with respect to a direc-
16 tory containing provider directory information with
17 respect to a health plan, a notification that such in-
18 formation contained in such directory was accurate
19 as of the date of publication of such directory and
20 that an individual enrolled under such plan should
21 consult the database described in paragraph (4) with
22 respect to such plan or contact such plan to obtain
23 the most current provider directory information with
24 respect to such plan.

1 “(6) DEFINITION.—For purposes of this sec-
2 tion, the term ‘provider directory information’ in-
3 cludes, with respect to a health plan, the name, ad-
4 dress, specialty, and telephone number of each
5 health care provider or health care facility with
6 which such plan has a contractual relationship for
7 furnishing items and services under such plan.

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

16 “(1) information in plain language on—

17 “(A) the requirements and prohibitions ap-
18 plied under section 1150C of the Social Secu-
19 rity Act (relating to prohibitions on balance bill-
20 ing in certain circumstances);

21 “(B) if provided for under applicable State
22 law, any other requirements on providers and
23 facilities regarding the amounts such providers
24 and facilities may, with respect to an item or
25 service, charge a participant, beneficiary, or en-

1 rollee of such plan with respect to which such
2 a provider is a nonparticipating provider or fa-
3 cility is a nonparticipating facility, with respect
4 to such plan, for furnishing such item or service
5 after receiving payment from the plan for such
6 item or service and any applicable cost-sharing
7 payment from such participant, beneficiary, or
8 enrollee; and

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

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

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

21 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

24 “(A) establish the verification process de-
25 scribed in paragraph (2);

1 “(B) establish the response protocol de-
2 scribed in paragraph (3);

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

5 “(D) include in any directory (other than
6 the database described in subparagraph (C))
7 containing provider directory information with
8 respect to such plan the information described
9 in paragraph (5).

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

13 “(A) under which such plan verifies and
14 updates the provider directory information in-
15 cluded on the database described in paragraph
16 (4) of such plan of—

17 “(i) not less frequently than once
18 every 90 days, a random sample of at least
19 10 percent of health care providers and
20 health care facilities included in such data-
21 base; and

22 “(ii) any such provider or such facility
23 included in such database that has not
24 submitted any claim to such plan during a
25 12-month period;

1 “(B) that establishes a procedure for the
2 removal from such database of such a provider
3 or facility with respect to which such plan has
4 been unable to verify such information during a
5 period specified by the plan; and

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

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

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

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

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

8 “(A) a list of each health care provider and
9 health care facility with which such plan has a
10 contractual relationship for furnishing items
11 and services under such plan; and

12 “(B) provider directory information with
13 respect to each such provider and facility.

14 “(5) INFORMATION.—The information de-
15 scribed in this paragraph is, with respect to a direc-
16 tory containing provider directory information with
17 respect to a health plan, a notification that such in-
18 formation contained in such directory was accurate
19 as of the date of publication of such directory and
20 that an individual enrolled under such plan should
21 consult the database described in paragraph (4) with
22 respect to such plan or contact such plan to obtain
23 the most current provider directory information with
24 respect to such plan.

1 “(6) DEFINITION.—For purposes of this sec-
2 tion, the term ‘provider directory information’ in-
3 cludes, with respect to a health plan, the name, ad-
4 dress, specialty, and telephone number of each
5 health care provider or health care facility with
6 which such plan has a contractual relationship for
7 furnishing items and services under such plan.

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

16 “(1) information in plain language on—

17 “(A) the requirements and prohibitions ap-
18 plied under section 1150C of the Social Secu-
19 rity Act (relating to prohibitions on balance bill-
20 ing in certain circumstances);

21 “(B) if provided for under applicable State
22 law, any other requirements on providers and
23 facilities regarding the amounts such providers
24 and facilities may, with respect to an item or
25 service, charge a participant or beneficiary of

1 such plan with respect to which such a provider
2 is a nonparticipating provider or facility is a
3 nonparticipating facility, with respect to such
4 plan, for furnishing such item or service after
5 receiving payment from the plan for such item
6 or service and any applicable cost-sharing pay-
7 ment from such participant or beneficiary; and

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

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

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

21 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

24 “(A) establish the verification process de-
25 scribed in paragraph (2);

1 “(B) establish the response protocol de-
2 scribed in paragraph (3);

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

5 “(D) include in any directory (other than
6 the database described in subparagraph (C))
7 containing provider directory information with
8 respect to such plan the information described
9 in paragraph (5).

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

13 “(A) under which such plan verifies and
14 updates the provider directory information in-
15 cluded on the database described in paragraph
16 (4) of such plan of—

17 “(i) not less frequently than once
18 every 90 days, a random sample of at least
19 10 percent of health care providers and
20 health care facilities included in such data-
21 base; and

22 “(ii) any such provider or such facility
23 included in such database that has not
24 submitted any claim to such plan during a
25 12-month period;

1 “(B) that establishes a procedure for the
2 removal from such database of such a provider
3 or facility with respect to which such plan has
4 been unable to verify such information during a
5 period specified by the plan; and

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

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

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

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

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

8 “(A) a list of each health care provider and
9 health care facility with which such plan has a
10 contractual relationship for furnishing items
11 and services under such plan; and

12 “(B) provider directory information with
13 respect to each such provider and facility.

14 “(5) INFORMATION.—The information de-
15 scribed in this paragraph is, with respect to a direc-
16 tory containing provider directory information with
17 respect to a health plan, a notification that such in-
18 formation contained in such directory was accurate
19 as of the date of publication of such directory and
20 that an individual enrolled under such plan should
21 consult the database described in paragraph (4) with
22 respect to such plan or contact such plan to obtain
23 the most current provider directory information with
24 respect to such plan.

1 “(6) DEFINITION.—For purposes of this sec-
2 tion, the term ‘provider directory information’ in-
3 cludes, with respect to a health plan, the name, ad-
4 dress, specialty, and telephone number of each
5 health care provider or health care facility with
6 which such plan has a contractual relationship for
7 furnishing items and services under such plan.

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

16 “(1) information in plain language on—

17 “(A) the requirements and prohibitions ap-
18 plied under section 1150C of the Social Secu-
19 rity Act (relating to prohibitions on balance bill-
20 ing in certain circumstances);

21 “(B) if provided for under applicable State
22 law, any other requirements on providers and
23 facilities regarding the amounts such providers
24 and facilities may, with respect to an item or
25 service, charge a participant or beneficiary of

1 such plan with respect to which such a provider
2 is a nonparticipating provider or facility is a
3 nonparticipating facility, with respect to such
4 plan, for furnishing such item or service after
5 receiving payment from the plan for such item
6 or service and any applicable cost-sharing pay-
7 ment from such participant or beneficiary; and

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

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

16 **SEC. 6. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**
17 **REQUIREMENT FOR FAIR AND HONEST AD-**
18 **VANCE COST ESTIMATE.**

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

24 “(h) **ADVANCED EXPLANATION OF BENEFITS.**—Be-
25 ginning on January 1, 2022, each health plan shall, with

1 respect to a notification submitted under section
2 1150D(b)(2)(A) of the Social Security Act by a health
3 care provider or health care facility, respectively, to the
4 health plan for a participant, beneficiary, or enrollee under
5 such health plan scheduled to receive an item or service
6 from the provider or facility, not later than 1 business day
7 (or, in the case such item or service was so scheduled at
8 least 10 business days before such item or service is to
9 be furnished (or in the case such notification was made
10 pursuant to a request by such participant, beneficiary, or
11 enrollee), 3 business days) after the date on which the
12 health plan receives such notification, provide to the par-
13 ticipant, beneficiary, or enrollee (through mail or elec-
14 tronic means, as requested by the participant, beneficiary,
15 or enrollee) a notification including the following:

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

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

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

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

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

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

19 “(5) A good faith estimate of the amount that
20 the participant, beneficiary, or enrollee has incurred
21 toward meeting the limit of the financial responsi-
22 bility (including with respect to deductibles and out-
23 of-pocket maximums) under the health plan (as of
24 the date of such notification).

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

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

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

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

20 “(1) IN GENERAL.—For plan years beginning
21 on or after January 1, 2022, in the case of an item
22 or service furnished to a participant, beneficiary, or
23 enrollee of a health plan by a nonparticipating pro-
24 vider or a nonparticipating facility, if such item or
25 service would otherwise be covered under such plan

1 if furnished by a participating provider or partici-
2 pating facility and if either of the criteria described
3 in paragraph (2) applies with respect to such partici-
4 pant, beneficiary, or enrollee and item or service, the
5 plan—

6 “(A) shall not impose on such enrollee a
7 cost-sharing amount (expressed as a copayment
8 amount or coinsurance rate) for such item or
9 service so furnished that is greater than the
10 cost-sharing amount that would apply under
11 such plan had such item or service been fur-
12 nished by a participating provider;

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

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

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

1 “(C) shall pay to such nonparticipating
2 provider or facility furnishing such item or serv-
3 ice to such participant, beneficiary, or enrollee
4 the amount by which—

5 “(i) if a contracted rate described in
6 subparagraph (B)(i) exists, the most re-
7 cent (as of the date such item or services
8 was furnished) such rate; or

9 “(ii) if no contracted rate described in
10 such subparagraph exists, the out-of-net-
11 work rate;

12 for such items and services exceeds the cost-
13 sharing amount imposed under the plan for
14 such items and services (as determined in ac-
15 cordance with subparagraphs (A) and (B)); and

16 “(D) shall apply the deductible or out-of-
17 pocket maximum, if any, that would apply if
18 such services were furnished by a participating
19 provider or a participating facility.

20 “(2) CRITERIA DESCRIBED.—For purposes of
21 paragraph (1), the criteria described in this para-
22 graph, with respect to an item or service furnished
23 to a participant, beneficiary, or enrollee of a health
24 plan by a nonparticipating provider or a nonpartici-
25 pating facility, are the following:

1 “(A) The participant, beneficiary, or en-
2 rollee received a notification under subsection
3 (h) with respect to such item and service to be
4 furnished and such notification provided infor-
5 mation that the provider was a participating
6 provider or facility was a participating facility,
7 with respect to the plan for furnishing such
8 item or service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 “(A) shall not impose on such enrollee a
8 cost-sharing amount (expressed as a copayment
9 amount or coinsurance rate) for such item or
10 service so furnished that is greater than the
11 cost-sharing amount that would apply under
12 such plan had such item or service been fur-
13 nished by a participating provider;

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

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

1 “(ii) if no contracted rate described in
2 clause (i) exists, the recognized amount for
3 such item or service;

4 “(C) shall pay to such nonparticipating
5 provider or facility furnishing such item or serv-
6 ice to such participant or beneficiary the
7 amount by which—

8 “(i) if a contracted rate described in
9 subparagraph (B)(i) exists, the most re-
10 cent (as of the date such item or services
11 was furnished) such rate; or

12 “(ii) if no contracted rate described in
13 such subparagraph exists, the out-of-net-
14 work rate;

15 for such items and services exceeds the cost-
16 sharing amount imposed under the plan for
17 such items and services (as determined in ac-
18 cordance with subparagraphs (A) and (B)); and

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

23 “(2) CRITERIA DESCRIBED.—For purposes of
24 paragraph (1), the criteria described in this para-
25 graph, with respect to an item or service furnished

1 to a participant or beneficiary of a health plan by
2 a nonparticipating provider or a nonparticipating fa-
3 cility, are the following:

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

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

23 (c) ERISA AMENDMENTS.—Section 716 of the Em-
24 ployee Retirement Income Security Act of 1974, as added
25 by section 2(c) and amended by sections 3(c) and 5(c),

1 is further amended by inserting before subsection (k) the
2 following new subsections:

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

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

24 “(A) in the case the provider or facility is
25 a participating provider or facility with respect

1 to the health plan with respect to the furnishing
2 of such item or service, the contracted rate
3 under such plan for such item or service; and

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

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

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

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

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

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

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

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

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

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

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

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

7 “(A) shall not impose on such enrollee a
8 cost-sharing amount (expressed as a copayment
9 amount or coinsurance rate) for such item or
10 service so furnished that is greater than the
11 cost-sharing amount that would apply under
12 such plan had such item or service been fur-
13 nished by a participating provider;

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

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

1 “(ii) if no contracted rate described in
2 clause (i) exists, the recognized amount for
3 such item or service;

4 “(C) shall pay to such nonparticipating
5 provider or facility furnishing such item or serv-
6 ice to such participant or beneficiary the
7 amount by which—

8 “(i) if a contracted rate described in
9 subparagraph (B)(i) exists, the most re-
10 cent (as of the date such item or services
11 was furnished) such rate; or

12 “(ii) if no contracted rate described in
13 such subparagraph exists, the out-of-net-
14 work rate;

15 for such items and services exceeds the cost-
16 sharing amount imposed under the plan for
17 such items and services (as determined in ac-
18 cordance with subparagraphs (A) and (B)); and

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

23 “(2) CRITERIA DESCRIBED.—For purposes of
24 paragraph (1), the criteria described in this para-
25 graph, with respect to an item or service furnished

1 to a participant or beneficiary of a health plan by
2 a nonparticipating provider or a nonparticipating fa-
3 cility, are the following:

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

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

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

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

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

11 “(1) DETERMINATION THROUGH OPEN NEGO-
12 TIATION.—

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

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

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

20 “(i) the health plan that is party to
21 such negotiations shall notify the provider
22 or facility that is party to such negotia-
23 tions of the median contracted rate for
24 such item or service and year; and

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

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

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

19 “(III) any additional information
20 specified by the Secretary.

21 “(C) ACCESSING MEDIATED DISPUTE
22 PROCESS IN CASE OF FAILED NEGOTIATIONS.—
23 In the case of open negotiations pursuant to
24 subparagraph (A), with respect to an item or
25 service, that do not result in a determination of

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

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

24 “(A) ESTABLISHMENT.—Not later than
25 July 1, 2021, the Secretary, in coordination

1 with the Secretary of the Treasury and the Sec-
2 retary of Labor, shall establish a process (in
3 this subsection referred to as the ‘mediated dis-
4 pute process’) under which, in the case of an
5 item or service with respect to which a provider
6 or facility (as applicable) or health plan submits
7 a notification under paragraph (1)(C) (in this
8 subsection referred to as a ‘qualified mediated
9 dispute item or service’), an entity selected
10 under paragraph (3) determines, subject to sub-
11 paragraph (B) and in accordance with the suc-
12 ceeding provisions of this subsection, the
13 amount of payment under the health plan for
14 such item or service furnished by such provider
15 or facility.

16 “(B) AUTHORITY TO CONTINUE NEGOTIA-
17 TIONS.—Under the mediated dispute process, in
18 the case that the parties to a determination for
19 a qualified mediated dispute item or service
20 agree on a payment amount for such item or
21 service during such process but before the date
22 on which the entity selected with respect to
23 such determination under paragraph (3) makes
24 such determination, such amount shall be treat-
25 ed for purposes of subsection (k)(11)(B) as the

1 amount agreed to by such parties for such item
2 or service. In the case of an agreement de-
3 scribed in the previous sentence, the mediated
4 dispute process shall provide for a method to
5 determine how to allocate between the parties
6 to such determination the payment of the com-
7 pensation of the entity selected with respect to
8 such determination.

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

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

22 “(i) is not a party to such determina-
23 tion or an employee or agent of such a
24 party;

1 “(ii) does not have a material familial,
2 financial, or professional relationship with
3 such a party; and

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

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

11 “(i) select such an entity that satisfies
12 clauses (i) through (iii) of subparagraph
13 (A); and

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

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

23 “(4) TREATMENT OF CONSIDERATION OF MUL-
24 TIPLE ITEMS AND SERVICES.—

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

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

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

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

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

1 dled payment may be part of a single deter-
2 mination under this subsection.

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

10 “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

18 “(i) taking into account only the con-
19 siderations specified in subparagraph
20 (C)(i), select one of the offers submitted
21 under subparagraph (B) to be the amount
22 of payment for such item or service deter-
23 mined under this subsection for purposes
24 of subsection (b)(1), (e)(1), or (i)(1), as
25 applicable; and

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

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

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

15 “(ii) information relating to such
16 offer; and

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

19 “(C) CONSIDERATIONS.—

20 “(i) IN GENERAL.—For purposes of
21 subparagraph (A), the considerations spec-
22 ified in this subparagraph, with respect to
23 a determination for a qualified mediated
24 dispute item or service, are the following:

1 “(I) The median contracted rate
2 for such item or service.

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

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

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

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

1 for the services of such entity in accordance
2 with the guidelines on such compensation estab-
3 lished by the Secretary under subparagraph
4 (B).

5 “(B) GUIDELINES ON COMPENSATION.—
6 For purposes of subparagraph (A), the Sec-
7 retary shall establish guidelines with respect to
8 the compensation of a selected independent en-
9 tity for the services of such entity with respect
10 to determinations under the mediated dispute
11 process. Such guidelines shall provide that such
12 compensation reimburses the entity for at least
13 the costs of such entity in performing the duties
14 of the entity under the mediated dispute pro-
15 cess.

16 “(7) CERTIFICATION OF ENTITIES.—

17 “(A) IN GENERAL.—The Secretary shall
18 establish or recognize a process to certify (in-
19 cluding recertification of) entities under this
20 paragraph. Such process shall ensure that an
21 entity so certified—

22 “(i) has (directly or through contracts
23 or other arrangements) sufficient medical,
24 legal, and other expertise and sufficient

1 staffing to make determinations described
2 in paragraph (2) on a timely basis;

3 “(ii) is not—

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

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

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

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

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

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

23 “(vi) does not under the mediated dis-
24 pute process carry out any determination
25 with respect to which the entity would not

1 pursuant to clause (i), (ii), or (iii) of para-
2 graph (3)(A) be eligible for selection; and

3 “(vii) meets such other requirements
4 as determined appropriate by the Sec-
5 retary.

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

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

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

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

7 “(F) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

6 “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

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

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

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

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

10 “(C) CONSIDERATIONS.—

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

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

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

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

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

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

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

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

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

6 “(7) CERTIFICATION OF ENTITIES.—

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

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

17 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(F) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

19 “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 An entity selected pursuant to the previous sentence
25 to make a determination described in such sentence

1 shall be referred to in this subsection as the ‘selected
2 independent entity’ with respect to such determina-
3 tion.

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

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

15 “(i) such items and services to be in-
16 cluded in such determination are furnished
17 by the same provider or facility;

18 “(ii) payment for such items and serv-
19 ices is required to be made by the same
20 health plan; and

21 “(iii) such items and services are re-
22 lated to the treatment of a similar condi-
23 tion.

24 “(B) TREATMENT OF BUNDLED PAY-
25 MENTS.—In carrying out subparagraph (A), the

1 Secretary shall provide that, in the case of
2 items and services which are included by a pro-
3 vider or facility as part of a bundled payment,
4 such items and services included in such bun-
5 dled payment may be part of a single deter-
6 mination under this subsection.

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

14 “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

22 “(i) taking into account only the con-
23 siderations specified in subparagraph
24 (C)(i), select one of the offers submitted
25 under subparagraph (B) to be the amount

1 of payment for such item or service deter-
2 mined under this subsection for purposes
3 of subsection (b)(1), (e)(1), or (i)(1), as
4 applicable; and

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

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

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

19 “(ii) information relating to such
20 offer; and

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

23 “(C) CONSIDERATIONS.—

24 “(i) IN GENERAL.—For purposes of
25 subparagraph (A), the considerations spec-

1 ified in this subparagraph, with respect to
2 a determination for a qualified mediated
3 dispute item or service, are the following:

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

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

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

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

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

1 mination whose offer submitted under para-
2 graph (5)(B) was not selected by the entity
3 shall pay to such entity a fee in compensation
4 for the services of such entity in accordance
5 with the guidelines on such compensation estab-
6 lished by the Secretary under subparagraph
7 (B).

8 “(B) GUIDELINES ON COMPENSATION.—
9 For purposes of subparagraph (A), the Sec-
10 retary shall establish guidelines with respect to
11 the compensation of a selected independent en-
12 tity for the services of such entity with respect
13 to determinations under the mediated dispute
14 process. Such guidelines shall provide that such
15 compensation reimburses the entity for at least
16 the costs of such entity in performing the duties
17 of the entity under the mediated dispute proc-
18 ess.

19 “(7) CERTIFICATION OF ENTITIES.—

20 “(A) IN GENERAL.—The Secretary shall
21 establish or recognize a process to certify (in-
22 cluding recertification of) entities under this
23 paragraph. Such process shall ensure that an
24 entity so certified—

1 “(i) has (directly or through contracts
2 or other arrangements) sufficient medical,
3 legal, and other expertise and sufficient
4 staffing to make determinations described
5 in paragraph (2) on a timely basis;

6 “(ii) is not—

7 “(I) a health plan, provider, or
8 facility;

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

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

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

19 “(iv) meets appropriate indicators of
20 fiscal integrity;

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

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

6 “(vii) meets such other requirements
7 as determined appropriate by the Sec-
8 retary.

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

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

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

1 paragraph for failure of meeting a requirement
2 of this subsection.

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

9 “(F) PROVISION OF INFORMATION.—

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

1 “(ii) INFORMATION TO BE IN-
2 CLUDED.—The information described in
3 this clause with respect to an entity is the
4 following:

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

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

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

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

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

23 “(IV) The amount of each such
24 determination.

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

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

6 “(VII) Any other information
7 specified by the Secretary.

8 “(8) ADMINISTRATIVE FEE.—

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

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

1 “(9) SECRETARIAL REPORT; PUBLICATION OF
2 INFORMATION.—

3 “(A) SECRETARIAL REPORT.—Beginning
4 not later than July 1, 2023, the Secretary shall,
5 in coordination with the Secretary of Health
6 and Human Services and the Secretary of the
7 Treasury, periodically study and submit to Con-
8 gress a report on—

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

22 “(ii) the effect of such difference on
23 the cost-sharing for such item or service
24 for a participant or beneficiary of a health
25 plan.

1 “(B) PUBLICATION OF INFORMATION.—
2 Beginning with July 1, 2023, and for each cal-
3 endar quarter thereafter, the Secretary shall, in
4 coordination with the Secretary of Health and
5 Human Services and the Secretary of Labor,
6 make publicly available a summary of the fol-
7 lowing:

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

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

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

18 “(iv) The total amount of compensa-
19 tion paid to selected independent entities
20 under paragraph (6) during such quar-
21 ter.”.

22 (d) RULE OF CONSTRUCTION.—Nothing in this Act,
23 or the amendment made by this Act, shall be construed
24 as removing any obligation of a health plan (as defined
25 in section 2719A of the Public Health Service Act (42

1 U.S.C. 300gg–19A), as amended by this Act) to provide
2 payment to a health care provider or health care facility
3 for items and services furnished by such provider or facil-
4 ity to an individual enrolled in such plan.

5 **SEC. 8. PROHIBITING BALANCE BILLING PRACTICES BY**
6 **PROVIDERS FOR EMERGENCY SERVICES, FOR**
7 **SERVICES FURNISHED BY NONPARTICI-**
8 **PATING PROVIDER AT PARTICIPATING FACIL-**
9 **ITY, AND IN CERTAIN CASES OF MISINFORMA-**
10 **TION.**

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

14 **“SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING**
15 **PRACTICES.**

16 “(a) EMERGENCY SERVICES.—In the case of an indi-
17 vidual with benefits under a group health plan or health
18 insurance coverage offered in the group or individual mar-
19 ket who is furnished in a plan year that begins on or after
20 January 1, 2022, emergency services with respect to an
21 emergency medical condition during a visit at an emer-
22 gency department of a hospital or an independent free-
23 standing emergency department—

24 “(1) if the hospital or independent freestanding
25 emergency department does not have a contractual

1 relationship with such plan or coverage for fur-
2 nishing such services, the hospital or independent
3 freestanding emergency department shall not bill,
4 and shall not hold liable, the individual for a pay-
5 ment amount for such emergency services so fur-
6 nished that is more than the cost-sharing amount
7 for such services (as determined in accordance with
8 section 2719A(b) of the Public Health Service Act,
9 section 716(b) of the Employee Retirement Income
10 Security Act of 1974, or section 9816(b) of the In-
11 ternal Revenue Code of 1986, as applicable); and

12 “(2) a health care provider without a contrac-
13 tual relationship with such plan or coverage for fur-
14 nishing such services shall not bill, and shall not
15 hold liable, such individual for a payment amount
16 for such services furnished to such individual by
17 such provider with respect to such emergency med-
18 ical condition and visit for which the individual re-
19 ceives emergency services at the emergency depart-
20 ment of the hospital or independent freestanding
21 emergency department that is more than the cost-
22 sharing amount for such services furnished by the
23 provider (as determined in accordance with section
24 2719A(b) of the Public Health Service Act, section
25 716(b) of the Employee Retirement Income Security

1 Act of 1974, or section 9816(b) of the Internal Rev-
2 enue Code of 1986, as applicable).

3 “(b) SERVICES FURNISHED BY NONPARTICIPATING
4 PROVIDER AT PARTICIPATING FACILITY.—

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

23 “(2) EXCEPTION IN CASE NOTICE PROVIDED.—
24 Paragraph (1) shall not apply with respect to items
25 and services (other than items and services described

1 in paragraph (3)) furnished to an individual enrolled
2 in a group health plan or in health insurance cov-
3 erage offered in the group or individual market by
4 a health care provider that does not have a contrac-
5 tual relationship with such plan or coverage for fur-
6 nishing such items and services if the following cri-
7 teria are met:

8 “(A) A written notice (as specified by the
9 Secretary) is provided by the provider to such
10 individual, not later than 48 hours before such
11 items and services are to be so furnished, that
12 includes the following information:

13 “(i) That the provider does not have
14 such a relationship with such plan or cov-
15 erage.

16 “(ii) The estimated amount that such
17 provider may charge the individual for
18 such items and services.

19 “(iii) A statement that the individual
20 may seek such items or services from a
21 health care provider that does have such a
22 contractual relationship.

23 “(B) On the date such item or service is
24 to be furnished, before such item or service is
25 so furnished, the individual signs and dates

1 such notice confirming receipt of the notice and
2 consent of the individual to be so furnished
3 such items and services.

4 “(C) A copy of such signed and dated no-
5 tice is provided by the provider to the plan or
6 coverage.

7 “(3) ITEMS AND SERVICES DESCRIBED.—The
8 items and services described in this paragraph are
9 items and services furnished by a specified provider
10 (as defined in subsection (f)(3)).

11 “(c) RELIANCE ON INCORRECT PROVIDER INFORMA-
12 TION.—In the case of an individual who is furnished items
13 or services by a health care provider or health care facility
14 for which a group health plan or health insurance issuer
15 is required to make payment under section 2719A(i) of
16 the Public Health Service Act, section 716(i) of the Em-
17 ployee Retirement Income Security Act of 1974, or section
18 9816(i) of the Internal Revenue Code of 1986, such pro-
19 vider or facility shall not bill, and shall not hold liable,
20 such individual for a payment amount for such an item
21 or service that is more than the cost-sharing amount for
22 such item or service (as determined in accordance with
23 section 2719A(i) of the Public Health Service Act, section
24 716(i) of the Employee Retirement Income Security Act

1 of 1974, or section 9816(i) of the Internal Revenue Code
2 of 1986, as applicable).

3 “(d) COMPLIANCE WITH REQUIREMENTS UNDER
4 OPEN NEGOTIATION AND MEDIATED DISPUTE RESOLU-
5 TION PROCESSES.—A health care provider or health care
6 facility shall comply with any requirement imposed on
7 such provider or facility, respectively, under section
8 2719A(j) of the Public Health Service Act, 9816(j) of the
9 Internal Revenue Code of 1986, or 716(j) of the Employee
10 Retirement Income Security Act of 1974.

11 “(e) PENALTY.—

12 “(1) GENERAL PENALTY.—

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

19 “(B) APPLICATION OF PROVISIONS.—The
20 provisions of section 1128A (other than sub-
21 section (a), subsection (b), the first sentence of
22 subsection (c)(1), and subsection (o)) shall
23 apply with respect to a civil monetary penalty
24 imposed under this paragraph in the same man-
25 ner as such provisions apply with respect to a

1 penalty or proceeding under subsection (a) of
2 such section.

3 “(2) ADDITIONAL PENALTY FOR FACILITY
4 FAILURE TO PROVIDE CERTAIN NOTICE.—

5 “(A) IN GENERAL.—In the case of a hos-
6 pital or independent freestanding emergency de-
7 partment that furnishes emergency services de-
8 scribed in subparagraph (A) of section
9 2719A(k)(5) to an individual enrolled in a
10 health plan, after stabilization of such indi-
11 vidual, if the hospital or independent free-
12 standing emergency department does not pro-
13 vide such individual a notice in accordance with
14 subparagraph (C)(i) of such section and—

15 “(i) in the case the hospital or inde-
16 pendent freestanding emergency depart-
17 ment is a nonparticipating facility with re-
18 spect to such plan, if the hospital or de-
19 partment furnishes services described in
20 subparagraph (B) of such section to such
21 individual and bills the individual in viola-
22 tion of subsection (a) of this section; or

23 “(ii) in the case the hospital or inde-
24 pendent freestanding emergency depart-
25 ment is a participating facility with respect

1 to such plan and a nonparticipating pro-
2 vider furnishes services described in such
3 subparagraph (B) during the visit at such
4 hospital or independent freestanding emer-
5 gency department;

6 in addition to any penalty applicable to the hos-
7 pital or department under paragraph (1), the
8 hospital or department shall be subject to a civil
9 monetary penalty of \$50,000.

10 “(B) APPLICATION OF PROVISIONS.—The
11 provisions of section 1128A (other than sub-
12 section (a), subsection (b), the first sentence of
13 subsection (c)(1), subsection (d), and subsection
14 (o)) shall apply with respect to a civil monetary
15 penalty imposed under this paragraph in the
16 same manner as such provisions apply with re-
17 spect to a penalty or proceeding under sub-
18 section (a) of such section.

19 “(f) DEFINITIONS.—For purposes of this section and
20 sections 1150D and 1150E:

21 “(1) The terms ‘during a visit’, ‘emergency de-
22 partment of a hospital’, ‘emergency medical condi-
23 tion’, ‘emergency services’, ‘independent freestanding
24 emergency department’, ‘nonparticipating provider’,
25 ‘nonparticipating facility’, ‘participating facility’,

1 ‘participating provider’ have the meanings given
2 such terms, respectively, in section 2719A(k) of the
3 Public Health Service Act.

4 “(2) The terms ‘group health plan’, ‘group mar-
5 ket’, ‘health insurance issuer’, ‘health insurance cov-
6 erage’, and ‘individual market’ have the meanings
7 given such terms, respectively, in section 2791 of the
8 Public Health Service Act.

9 “(3) The term ‘specified provider’, with respect
10 to an individual with benefits under a group health
11 plan or health insurance coverage and a hospital
12 with a contractual relationship with such plan or
13 coverage for furnishing items and services—

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

22 “(B) includes, with respect to an item or
23 service, any health care provider furnishing
24 such item or service at such hospital if there is
25 no health care provider at such hospital who

1 can furnish such item or service who has such
2 a relationship with such plan or coverage for
3 furnishing such item or service.”.

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

9 **“SEC. 1150D. PATIENT PROTECTIONS AGAINST SURPRISE**
10 **BILLING THROUGH TRANSPARENCY.**

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

1 or facility, as applicable. Such provider or facility shall so
2 transmit such information to such issuer offering such
3 coverage or such group health plan—

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

10 “(2) at any other time (including upon the re-
11 quest of such issuer or plan) determined appropriate
12 by the provider, facility, or the Secretary.

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

1 “(1) inquire if such individual is enrolled in a
2 group health plan, group or individual health insur-
3 ance coverage offered by a health insurance issuer,
4 or a Federal health care program (and if is so en-
5 rolled in such plan or coverage, seeking to have a
6 claim for such item or service submitted to such
7 plan or coverage); and

8 “(2) provide a notification of the good faith es-
9 timate of the expected charges for furnishing such
10 item or service (including any item or service that is
11 reasonably expected to be provided in conjunction
12 with such scheduled item or service) to—

13 “(A) in the case the individual is enrolled
14 in such a plan or such coverage (and is seeking
15 to have a claim for such item or service sub-
16 mitted to such plan or coverage), such plan or
17 issuer of such coverage; and

18 “(B) in the case the individual is not de-
19 scribed in subparagraph (A) and not enrolled in
20 a Federal health care program, the individual.

21 “(c) CONTINUITY OF CARE.—A health care provider
22 or health care facility shall, in the case of an individual
23 furnished items and services by such provider or facility
24 for which coverage is provided under a group health plan
25 or group or individual health insurance coverage pursuant

1 to section 2730 of such Act, section 9817 of the Internal
2 Revenue Code of 1986, or section 717 of the Employee
3 Retirement Income Security Act of 1974—

4 “(1) accept payment from such plan or such
5 issuer (as applicable) (and cost-sharing from such
6 individual, if applicable, in accordance with sub-
7 section (a)(2)(C) of such section 2730, 9817, or
8 717) for such items and services as payment in full
9 for such items and services; and

10 “(2) continue to adhere to all policies, proce-
11 dures, and quality standards imposed by such plan
12 or issuer with respect to such individual and such
13 items and services in the same manner as if such
14 termination had not occurred.

15 “(d) LIMITATION.—Beginning on January 1, 2022,
16 a health care provider or health care facility may not ini-
17 tiate a process to seek reimbursement of payment for
18 items and services furnished to an individual enrolled in
19 a group health plan or health insurance coverage offered
20 in the group or individual market more than 1 year after
21 the date on which such items and services were so fur-
22 nished.

23 “(e) PENALTY.—

24 “(1) GENERAL PENALTY.—

1 “(A) IN GENERAL.—Except as provided in
2 paragraph (2), any health care provider or
3 health care facility that violates a provision of
4 this section shall be subject to a civil monetary
5 penalty in an amount not to exceed \$10,000 for
6 each such violation.

7 “(B) APPLICATION OF PROVISIONS.—The
8 provisions of section 1128A (other than sub-
9 section (a), subsection (b), the first sentence of
10 subsection (c)(1), and subsection (o)) shall
11 apply with respect to a civil monetary penalty
12 imposed under this paragraph in the same man-
13 ner as such provisions apply with respect to a
14 penalty or proceeding under subsection (a) of
15 such section.

16 “(2) PROVIDER DIRECTORY INFORMATION PEN-
17 ALTY.—

18 “(A) IN GENERAL.—Each health care pro-
19 vider or health care facility that fails to trans-
20 mit information as required under subsection
21 (a) shall be subject to a civil monetary penalty
22 of \$1,000 for each day such provider or facility
23 (as applicable) fails to so transmit such infor-
24 mation.

1 “(B) APPLICATION OF PROVISIONS.—The
2 provisions of section 1128A (other than sub-
3 section (a), subsection (b), the first sentence of
4 subsection (c)(1), subsection (d), and subsection
5 (o)) shall apply with respect to a civil monetary
6 penalty imposed under this paragraph in the
7 same manner as such provisions apply with re-
8 spect to a penalty or proceeding under sub-
9 section (a) of such section.

10 **“SEC. 1150E. PATIENT-PROVIDER DISPUTE RESOLUTION.**

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

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

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

22 “(1) a method to select to make such deter-
23 mination an entity certified under subsection (d)
24 that—

1 “(A) is not a party to such determination
2 or an employee or agent of such party;

3 “(B) does not have a material familial, fi-
4 nancial, or professional relationship with such a
5 party; and

6 “(C) does not otherwise have a conflict of
7 interest with such a party (as determined by
8 the Secretary); and

9 “(2) the provision of a notification of such se-
10 lection to the individual and the provider or facility
11 (as applicable) party to such determination.

12 An entity selected pursuant to the previous sentence to
13 make a determination described in such sentence shall be
14 referred to in this subsection as the ‘selected dispute reso-
15 lution entity’ with respect to such determination.

16 “(c) ADMINISTRATIVE FEE.—The Secretary shall es-
17 tablish a fee to participate in the patient-provider dispute
18 resolution process in such a manner as to not create a
19 barrier to an uninsured individual’s access to such process.

20 “(d) CERTIFICATION.—The Secretary shall establish
21 or recognize a process to certify entities under this sub-
22 paragraph. Such process shall ensure that an entity so cer-
23 tified satisfies at least the criteria specified in section
24 2719A(j)(7) of the Public Health Service Act.”.

1 **SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.**

2 (a) PUBLIC HEALTH SERVICE ACT.—Subpart II of
3 part A of title XXVII of the Public Health Service Act
4 (42 U.S.C. 300gg–11 et seq.) is amended by adding at
5 the end the following new sections:

6 **“SEC. 2730. CONTINUITY OF CARE.**

7 “(a) ENSURING CONTINUITY OF CARE WITH RE-
8 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
9 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
10 NETWORK STATUS.—

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

21 “(A) such contractual relationship is termi-
22 nated (as defined in subsection (b));

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

1 such provider or facility in such plan or cov-
2 erage; or

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

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

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

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

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

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

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

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

19 “(b) DEFINITIONS.—In this section:

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

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

1 “(B) is undergoing a course of institu-
2 tional or inpatient care from the provider or fa-
3 cility;

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

8 “(D) is pregnant and undergoing a course
9 of treatment for the pregnancy from the pro-
10 vider or facility; or

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

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

20 “(A) in the case of an acute illness, a con-
21 dition that is serious enough to require special-
22 ized medical treatment to avoid the reasonable
23 possibility of death or permanent harm; or

24 “(B) in the case of a chronic illness or con-
25 dition, a condition that is—

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

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

5 “(3) **TERMINATED.**—The term ‘terminated’ in-
6 cludes, with respect to a contract, the expiration or
7 nonrenewal of the contract, but does not include a
8 termination of the contract for failure to meet appli-
9 cable quality standards or for fraud.

10 **“SEC. 2731. INFORMATION REQUIRED TO BE INCLUDED ON**
11 **HEALTH INSURANCE MEMBERSHIP CARDS.**

12 “In the case of a group health plan or health insur-
13 ance issuer offering group or individual health insurance
14 coverage that provides a physical or electronic card indi-
15 cating membership in such plan or coverage to an indi-
16 vidual enrolled under such plan or coverage, such group
17 health plan or issuer shall include on such card each of
18 the following:

19 “(1) The nearest hospital to the primary resi-
20 dence of such individual that has in effect a contrac-
21 tual relationship with such plan or coverage for fur-
22 nishing items and services under such plan or cov-
23 erage.

24 “(2) A telephone number or Internet website
25 address through which such individual may seek con-

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

6 “(3) Any deductible applicable to such indi-
7 vidual.

8 “(4) Any out-of-pocket maximum applicable to
9 such individual.

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

16 **“SEC. 2732. MAINTENANCE OF PRICE COMPARISON TOOL.**

17 “‘In connection with the offering of a group health
18 plan or group or individual health insurance coverage in
19 a geographic region for a plan year, a plan sponsor or
20 health insurance issuer, respectively, shall employ an indi-
21 vidual to offer price comparison guidance, or make avail-
22 able on an Internet website a price comparison tool, that
23 (to the extent practicable) allows an individual enrolled
24 under such plan or coverage, with respect to such plan
25 year and such geographic region, to compare the amount

1 (determined by historic claims data of participating pro-
2 viders with respect to such plan or coverage) of cost-shar-
3 ing (including deductibles, copayments, and coinsurance)
4 that the individual would be responsible for paying under
5 such plan or coverage with respect to the furnishing of
6 a specific item or service by any such provider.

7 **“SEC. 2733. ASSIGNMENT OF BENEFITS.**

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

23 (b) INTERNAL REVENUE CODE.—

24 (1) IN GENERAL.—Subchapter B of chapter
25 100 of the Internal Revenue Code of 1986, as

1 amended by the previous sections, is further amend-
2 ed by adding at the end the following new sections:

3 **“SEC. 9817. CONTINUITY OF CARE.**

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

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

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

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

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

1 such plan is terminated, resulting in a loss of
2 benefits provided under such plan with respect
3 to such provider or facility;
4 the plan shall meet the requirements of paragraph
5 (2) with respect to such individual.

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

8 “(A) notify each individual enrolled under
9 such plan who is a continuing care patient with
10 respect to a provider or facility at the time of
11 a termination described in paragraph (1) affect-
12 ing such provider on a timely basis of such ter-
13 mination and such individual’s right to elect
14 continued transitional care from such provider
15 or facility under this section;

16 “(B) provide such individual with an op-
17 portunity to notify the plan of the individual’s
18 need for transitional care; and

19 “(C) permit the patient to elect to continue
20 to have benefits provided under such plan,
21 under the same terms and conditions as would
22 have applied and with respect to such items and
23 services as would have been covered under such
24 plan had such termination not occurred, with
25 respect to the course of treatment furnished by

1 such provider or facility relating to such indi-
2 vidual's status as a continuing care patient dur-
3 ing the period beginning on the date on which
4 the notice under subparagraph (A) is provided
5 and ending on the earlier of—

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

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

11 “(b) DEFINITIONS.—In this section:

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

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

18 “(B) is undergoing a course of institu-
19 tional or inpatient care from the provider or fa-
20 cility;

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

1 “(D) is pregnant and undergoing a course
2 of treatment for the pregnancy from the pro-
3 vider or facility; or

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

9 “(2) SERIOUS AND COMPLEX CONDITION.—The
10 term ‘serious and complex condition’ means, with re-
11 spect to a participant, beneficiary, or enrollee under
12 a group health plan—

13 “(A) in the case of an acute illness, a con-
14 dition that is serious enough to require special-
15 ized medical treatment to avoid the reasonable
16 possibility of death or permanent harm; or

17 “(B) in the case of a chronic illness or con-
18 dition, a condition that—

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

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

23 “(3) TERMINATED.—The term ‘terminated’ in-
24 cludes, with respect to a contract, the expiration or
25 nonrenewal of the contract, but does not include a

1 termination of the contract for failure to meet appli-
2 cable quality standards or for fraud.

3 **“SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON**
4 **HEALTH INSURANCE MEMBERSHIP CARDS.**

5 “In the case of a group health plan that provides a
6 physical or electronic card indicating membership in such
7 plan to an individual enrolled under such plan, such group
8 health plan shall include on such card each of the fol-
9 lowing:

10 “(1) The nearest hospital to the primary resi-
11 dence of such individual that has in effect a contrac-
12 tual relationship with such plan for furnishing items
13 and services under such plan.

14 “(2) A telephone number or Internet website
15 address through which such individual may seek con-
16 sumer assistance information, such as information
17 related to hospitals and urgent care facilities that
18 have in effect a contractual relationship with such
19 plan for furnishing items and services under such
20 plan.

21 “(3) Any deductible applicable to such indi-
22 vidual.

23 “(4) Any out-of-pocket maximum applicable to
24 such individual.

1 “(5) Any cost-sharing obligation applicable to
2 such individual for a visit at an emergency depart-
3 ment, or urgent care facility, that has in effect a
4 contractual relationship with such plan for fur-
5 nishing items and services under such plan.

6 **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

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

20 **“SEC. 9820. ASSIGNMENT OF BENEFITS.**

21 “With respect to an item or service furnished to a
22 beneficiary, participant, or enrollee of a group health plan
23 by a nonparticipating provider (as defined in section
24 2719A(k)(10)(A)) or a nonparticipating facility (as de-
25 fined in section 2719A(k)(9)(A)) and for which a payment

1 is required to be made by the group health plan pursuant
2 to subsection (b)(1), (e)(1), or (i)(1) of section 2719A, if
3 the beneficiary, participant, or enrollee assigns the bene-
4 fits, or right to payment of benefits, of such beneficiary,
5 participant, or enrollee to the provider or facility, then
6 payment for such item or service by such group health
7 plan shall be made directly to the provider or facility.”.

8 (2) CONFORMING AMENDMENT.—Section
9 9815(a) of the Internal Revenue Code of 1986, as
10 amended by section 2(b), is further amended—

11 (A) in paragraph (1), by striking “section
12 2719A” and inserting “section 2719A, 2730,
13 2731, 2732, or 2733”; and

14 (B) in paragraph (2), by striking “section
15 2719A” and inserting “section 2719A, 2730,
16 2731, 2732, or 2733”.

17 (3) CLERICAL AMENDMENT.—The table of sec-
18 tions for such subchapter, as amended by section
19 2(b), is further amended by adding at the end the
20 following new items:

“Sec. 9817. Continuity of care.

“Sec. 9818. Information required to be included on health insurance member-
ship cards.

“Sec. 9819. Maintenance of price comparison tool.

“Sec. 9820. Assignment of benefits.”.

21 (c) EMPLOYEE RETIREMENT INCOME SECURITY
22 ACT.—

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.), as
4 amended by section 2(e), is further amended by add-
5 ing at the end the following new sections:

6 **“SEC. 717. CONTINUITY OF CARE.**

7 “(a) ENSURING CONTINUITY OF CARE WITH RE-
8 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
9 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
10 NETWORK STATUS.—

11 “(1) IN GENERAL.—In the case of an individual
12 with benefits under a group health plan or health in-
13 surance coverage offered by a health insurance
14 issuer in connection with a group health plan and
15 with respect to a health care provider or facility that
16 has a contractual relationship with such plan or
17 such issuer (as applicable) for furnishing items and
18 services under such plan or such coverage, if, while
19 such individual is a continuing care patient (as de-
20 fined in subsection (b)) with respect to such provider
21 or facility—

22 “(A) such contractual relationship is termi-
23 nated (as defined in paragraph (b));

24 “(B) benefits provided under such plan or
25 such health insurance coverage with respect to

1 such provider or facility are terminated because
2 of a change in the terms of the participation of
3 the provider or facility in such plan or coverage;
4 or

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

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

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

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

1 “(B) provide such individual with an op-
2 portunity to notify the plan or issuer of the in-
3 dividual’s need for transitional care; and

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

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

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

22 “(b) DEFINITIONS.—In this section:

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

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

4 “(B) is undergoing a course of institu-
5 tional or inpatient care from the provider or fa-
6 cility;

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

11 “(D) is pregnant and undergoing a course
12 of treatment for the pregnancy from the pro-
13 vider or facility; or

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

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

23 “(A) in the case of an acute illness, a con-
24 dition that is serious enough to require special-

1 ized medical treatment to avoid the reasonable
2 possibility of death or permanent harm; or

3 “(B) in the case of a chronic illness or con-
4 dition, a condition that—

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

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

9 “(3) TERMINATED.—The term ‘terminated’ in-
10 cludes, with respect to a contract, the expiration or
11 nonrenewal of the contract, but does not include a
12 termination of the contract for failure to meet appli-
13 cable quality standards or for fraud.

14 **“SEC. 718. INFORMATION REQUIRED TO BE INCLUDED ON**
15 **HEALTH INSURANCE MEMBERSHIP CARDS.**

16 “In the case of a group health plan or health insur-
17 ance issuer offering group health insurance coverage that
18 provides a physical or electronic card indicating member-
19 ship in such plan or coverage to an individual enrolled
20 under such plan or coverage, such group health plan or
21 issuer shall include on such card each of the following:

22 “(1) The nearest hospital to the primary resi-
23 dence of such individual that has in effect a contrac-
24 tual relationship with such plan or coverage for fur-

1 nishing items and services under such plan or cov-
2 erage.

3 “(2) A telephone number or Internet website
4 address through which such individual may seek con-
5 sumer assistance information, such as information
6 related to hospitals and urgent care facilities that
7 have in effect a contractual relationship with such
8 plan or coverage for furnishing items and services
9 under such plan or coverage.

10 “(3) Any deductible applicable to such indi-
11 vidual.

12 “(4) Any out-of-pocket maximum applicable to
13 such individual.

14 “(5) Any cost-sharing obligation applicable to
15 such individual for a visit at an emergency depart-
16 ment, or urgent care facility, that has in effect a
17 contractual relationship with such plan or coverage
18 for furnishing items and services under such plan or
19 coverage.

20 **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

21 “‘In connection with the offering of a group health
22 plan or group health insurance coverage in a geographic
23 region for a plan year, a plan sponsor or health insurance
24 issuer, respectively, shall employ an individual to offer
25 price comparison guidance, or make available on an Inter-

1 net website a price comparison tool, that (to the extent
2 practicable) allows an individual enrolled under such plan
3 or coverage, with respect to such plan year and such geo-
4 graphic region, to compare the amount (determined by
5 historic claims data of participating providers with respect
6 to such plan or coverage) of cost-sharing (including
7 deductibles, copayments, and coinsurance) that the indi-
8 vidual would be responsible for paying under such plan
9 or coverage with respect to the furnishing of a specific
10 item or service by any such provider.

11 **“SEC. 720. ASSIGNMENT OF BENEFITS.**

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

1 (2) CONFORMING AMENDMENT.—Section
2 715(a) of the Employee Retirement Income Security
3 Act of 1974 (29 U.S.C. 1185d(a)), as amended by
4 section 2(c), is further amended—

5 (A) in paragraph (1), by striking “section
6 2719A” and inserting “section 2719A, 2730,
7 2731, 2732, or 2733”; and

8 (B) in paragraph (2), by striking “section
9 2719A” and inserting “section 2719A, 2730,
10 2731, 2732, or 2733”.

11 (3) CLERICAL AMENDMENT.—The table of con-
12 tents in section 1 of the Employee Retirement In-
13 come Security Act of 1974 is amended by inserting
14 after the item relating to section 716 the following
15 new items:

“Sec. 717. Continuity of care.

“Sec. 718. Information required to be included on health insurance membership
 cards.

“Sec. 719. Maintenance of price comparison tool.

“Sec. 720. Assignment of benefits.”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply with respect to plan years begin-
18 ning on or after January 1, 2022.

19 **SEC. 10. AIR AMBULANCE COST DATA REPORTING PRO-**
20 **GRAM.**

21 (a) COST DATA REPORTING PROGRAM.—

22 (1) IN GENERAL.—Not later than 1 year after
23 the date of the enactment of this Act, and annually

1 thereafter, a provider of emergency air medical serv-
2 ices shall submit to the Secretary of Health and
3 Human Services the information specified in sub-
4 section (b) with respect to the preceding 180-day pe-
5 riod (in the case of the initial period) and the pre-
6 ceding 1-year period (in each subsequent period).

7 (2) PUBLICATION.—Not later than 180 days
8 after the date the Secretary of Health and Human
9 Services receives from a provider described in para-
10 graph (1) the information specified in subsection (b),
11 the Secretary shall make publicly available such in-
12 formation.

13 (b) SPECIFIED INFORMATION.—For purposes of sub-
14 section (a), information specified in this subsection is—

15 (1) information, with respect to a claim for an
16 item or service—

17 (A) identified as paid by health insurance
18 coverage offered in the group or individual mar-
19 ket or a group health plan (including a self-in-
20 sured plan);

21 (B) identified as paid for non-emergent
22 transport requiring prior authorization and
23 emergent transport;

24 (C) identified as paid for hospital-affiliated
25 providers and independent providers;

1 (D) identified as paid for rural transport
2 and urban transport;

3 (E) identified as provided using rotor
4 transport and fixed wing transport; and

5 (F) identified as furnished by a provider of
6 emergency air medical services that has a con-
7 tractual relationship with the plan or coverage
8 of an individual for which such item or service
9 is provided and such a provider that does not
10 have a contractual relationship with the plan or
11 coverage or such an individual; and

12 (2) cost data for an air ambulance service fur-
13 nished by such a provider of emergency air medical
14 services that the Secretary of Health and Human
15 Services, in consultation with suppliers and pro-
16 viders of such services, determines appropriate, sepa-
17 rated by the cost of air travel and the cost of emer-
18 gency medical services and supplies.

19 (c) RULEMAKING.—Not later than 1 year after the
20 date of the enactment of this Act, the Secretary of Health
21 and Human Services shall determine the form and manner
22 for submitting the information described in subsection (b)
23 through notice and comment rulemaking.

24 (d) CIVIL MONETARY PENALTIES.—

1 (1) IN GENERAL.—A provider of emergency air
2 medical services who violates the requirements of
3 subsection (a)(1) shall be subject to a civil monetary
4 penalty of not more than \$10,000 for each act con-
5 stituting such violation.

6 (2) PROCEDURE.—The provisions of section
7 1128A of the Social Security Act (42 U.S.C. 1320a-
8 7a) (other than subsection (a), subsection (b), the
9 first sentence of subsection (c)(1) of such subsection,
10 and subsection (o)) shall apply to civil monetary
11 penalties under this subsection in the same manner
12 as such provisions apply to a penalty or proceeding
13 under such section.

14 (e) REPORTING.—

15 (1) SECRETARY OF HEALTH AND HUMAN SERV-
16 ICES.—Not later than July 1, 2023, the Secretary of
17 Health and Human Services shall submit to Con-
18 gress a report summarizing the information specified
19 in subsection (b).

20 (2) COMPTROLLER GENERAL.—Not later than
21 July 1, 2023, the Comptroller General of the United
22 States shall submit to Congress a report that in-
23 cludes—

1 (A) an analysis of the cost variation of
2 suppliers and providers emergency air ambu-
3 lance services by geography and status; and

4 (B) any other recommendations the Comp-
5 troller General determines appropriate, which
6 may include a recommendation of an adequate
7 amount of reimbursement for such services that
8 reflects operational costs of providers in order
9 to preserve access to emergency air ambulance
10 services.

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

14 **SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.**

15 Not later than 2 years after the date of the enact-
16 ment of this Act, the Comptroller General of the United
17 States shall submit to Congress a report summarizing the
18 effects of the provisions of this Act, including the amend-
19 ments made by such provisions, on changes during such
20 period in health care provider networks of group health
21 plans and health insurance coverage offered by a health
22 insurance issuer in the group or individual market, in fee
23 schedules and amounts for health care services, and to
24 contracted rates under such plans or coverage. Such re-
25 port shall—

1 (1) to the extent practicable, sample a statis-
2 tically significant group of national health care pro-
3 viders; and

4 (2) examine—

5 (A) provider network participation, includ-
6 ing nonparticipating providers furnishing items
7 and services at participating facilities;

8 (B) health care provider group network
9 participation, including specialty, size, and own-
10 ership; and

11 (C) the impact of State surprise billing
12 laws and network adequacy standards on par-
13 ticipation of health care providers and facilities
14 in provider networks of group health plans and
15 of health insurance coverage offered by health
16 insurance issuers in the group or individual
17 market.

