

[DISCUSSION DRAFT]

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DIVISION _____

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1 **TITLE I—NO SURPRISES ACT**

2 **SEC. 101. SHORT TITLE.**

3 This title may be cited as the “No Surprises Act”.

4 **SEC. 102. HEALTH INSURANCE REQUIREMENTS REGARD-**
5 **ING SURPRISE MEDICAL BILLING.**

6 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

7 (1) IN GENERAL.—Title XXVII of the Public
8 Health Service Act (42 U.S.C. 300gg–11 et seq.) is
9 amended by adding at the end the following new
10 part:

11 **“PART D—ADDITIONAL COVERAGE PROVISIONS**

12 **“SEC. 2799A–1. PREVENTING SURPRISE MEDICAL BILLS.**

13 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

1 “(B) whether the health care provider fur-
2 nishing such services is a participating provider
3 or a participating emergency facility, as appli-
4 cable, with respect to such services;

5 “(C) in a manner so that, if such services
6 are provided to a participant, beneficiary, or en-
7 rollee by a nonparticipating provider or a non-
8 participating emergency facility—

9 “(i) such services will be provided
10 without imposing any requirement under
11 the plan or coverage for prior authoriza-
12 tion of services or any limitation on cov-
13 erage that is more restrictive than the re-
14 quirements or limitations that apply to
15 emergency services received from partici-
16 pating providers and participating emer-
17 gency facilities with respect to such plan or
18 coverage, respectively;

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

24 “(iii) such cost-sharing requirement is
25 calculated as if the total amount that

1 would have been charged for such services
2 by such participating provider or partici-
3 pating emergency facility were equal to the
4 recognized amount (as defined in para-
5 graph (3)(H)) for such services, plan or
6 coverage, and year;

7 “(iv) the group health plan or health
8 insurance issuer, respectively, pays directly
9 to such provider or facility, respectively (in
10 a time and manner that ensures such pro-
11 vider or facility can comply with section
12 2799B–10 and, if applicable, in accordance
13 with the timing requirement described in
14 subsection (c)(6)) the amount by which the
15 out-of-network rate (as defined in para-
16 graph (3)(K)) for such services exceeds the
17 cost-sharing amount for such services (as
18 determined in accordance with clauses (ii)
19 and (iii)) and year; and

20 “(v) any cost-sharing payments made
21 by the participant, beneficiary, or enrollee
22 with respect to such emergency services so
23 furnished shall be counted toward any in-
24 network deductible or out-of-pocket maxi-
25 mums applied under the plan or coverage,

1 respectively (and such in-network deduct-
2 ible and out-of-pocket maximums shall be
3 applied) in the same manner as if such
4 cost-sharing payments were made with re-
5 spect to emergency services furnished by a
6 participating provider or a participating
7 emergency facility; and

8 “(D) without regard to any other term or
9 condition of such coverage (other than exclusion
10 or coordination of benefits, or an affiliation or
11 waiting period, permitted under section 2704 of
12 this Act, including as incorporated pursuant to
13 section 715 of the Employee Retirement Income
14 Security Act of 1974 and section 9815 of the
15 Internal Revenue Code of 1986, and other than
16 applicable cost-sharing).

17 “(2) AUDIT PROCESS AND REGULATIONS FOR
18 QUALIFYING PAYMENT AMOUNTS.—

19 “(A) AUDIT PROCESS.—

20 “(i) IN GENERAL.—Not later than
21 July 1, 2021, the Secretary, in consulta-
22 tion with the Secretary of Labor and the
23 Secretary of the Treasury, shall establish
24 through rulemaking a process, in accord-
25 ance with clause (ii), under which group

1 health plans and health insurance issuers
2 offering group or individual health insur-
3 ance coverage are audited by the Secretary
4 or applicable State authority to ensure
5 that—

6 “(I) such plans and coverage are
7 in compliance with the requirement of
8 applying a qualifying payment amount
9 under this section; and

10 “(II) such qualifying payment
11 amount so applied satisfies the defini-
12 tion under paragraph (3)(E) with re-
13 spect to the year involved, including
14 with respect to a group health plan or
15 health insurance issuer described in
16 clause (ii) of such paragraph (3)(E).

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, with respect to
22 a year (beginning with 2022), of a
23 sample with respect to such year of
24 claims data from not more than 25
25 group health plans and health insur-

1 ance issuers offering group or indi-
2 vidual health insurance coverage; and

3 “**(II)** may audit any group health
4 plan or health insurance issuer offer-
5 ing group or individual health insur-
6 ance coverage if the Secretary has re-
7 ceived any complaint about such plan
8 or coverage, respectively, that involves
9 the compliance of the plan or cov-
10 erage, respectively, with either of the
11 requirements described in subclauses
12 **(I)** and **(II)** of such clause.

13 “**(iii) REPORTS.**—Beginning for 2022,
14 the Secretary shall annually submit to
15 Congress a report on the number of plans
16 and issuers with respect to which audits
17 were conducted during such year pursuant
18 to this subparagraph.

19 “**(B) RULEMAKING.**—Not later than July
20 1, 2021, the Secretary, in consultation with the
21 Secretary of Labor and the Secretary of the
22 Treasury, shall establish through rulemaking—

23 “(i) the methodology the group health
24 plan or health insurance issuer offering
25 group or individual health insurance cov-

1 erage shall use to determine the qualifying
2 payment amount, differentiating by indi-
3 vidual market, large group market, and
4 small group market;

5 “(ii) the information such plan or
6 issuer, respectively, shall share with the
7 nonparticipating provider or nonpartici-
8 pating facility, as applicable, when making
9 such a determination;

10 “(iii) the geographic regions applied
11 for purposes of this subparagraph, taking
12 into account access to items and services in
13 rural and underserved areas, including
14 health professional shortage areas, as de-
15 fined in section 332; and

16 “(iv) a process to receive complaints
17 of violations of the requirements described
18 in subclauses (I) and (II) of subparagraph
19 (A)(i) by group health plans and health in-
20 surance issuers offering group or indi-
21 vidual health insurance coverage.

22 Such rulemaking shall take into account pay-
23 ments that are made by such plan or issuer, re-
24 spectively, that are not on a fee-for-service
25 basis. Such methodology may account for rel-

1 evant payment adjustments that take into ac-
2 count quality or facility type (including higher
3 acuity settings and the case-mix of various fa-
4 cility types) that are otherwise taken into ac-
5 count for purposes of determining payment
6 amounts with respect to participating facilities.
7 In carrying out clause (iii), the Secretary shall
8 consult with the National Association of Insur-
9 ance Commissioners to establish the geographic
10 regions under such clause and shall periodically
11 update such regions, as appropriate, taking into
12 account the findings of the report submitted
13 under section 109(a) of the No Surprises Act.

14 “(3) DEFINITIONS.—In this part and part E:

15 “(A) EMERGENCY DEPARTMENT OF A HOS-
16 PITAL.—The term ‘emergency department of a
17 hospital’ includes a hospital outpatient depart-
18 ment that provides emergency services (as de-
19 fined in subparagraph (C)(i)).

20 “(B) EMERGENCY MEDICAL CONDITION.—
21 The term ‘emergency medical condition’ means
22 a medical condition manifesting itself by acute
23 symptoms of sufficient severity (including se-
24 vere pain) such that a prudent layperson, who
25 possesses an average knowledge of health and

1 medicine, could reasonably expect the absence
2 of immediate medical attention to result in a
3 condition described in clause (i), (ii), or (iii) of
4 section 1867(e)(1)(A) of the Social Security
5 Act.

6 “(C) EMERGENCY SERVICES.—

7 “(i) IN GENERAL.—The term ‘emer-
8 gency services’, with respect to an emer-
9 gency medical condition, means—

10 “(I) a medical screening exam-
11 ination (as required under section
12 1867 of the Social Security Act, or as
13 would be required under such section
14 if such section applied to an inde-
15 pendent freestanding emergency de-
16 partment) that is within the capability
17 of the emergency department of a hos-
18 pital or of an independent free-
19 standing emergency department, as
20 applicable, including ancillary services
21 routinely available to the emergency
22 department to evaluate such emer-
23 gency medical condition; and

24 “(II) within the capabilities of
25 the staff and facilities available at the

1 hospital or the independent free-
2 standing emergency department, as
3 applicable, such further medical exam-
4 ination and treatment as are required
5 under section 1867 of such Act, or as
6 would be required under such section
7 if such section applied to an inde-
8 pendent freestanding emergency de-
9 partment, to stabilize the patient (re-
10 gardless of the department of the hos-
11 pital in which such further examina-
12 tion or treatment is furnished).

13 “(ii) INCLUSION OF ADDITIONAL
14 SERVICES.—

15 “(I) IN GENERAL.—For purposes
16 of this subsection and section 2799B-
17 1, in the case of a participant, bene-
18 ficiary, or enrollee who is in a group
19 health plan or group or individual
20 health insurance coverage offered by a
21 health insurance issuer and who is
22 furnished services described in clause
23 (i) with respect to an emergency med-
24 ical condition, the term ‘emergency
25 services’ shall include, unless each of

1 the conditions described in subclause
2 (II) are met, in addition to the items
3 and services described in clause (i),
4 items and services—

5 “(aa) for which benefits are
6 provided or covered under the
7 plan or coverage, respectively;
8 and

9 “(bb) that are furnished by
10 a nonparticipating provider or
11 nonparticipating emergency facil-
12 ity (regardless of the department
13 of the hospital in which such
14 items or services are furnished)
15 after the participant, beneficiary,
16 or enrollee is stabilized and as
17 part of outpatient observation or
18 an inpatient or outpatient stay
19 with respect to the visit in which
20 the services described in clause
21 (i) are furnished.

22 “(II) CONDITIONS.—For pur-
23 poses of subclause (I), the conditions
24 described in this subclause, with re-
25 spect to a participant, beneficiary, or

1 enrollee who is stabilized and fur-
2 nished additional items and services
3 described in subclause (I) after such
4 stabilization by a provider or facility
5 described in subclause (I), are the fol-
6 lowing;

7 “(aa) Such a provider or fa-
8 cility determines such individual
9 is able to travel using nonmedical
10 transportation or nonemergency
11 medical transportation.

12 “(bb) Such provider fur-
13 nishing such additional items and
14 services satisfies the notice and
15 consent criteria of section
16 2799B–2(d) with respect to such
17 items and services.

18 “(cc) Such an individual is
19 in a condition to receive (as de-
20 termined in accordance with
21 guidelines issued by the Sec-
22 retary pursuant to rulemaking)
23 the information described in sec-
24 tion 2799B–2 and to provide in-
25 formed consent under such sec-

1 tion, in accordance with applica-
2 ble State law.

3 “(dd) Such other conditions,
4 as specified by the Secretary,
5 such as conditions relating to co-
6 ordinating care transitions to
7 participating providers and facili-
8 ties.

9 “(D) INDEPENDENT FREESTANDING
10 EMERGENCY DEPARTMENT.—The term ‘inde-
11 pendent freestanding emergency department’
12 means a health care facility that—

13 “(i) is geographically separate and
14 distinct and licensed separately from a hos-
15 pital under applicable State law; and

16 “(ii) provides any of the emergency
17 services (as defined in subparagraph
18 (C)(i)).

19 “(E) QUALIFYING PAYMENT AMOUNT.—

20 “(i) IN GENERAL.—The term ‘quali-
21 fying payment amount’ means, subject to
22 clauses (ii) and (iii), with respect to a
23 sponsor of a group health plan and health
24 insurance issuer offering group or indi-
25 vidual health insurance coverage—

1 “(I) for an item or service fur-
2 nished during 2022, the median of the
3 contracted rates recognized by the
4 plan or issuer, respectively (deter-
5 mined with respect to all such plans
6 of such sponsor or all such coverage
7 offered by such issuer that are offered
8 within the same insurance market
9 (specified in subclause (I), (II), (III),
10 or (IV) of clause (iv)) as the plan or
11 coverage) as the total maximum pay-
12 ment (including the cost-sharing
13 amount imposed for such item or
14 service and the amount to be paid by
15 the plan or issuer, respectively) under
16 such plans or coverage, respectively,
17 on January 31, 2019, for the same or
18 a similar item or service that is pro-
19 vided by a provider in the same or
20 similar specialty and provided in the
21 geographic region in which the item or
22 service is furnished, consistent with
23 the methodology established by the
24 Secretary under paragraph (2)(B), in-
25 creased by the percentage increase in

1 the consumer price index for all urban
2 consumers (United States city aver-
3 age) over 2019, such percentage in-
4 crease over 2020, and such percentage
5 increase over 2021; and

6 “(II) for an item or service fur-
7 nished during 2023 or a subsequent
8 year, the qualifying payment amount
9 determined under this clause for such
10 an item or service furnished in the
11 previous year, increased by the per-
12 centage increase in the consumer price
13 index for all urban consumers (United
14 States city average) over such pre-
15 vious year.

16 “(ii) NEW PLANS AND COVERAGE.—
17 The term ‘qualifying payment amount’
18 means, with respect to a sponsor of a
19 group health plan or health insurance
20 issuer offering group or individual health
21 insurance coverage in a geographic region
22 in which such sponsor or issuer, respec-
23 tively, did not offer any group health plan
24 or health insurance coverage during
25 2019—

1 “(I) for the first year in which
2 such group health plan, group health
3 insurance coverage, or individual
4 health insurance coverage, respec-
5 tively, is offered in such region, a rate
6 (determined in accordance with a
7 methodology established by the Sec-
8 retary) for items and services that are
9 covered by such plan or coverage and
10 furnished during such first year; and

11 “(II) for each subsequent year
12 such group health plan, group health
13 insurance coverage, or individual
14 health insurance coverage, respec-
15 tively, is offered in such region, the
16 qualifying payment amount deter-
17 mined under this clause for such
18 items and services furnished in the
19 previous year, increased by the per-
20 centage increase in the consumer price
21 index for all urban consumers (United
22 States city average) over such pre-
23 vious year.

24 “(iii) INSUFFICIENT INFORMATION;
25 NEWLY COVERED ITEMS AND SERVICES.—

1 In the case of a sponsor of a group health
2 plan or health insurance issuer offering
3 group or individual health insurance cov-
4 erage that does not have sufficient infor-
5 mation to calculate the median of the con-
6 tracted rates described in clause (i)(I) in
7 2019 (or, in the case of a newly covered
8 item or service (as defined in clause
9 (v)(III)), in the first coverage year (as de-
10 fined in clause (v)(I)) for such item or
11 service with respect to such plan or cov-
12 erage) for an item or service (including
13 with respect to provider type, or amount,
14 of claims for items or services (as deter-
15 mined by the Secretary) provided in a par-
16 ticular geographic region (other than in a
17 case with respect to which clause (ii) ap-
18 plies)) the term ‘qualifying payment
19 amount’—

20 “(I) for an item or service fur-
21 nished during 2022 (or, in the case of
22 a newly covered item or service, dur-
23 ing the first coverage year for such
24 item or service with respect to such
25 plan or coverage), means such rate for

1 such item or service determined by
2 the sponsor or issuer, respectively,
3 through use of any database that is
4 determined, in accordance with rule-
5 making described in paragraph
6 (2)(B), to not have any conflicts of in-
7 terest and to have sufficient informa-
8 tion reflecting allowed amounts paid
9 to a health care provider or facility for
10 relevant services furnished in the ap-
11 plicable geographic region (such as a
12 State all-payer claims database);

13 “(II) for an item or service fur-
14 nished in a subsequent year (before
15 the first sufficient information year
16 (as defined in clause (v)(II)) for such
17 item or service with respect to such
18 plan or coverage), means the rate de-
19 termined under subclause (I) or this
20 subclause, as applicable, for such item
21 or service for the year previous to
22 such subsequent year, increased by
23 the percentage increase in the con-
24 sumer price index for all urban con-

1 sumers (United States city average)
2 over such previous year;

3 “(III) for an item or service fur-
4 nished in the first sufficient informa-
5 tion year for such item or service with
6 respect to such plan or coverage, has
7 the meaning given the term qualifying
8 payment amount in clause (i)(I), ex-
9 cept that in applying such clause to
10 such item or service, the reference to
11 ‘furnished during 2022’ shall be treat-
12 ed as a reference to furnished during
13 such first sufficient information year,
14 the reference to ‘in 2019’ shall be
15 treated as a reference to such suffi-
16 cient information year, and the in-
17 crease described in such clause shall
18 not be applied; and

19 “(IV) for an item or service fur-
20 nished in any year subsequent to the
21 first sufficient information year for
22 such item or service with respect to
23 such plan or coverage, has the mean-
24 ing given such term in clause (i)(II),
25 except that in applying such clause to

1 such item or service, the reference to
2 ‘furnished during 2023 or a subse-
3 quent year’ shall be treated as a ref-
4 erence to furnished during the year
5 after such first sufficient information
6 year or a subsequent year.

7 “(iv) INSURANCE MARKET.—For pur-
8 poses of clause (i)(I), a health insurance
9 market specified in this clause is one of the
10 following:

11 “(I) The individual market.

12 “(II) The large group market
13 (other than plans described in sub-
14 clause (IV)).

15 “(III) The small group market
16 (other than plans described in sub-
17 clause (IV)).

18 “(IV) In the case of a self-in-
19 sured group health plan, other self-in-
20 sured group health plans.

21 “(v) DEFINITIONS.—For purposes of
22 this subparagraph:

23 “(I) FIRST COVERAGE YEAR.—
24 The term ‘first coverage year’ means,
25 with respect to a group health plan or

1 group or individual health insurance
2 coverage offered by a health insurance
3 issuer and an item or service for
4 which coverage is not offered in 2019
5 under such plan or coverage, the first
6 year after 2019 for which coverage for
7 such item or service is offered under
8 such plan or health insurance cov-
9 erage.

10 “(II) FIRST SUFFICIENT INFOR-
11 MATION YEAR.—The term ‘first suffi-
12 cient information year’ means, with
13 respect to a group health plan or
14 group or individual health insurance
15 coverage offered by a health insurance
16 issuer—

17 “(aa) in the case of an item
18 or service for which the plan or
19 coverage does not have sufficient
20 information to calculate the me-
21 dian of the contracted rates de-
22 scribed in clause (i)(I) in 2019,
23 the first year subsequent to 2022
24 for which the sponsor or issuer
25 has such sufficient information to

1 calculate the median of such con-
2 tracted rates in the year previous
3 to such first subsequent year;
4 and

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

16 “(III) NEWLY COVERED ITEM OR
17 SERVICE.—The term ‘newly covered
18 item or service’ means, with respect to
19 a group health plan or group or indi-
20 vidual health insurance issuer offering
21 health insurance coverage, an item or
22 service for which coverage was not of-
23 fered in 2019 under such plan or cov-
24 erage, but is offered under such plan
25 or coverage in a year after 2019.

1 “(F) NONPARTICIPATING EMERGENCY FA-
2 CILITY; PARTICIPATING EMERGENCY FACIL-
3 ITY.—

4 “(i) NONPARTICIPATING EMERGENCY
5 FACILITY.—The term ‘nonparticipating
6 emergency facility’ means, with respect to
7 an item or service and a group health plan
8 or group or individual health insurance
9 coverage offered by a health insurance
10 issuer, an emergency department of a hos-
11 pital, or an independent freestanding emer-
12 gency department, that does not have a
13 contractual relationship directly or indi-
14 rectly with the plan or issuer, respectively,
15 for furnishing such item or service under
16 the plan or coverage, respectively.

17 “(ii) PARTICIPATING EMERGENCY FA-
18 CILITY.—The term ‘participating emer-
19 gency facility’ means, with respect to an
20 item or service and a group health plan or
21 group or individual health insurance cov-
22 erage offered by a health insurance issuer,
23 an emergency department of a hospital, or
24 an independent freestanding emergency de-
25 partment, that has a contractual relation-

1 ship directly or indirectly with the plan or
2 issuer, respectively, with respect to the fur-
3 nishing of such an item or service at such
4 facility.

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

7 “(i) NONPARTICIPATING PROVIDER.—

8 The term ‘nonparticipating provider’
9 means, with respect to an item or service
10 and a group health plan or group or indi-
11 vidual health insurance coverage offered by
12 a health insurance issuer, a physician or
13 other health care provider who is acting
14 within the scope of practice of that pro-
15 vider’s license or certification under appli-
16 cable State law and who does not have a
17 contractual relationship with the plan or
18 issuer, respectively, for furnishing such
19 item or service under the plan or coverage,
20 respectively.

21 “(ii) PARTICIPATING PROVIDER.—The
22 term ‘participating provider’ means, with
23 respect to an item or service and a group
24 health plan or group or individual health
25 insurance coverage offered by a health in-

1 surance issuer, a physician or other health
2 care provider who is acting within the
3 scope of practice of that provider’s license
4 or certification under applicable State law
5 and who has a contractual relationship
6 with the plan or issuer, respectively, for
7 furnishing such item or service under the
8 plan or coverage, respectively.

9 “(H) RECOGNIZED AMOUNT.—The term
10 ‘recognized amount’ means, with respect to an
11 item or service furnished by a nonparticipating
12 provider or emergency facility during a year
13 and a group health plan or group or individual
14 health insurance coverage offered by a health
15 insurance issuer—

16 “(i) subject to clause (iii), in the case
17 of such item or service furnished in a State
18 that has in effect a specified State law
19 with respect to such plan, coverage, or
20 issuer, respectively; such a nonparticipating
21 provider or emergency facility; and
22 such an item or service, the amount deter-
23 mined in accordance with such law;

24 “(ii) subject to clause (iii), in the case
25 of such item or service furnished in a State

1 that does not have in effect a specified
2 State law, with respect to such plan, cov-
3 erage, or issuer, respectively; such a non-
4 participating provider or emergency facil-
5 ity; and such an item or service, the
6 amount that is the qualifying payment
7 amount (as defined in subparagraph (E))
8 for such year and determined in accord-
9 ance with rulemaking described in para-
10 graph (2)(B)) for such item or service; or

11 “(iii) in the case of such item or serv-
12 ice furnished in a State with an All-Payer
13 Model Agreement under section 1115A of
14 the Social Security Act, the amount that
15 the State approves under such system for
16 such item or service so furnished.

17 “(I) SPECIFIED STATE LAW.—The term
18 ‘specified State law’ means, with respect to a
19 State, an item or service furnished by a non-
20 participating provider or emergency facility dur-
21 ing a year and a group health plan or group or
22 individual health insurance coverage offered by
23 a health insurance issuer, a State law that pro-
24 vides for a method for determining the total
25 amount payable under such a plan, coverage, or

1 issuer, respectively (to the extent such State
2 law applies to such plan, coverage, or issuer,
3 subject to section 514 of the Employee Retirement
4 Income Security Act of 1974) in the case
5 of a participant, beneficiary, or enrollee covered
6 under such plan or coverage and receiving such
7 item or service from such a nonparticipating
8 provider or emergency facility.

9 “(J) STABILIZE.—The term ‘to stabilize’,
10 with respect to an emergency medical condition
11 (as defined in subparagraph (B)), has the
12 meaning give in section 1867(e)(3) of the Social
13 Security Act (42 U.S.C. 1395dd(e)(3)).

14 “(K) OUT-OF-NETWORK RATE.—The term
15 ‘out-of-network rate’ means, with respect to an
16 item or service furnished in a State during a
17 year to a participant, beneficiary, or enrollee of
18 a group health plan or group or individual
19 health insurance coverage offered by a health
20 insurance issuer receiving such item or service
21 from a nonparticipating provider or facility—

22 “(i) subject to clause (iii), in the case
23 of such item or service furnished in a State
24 that has in effect a specified State law
25 with respect to such plan, coverage, or

1 issuer, respectively; such a nonparticipating provider or emergency facility; and
2 such an item or service, the amount determined in accordance with such law;
3
4

5 “(ii) subject to clause (iii), in the case
6 such State does not have in effect such a
7 law with respect to such item or service,
8 plan, and provider or facility—

9 “(I) subject to subclause (II), if
10 the provider or facility (as applicable)
11 and such plan or coverage agree on an
12 amount of payment (including if
13 agreed on through open negotiations
14 under subsection (c)(1)) with respect
15 to such item or service, such agreed
16 on amount; or

17 “(II) if such provider or facility
18 (as applicable) and such plan or coverage enter the independent dispute
19 resolution process under subsection
20 (c) and do not so agree before the
21 date on which a certified independent
22 entity (as defined in paragraph (4) of
23 such subsection) makes a determination
24 with respect to such item or serv-
25

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

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

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

12 “(b) COVERAGE OF NON-EMERGENCY SERVICES
13 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
14 TAIN PARTICIPATING FACILITIES.—

15 “(1) IN GENERAL.—In the case of items or
16 services (other than emergency services to which
17 subsection (a) applies) for which any benefits are
18 provided or covered by a group health plan or health
19 insurance issuer offering group or individual health
20 insurance coverage furnished to a participant, bene-
21 ficiary, or enrollee of such plan or coverage by a
22 nonparticipating provider (as defined in subsection
23 (a)(3)(G)(i)) (and who, with respect to such items
24 and services, has not satisfied the notice and consent
25 criteria of section 2799B–2(d)) with respect to a

1 visit (as defined by the Secretary in accordance with
2 paragraph (2)(B)) at a participating health care fa-
3 cility (as defined in paragraph (2)(A)), with respect
4 to such plan or coverage, respectively, the plan or
5 coverage, respectively—

6 “(A) shall not impose on such participant,
7 beneficiary, or enrollee a cost-sharing require-
8 ment for such items and services so furnished
9 that is greater than the cost-sharing require-
10 ment that would apply under such plan or cov-
11 erage, respectively, had such items or services
12 been furnished by a participating provider (as
13 defined in subsection (a)(3)(G)(ii));

14 “(B) shall calculate such cost-sharing re-
15 quirement as if the total amount that would
16 have been charged for such items and services
17 by such participating provider were equal to the
18 recognized amount (as defined in subsection
19 (a)(3)(H)) for such items and services, plan or
20 coverage, and year;

21 “(C) shall pay directly, in accordance with
22 timing consistent with the requirements under
23 section 2799B–10 and, if applicable, in accord-
24 ance with the timing requirement described in
25 subsection (e)(6), to such provider furnishing

1 such items and services to such participant,
2 beneficiary, or enrollee the amount by which the
3 out-of-network rate (as defined in subsection
4 (a)(3)(K)) for such items and services involved
5 exceeds the cost-sharing amount imposed under
6 the plan or coverage, respectively, for such
7 items and services (as determined in accordance
8 with subparagraphs (A) and (B)) and year; and

9 “(D) shall count toward any in-network
10 deductible and in-network out-of-pocket maxi-
11 mums (as applicable) applied under the plan or
12 coverage, respectively, any cost-sharing pay-
13 ments made by the participant, beneficiary, or
14 enrollee (and such in-network deductible and
15 out-of-pocket maximums shall be applied) with
16 respect to such items and services so furnished
17 in the same manner as if such cost-sharing pay-
18 ments were with respect to items and services
19 furnished by a participating provider.

20 “(2) DEFINITIONS.—In this section:

21 “(A) PARTICIPATING HEALTH CARE FACIL-
22 ITY.—

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

1 health plan or health insurance issuer of-
2 fering group or individual health insurance
3 coverage, a health care facility described in
4 clause (ii) that has a direct or indirect con-
5 tractual relationship with the plan or
6 issuer, respectively, with respect to the fur-
7 nishing of such an item or service at the
8 facility.

9 “(ii) HEALTH CARE FACILITY DE-
10 SCRIBED.—A health care facility described
11 in this clause, with respect to a group
12 health plan or group or individual health
13 insurance coverage, is each of the fol-
14 lowing:

15 “(I) A hospital (as defined in
16 1861(e) of the Social Security Act).

17 “(II) A hospital outpatient de-
18 partment.

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

22 “(IV) An ambulatory surgical
23 center described in section
24 1833(i)(1)(A) of such Act.

1 “(V) Any other facility, specified
2 by the Secretary, that provides items
3 or services for which coverage is pro-
4 vided under the plan or coverage, re-
5 spectively.

6 “(B) VISIT.—The term ‘visit’ shall, with
7 respect to items and services furnished to an in-
8 dividual at a health care facility, include equip-
9 ment and devices, telemedicine services, imag-
10 ing services, laboratory services, preoperative
11 and postoperative services, and such other items
12 and services as the Secretary may specify, re-
13 gardless of whether or not the provider fur-
14 nishing such items or services is at the facility.

15 “(c) CERTAIN ACCESS FEES TO CERTAIN DATA-
16 BASES.—In the case of a sponsor of a group health plan
17 or health insurance issuer offering group or individual
18 health insurance coverage that, pursuant to subsection
19 (a)(3)(E)(iii), uses a database described in such sub-
20 section to determine a rate to apply under such subsection
21 for an item or service by reason of having insufficient in-
22 formation described in such subsection with respect to
23 such item or service, such sponsor or issuer shall cover
24 the cost for access to such database.”.

1 (2) TRANSFER AMENDMENT.—Part D of title
2 XXVII of the Public Health Service Act, as added
3 by paragraph (1), is amended by adding at the end
4 the following new section:

5 **“SEC. 2799A-7. OTHER PATIENT PROTECTIONS.**

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

14 “(b) ACCESS TO PEDIATRIC CARE.—

15 “(1) PEDIATRIC CARE.—In the case of a person
16 who has a child who is a participant, beneficiary, or
17 enrollee under a group health plan, or group or indi-
18 vidual health insurance coverage offered by a health
19 insurance issuer, if the plan or issuer requires or
20 provides for the designation of a participating pri-
21 mary care provider for the child, the plan or issuer
22 shall permit such person to designate a physician
23 (allopathic or osteopathic) who specializes in pediat-
24 rics as the child’s primary care provider if such pro-

1 vider participates in the network of the plan or
2 issuer.

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

8 “(c) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
9 COLOGICAL CARE.—

10 “(1) GENERAL RIGHTS.—

11 “(A) DIRECT ACCESS.—A group health
12 plan, or health insurance issuer offering group
13 or individual health insurance coverage, de-
14 scribed in paragraph (2) may not require au-
15 thorization or referral by the plan, issuer, or
16 any person (including a primary care provider
17 described in paragraph (2)(B)) in the case of a
18 female participant, beneficiary, or enrollee who
19 seeks coverage for obstetrical or gynecological
20 care provided by a participating health care
21 professional who specializes in obstetrics or
22 gynecology. Such professional shall agree to
23 otherwise adhere to such plan’s or issuer’s poli-
24 cies and procedures, including procedures re-
25 garding referrals and obtaining prior authoriza-

1 tion and providing services pursuant to a treat-
2 ment plan (if any) approved by the plan or
3 issuer.

4 “(B) OBSTETRICAL AND GYNECOLOGICAL
5 CARE.—A group health plan or health insur-
6 ance issuer described in paragraph (2) shall
7 treat the provision of obstetrical and gynecolo-
8 gical care, and the ordering of related obstet-
9 rical and gynecological items and services, pur-
10 suant to the direct access described under sub-
11 paragraph (A), by a participating health care
12 professional who specializes in obstetrics or
13 gynecology as the authorization of the primary
14 care provider.

15 “(2) APPLICATION OF PARAGRAPH.—A group
16 health plan, or health insurance issuer offering
17 group or individual health insurance coverage, de-
18 scribed in this paragraph is a group health plan or
19 health insurance coverage that—

20 “(A) provides coverage for obstetric or
21 gynecologic care; and

22 “(B) requires the designation by a partici-
23 pant, beneficiary, or enrollee of a participating
24 primary care provider.

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

3 “(A) waive any exclusions of coverage
4 under the terms and conditions of the plan or
5 health insurance coverage with respect to cov-
6 erage of obstetrical or gynecological care; or

7 “(B) preclude the group health plan or
8 health insurance issuer involved from requiring
9 that the obstetrical or gynecological provider
10 notify the primary care health care professional
11 or the plan or issuer of treatment decisions.”.

12 (3) CONFORMING AMENDMENTS.—

13 (A) Section 2719A of the Public Health
14 Service Act (300gg–19a) is amended by adding
15 at the end the following new subsection:

16 “(e) APPLICATION.—The provisions of this section
17 shall not apply with respect to a group health plan, health
18 insurance issuers, or group or individual health insurance
19 coverage beginning on January 1, 2022.”.

20 (B) Section 2722 of the Public Health
21 Service Act (42 U.S.C. 300gg–21) is amend-
22 ed—

23 (i) in subsection (a)(1), by inserting
24 “and part D” after “subparts 1 and 2”;

1 (ii) in subsection (b), by inserting
2 “and part D” after “subparts 1 and 2”;

3 (iii) in subsection (c)(1), by inserting
4 “and part D” after “subparts 1 and 2”;

5 (iv) in subsection (c)(2), by inserting
6 “and part D” after “subparts 1 and 2”;

7 (v) in subsection (c)(3), by inserting
8 “and part D” after “this part”; and

9 (vi) in subsection (d), in the matter
10 preceding paragraph (1), by inserting “and
11 part D” after “this part”.

12 (C) Section 2723 of the Public Health
13 Service Act (42 U.S.C. 300gg-22) is amend-
14 ed—

15 (i) in subsection (a)(1), by inserting
16 “and part D” after “this part”;

17 (ii) in subsection (a)(2), by inserting
18 “or part D” after “this part”;

19 (iii) in subsection (b)(1), by inserting
20 “or part D” after “this part”;

21 (iv) in subsection (b)(2)(A), by insert-
22 ing “or part D” after “this part”; and

23 (v) in subsection (b)(2)(C)(ii), by in-
24 serting “and part D” after “this part”.

1 (D) Section 2724 of the Public Health
2 Service Act (42 U.S.C. 300gg-23) is amend-
3 ed—

4 (i) in subsection (a)(1)—

5 (I) by striking “this part and
6 part C insofar as it relates to this
7 part” and inserting “this part, part
8 D, and part C insofar as it relates to
9 this part or part D”; and

10 (II) by inserting “or part D”
11 after “requirement of this part”;

12 (ii) in subsection (a)(2), by inserting
13 “or part D” after “this part”; and

14 (iii) in subsection (c), by inserting “or
15 part D” after “this part (other than sec-
16 tion 2704)”.

17 (b) ERISA AMENDMENTS.—

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

22 **“SEC. 716. PREVENTING SURPRISE MEDICAL BILLS.**

23 **“(a) COVERAGE OF EMERGENCY SERVICES.—**

24 **“(1) IN GENERAL.—**If a group health plan, or
25 a health insurance issuer offering group health in-

1 surance coverage, provides or covers any benefits
2 with respect to services in an emergency department
3 of a hospital or with respect to emergency services
4 in an independent freestanding emergency depart-
5 ment (as defined in paragraph (3)(D)), the plan or
6 issuer shall cover emergency services (as defined in
7 paragraph (3)(C))—

8 “(A) without the need for any prior au-
9 thorization determination;

10 “(B) whether the health care provider fur-
11 nishing such services is a participating provider
12 or a participating emergency facility, as appli-
13 cable, with respect to such services;

14 “(C) in a manner so that, if such services
15 are provided to a participant or beneficiary by
16 a nonparticipating provider or a nonpartici-
17 pating emergency facility—

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

1 spect to such plan or coverage, respec-
2 tively;

3 “(ii) the cost-sharing requirement is
4 not greater than the requirement that
5 would apply if such services were provided
6 by a participating provider or a partici-
7 pating emergency facility;

8 “(iii) such cost-sharing requirement is
9 calculated as if the total amount that
10 would have been charged for such services
11 by such participating provider or partici-
12 pating emergency facility were equal to the
13 recognized amount (as defined in para-
14 graph (3)(H)) for such services, plan or
15 coverage, and year;

16 “(iv) the group health plan or health
17 insurance issuer, respectively, pays directly
18 to such provider or facility, respectively (in
19 a time and manner that ensures such pro-
20 vider or facility can comply with section
21 2799B–10 of the Public Health Service
22 Act and, if applicable, in accordance with
23 the timing requirement described in sub-
24 section (c)(6)) the amount by which the
25 out-of-network rate (as defined in para-

1 graph (3)(K)) for such services exceeds the
2 cost-sharing amount for such services (as
3 determined in accordance with clauses (ii)
4 and (iii)) and year; and

5 “(v) any cost-sharing payments made
6 by the participant, beneficiary, or enrollee
7 with respect to such emergency services so
8 furnished shall be counted toward any in-
9 network deductible or out-of-pocket maxi-
10 mums applied under the plan or coverage,
11 respectively (and such in-network deduct-
12 ible and out-of-pocket maximums shall be
13 applied) in the same manner as if such
14 cost-sharing payments were made with re-
15 spect to emergency services furnished by a
16 participating provider or a participating
17 emergency facility; and

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

1 of 1986, and other than applicable cost-shar-
2 ing).

3 “(2) REGULATIONS FOR QUALIFYING PAYMENT
4 AMOUNTS.—Not later than July 1, 2021, the Sec-
5 retary, in consultation with the Secretary of the
6 Treasury and the Secretary of Health and Human
7 Services, shall establish through rulemaking—

8 “(A) the methodology the group health
9 plan or health insurance issuer offering health
10 insurance coverage in the group market shall
11 use to determine the qualifying payment
12 amount, differentiating by large group market,
13 and small group market;

14 “(B) the information such plan or issuer,
15 respectively, shall share with the nonpartici-
16 pating provider or nonparticipating facility, as
17 applicable, when making such a determination;

18 “(C) the geographic regions applied for
19 purposes of this subparagraph, taking into ac-
20 count access to items and services in rural and
21 underserved areas, including health professional
22 shortage areas, as defined in section 332 of the
23 Public Health Service Act; and

24 “(D) a process to receive complaints of vio-
25 lations of the requirements described in sub-

1 clauses (I) and (II) of subparagraph (A)(i) by
2 group health plans and health insurance issuers
3 offering health insurance coverage in the group
4 market.

5 Such rulemaking shall take into account payments
6 that are made by such plan or issuer, respectively,
7 that are not on a fee-for-service basis. Such method-
8 ology may account for relevant payment adjustments
9 that take into account quality or facility type (in-
10 cluding higher acuity settings and the case-mix of
11 various facility types) that are otherwise taken into
12 account for purposes of determining payment
13 amounts with respect to participating facilities. In
14 carrying out clause (iii), the Secretary shall consult
15 with the National Association of Insurance Commis-
16 sioners to establish the geographic regions under
17 such clause and shall periodically update such re-
18 gions, as appropriate, taking into account the find-
19 ings of the report submitted under section 109(a) of
20 the No Surprises Act.

21 “(3) DEFINITIONS.—In this subpart:

22 “(A) EMERGENCY DEPARTMENT OF A HOS-
23 PITAL.—The term ‘emergency department of a
24 hospital’ includes a hospital outpatient depart-

1 ment that provides emergency services (as de-
2 fined in subparagraph (C)(i)).

3 “(B) EMERGENCY MEDICAL CONDITION.—

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

14 “(C) EMERGENCY SERVICES.—

15 “(i) IN GENERAL.—The term ‘emer-
16 gency services’, with respect to an emer-
17 gency medical condition, means—

18 “(I) a medical screening exam-
19 ination (as required under section
20 1867 of the Social Security Act, or as
21 would be required under such section
22 if such section applied to an inde-
23 pendent freestanding emergency de-
24 partment) that is within the capability
25 of the emergency department of a hos-

1 pital or of an independent free-
2 standing emergency department, as
3 applicable, including ancillary services
4 routinely available to the emergency
5 department to evaluate such emer-
6 gency medical condition; and

7 “(II) within the capabilities of
8 the staff and facilities available at the
9 hospital or the independent free-
10 standing emergency department, as
11 applicable, such further medical exam-
12 ination and treatment as are required
13 under section 1867 of such Act, or as
14 would be required under such section
15 if such section applied to an inde-
16 pendent freestanding emergency de-
17 partment, to stabilize the patient (re-
18 gardless of the department of the hos-
19 pital in which such further examina-
20 tion or treatment is furnished).

21 “(ii) INCLUSION OF ADDITIONAL
22 SERVICES.—

23 “(I) IN GENERAL.—For purposes
24 of this subsection and section 2799B-
25 1 of the Public Health Service Act, in

1 the case of a participant, beneficiary,
2 or enrollee who is in a group health
3 plan or group health insurance cov-
4 erage offered by a health insurance
5 issuer and who is furnished services
6 described in clause (i) with respect to
7 an emergency medical condition, the
8 term ‘emergency services’ shall in-
9 clude, unless each of the conditions
10 described in subclause (II) are met, in
11 addition to the items and services de-
12 scribed in clause (i), items and serv-
13 ices—

14 “(aa) for which benefits are
15 provided or covered under the
16 plan or coverage, respectively;
17 and

18 “(bb) that are furnished by
19 a nonparticipating provider or
20 nonparticipating emergency facil-
21 ity (regardless of the department
22 of the hospital in which such
23 items or services are furnished)
24 after the participant, beneficiary,
25 or enrollee is stabilized and as

1 part of outpatient observation or
2 an inpatient or outpatient stay
3 with respect to the visit in which
4 the services described in clause
5 (i) are furnished.

6 “(II) CONDITIONS.—For pur-
7 poses of subclause (I), the conditions
8 described in this subclause, with re-
9 spect to a participant, beneficiary, or
10 enrollee who is stabilized and fur-
11 nished additional items and services
12 described in subclause (I) after such
13 stabilization by a provider or facility
14 described in subclause (I), are the fol-
15 lowing;

16 “(aa) Such a provider or fa-
17 cility determines such individual
18 is able to travel using nonmedical
19 transportation or nonemergency
20 medical transportation.

21 “(bb) Such provider fur-
22 nishing such additional items and
23 services satisfies the notice and
24 consent criteria of section

1 2799B–2(d) with respect to such
2 items and services.

3 “(cc) Such an individual is
4 in a condition to receive (as de-
5 termined in accordance with
6 guidelines issued by the Sec-
7 retary pursuant to rulemaking)
8 the information described in sec-
9 tion 2799B–2 and to provide in-
10 formed consent under such sec-
11 tion, in accordance with applica-
12 ble State law.

13 “(dd) Such other conditions,
14 as specified by the Secretary,
15 such as conditions relating to co-
16 ordinating care transitions to
17 participating providers and facili-
18 ties.

19 “(D) INDEPENDENT FREESTANDING
20 EMERGENCY DEPARTMENT.—The term ‘inde-
21 pendent freestanding emergency department’
22 means a health care facility that—

23 “(i) is geographically separate and
24 distinct and licensed separately from a hos-
25 pital under applicable State law; and

1 “(ii) provides any of the emergency
2 services (as defined in subparagraph
3 (C)(i)).

4 “(E) QUALIFYING PAYMENT AMOUNT.—

5 “(i) IN GENERAL.—The term ‘quali-
6 fying payment amount’ means, subject to
7 clauses (ii) and (iii), with respect to a
8 sponsor of a group health plan and health
9 insurance issuer offering group health in-
10 surance coverage—

11 “(I) for an item or service fur-
12 nished during 2022, the median of the
13 contracted rates recognized by the
14 plan or issuer, respectively (deter-
15 mined with respect to all such plans
16 of such sponsor or all such coverage
17 offered by such issuer that are offered
18 within the same insurance market
19 (specified in subclause (I), (II), or
20 (III) of clause (iv)) as the plan or cov-
21 erage) as the total maximum payment
22 (including the cost-sharing amount
23 imposed for such item or service and
24 the amount to be paid by the plan or
25 issuer, respectively) under such plans

1 or coverage, respectively, on January
2 31, 2019, for the same or a similar
3 item or service that is provided by a
4 provider in the same or similar spe-
5 cialty and provided in the geographic
6 region in which the item or service is
7 furnished, consistent with the method-
8 ology established by the Secretary
9 under paragraph (2), increased by the
10 percentage increase in the consumer
11 price index for all urban consumers
12 (United States city average) over
13 2019, such percentage increase over
14 2020, and such percentage increase
15 over 2021; and

16 “(II) for an item or service fur-
17 nished during 2023 or a subsequent
18 year, the qualifying payment amount
19 determined under this clause for such
20 an item or service furnished in the
21 previous year, increased by the per-
22 centage increase in the consumer price
23 index for all urban consumers (United
24 States city average) over such pre-
25 vious year.

1 “(ii) NEW PLANS AND COVERAGE.—

2 The term ‘qualifying payment amount’
3 means, with respect to a sponsor of a
4 group health plan or health insurance
5 issuer offering group health insurance cov-
6 erage in a geographic region in which such
7 sponsor or issuer, respectively, did not
8 offer any group health plan or health in-
9 surance coverage during 2019—

10 “(I) for the first year in which
11 such group health plan or health in-
12 surance coverage, respectively, is of-
13 fered in such region, a rate (deter-
14 mined in accordance with a method-
15 ology established by the Secretary) for
16 items and services that are covered by
17 such plan and furnished during such
18 first year; and

19 “(II) for each subsequent year
20 such group health plan or health in-
21 surance coverage, respectively, is of-
22 fered in such region, the qualifying
23 payment amount determined under
24 this clause for such items and services
25 furnished in the previous year, in-

1 creased by the percentage increase in
2 the consumer price index for all urban
3 consumers (United States city aver-
4 age) over such previous year.

5 “(iii) INSUFFICIENT INFORMATION;
6 NEWLY COVERED ITEMS AND SERVICES.—
7 In the case of a sponsor of a group health
8 plan or health insurance issuer offering
9 group health insurance coverage that does
10 not have sufficient information to calculate
11 the median of the contracted rates de-
12 scribed in clause (i)(I) in 2019 (or, in the
13 case of a newly covered item or service (as
14 defined in clause (v)(III)), in the first cov-
15 erage year (as defined in clause (v)(I)) for
16 such item or service with respect to such
17 plan or coverage) for an item or service
18 (including with respect to provider type, or
19 amount, of claims for items or services (as
20 determined by the Secretary) provided in a
21 particular geographic region (other than in
22 a case with respect to which clause (ii) ap-
23 plies)) the term ‘qualifying payment
24 amount’—

1 “(I) for an item or service fur-
2 nished during 2022 (or, in the case of
3 a newly covered item or service, dur-
4 ing the first coverage year for such
5 item or service with respect to such
6 plan or coverage), means such rate for
7 such item or service determined by
8 the sponsor or issuer, respectively,
9 through use of any database that is
10 determined, in accordance with rule-
11 making described in paragraph (2), to
12 not have any conflicts of interest and
13 to have sufficient information reflect-
14 ing allowed amounts paid to a health
15 care provider or facility for relevant
16 services furnished in the applicable ge-
17 ographic region (such as a State all-
18 payer claims database);

19 “(II) for an item or service fur-
20 nished in a subsequent year (before
21 the first sufficient information year
22 (as defined in clause (v)(II)) for such
23 item or service with respect to such
24 plan or coverage), means the rate de-
25 termined under subclause (I) or this

1 subclause, as applicable, for such item
2 or service for the year previous to
3 such subsequent year, increased by
4 the percentage increase in the con-
5 sumer price index for all urban con-
6 sumers (United States city average)
7 over such previous year;

8 “(III) for an item or service fur-
9 nished in the first sufficient informa-
10 tion year for such item or service with
11 respect to such plan or coverage, has
12 the meaning given the term qualifying
13 payment amount in clause (i)(I), ex-
14 cept that in applying such clause to
15 such item or service, the reference to
16 ‘furnished during 2022’ shall be treat-
17 ed as a reference to furnished during
18 such first sufficient information year,
19 the reference to ‘in 2019’ shall be
20 treated as a reference to such suffi-
21 cient information year, and the in-
22 crease described in such clause shall
23 not be applied; and

24 “(IV) for an item or service fur-
25 nished in any year subsequent to the

1 first sufficient information year for
2 such item or service with respect to
3 such plan or coverage, has the mean-
4 ing given such term in clause (i)(II),
5 except that in applying such clause to
6 such item or service, the reference to
7 ‘furnished during 2023 or a subse-
8 quent year’ shall be treated as a ref-
9 erence to furnished during the year
10 after such first sufficient information
11 year or a subsequent year.

12 “(iv) INSURANCE MARKET.—For pur-
13 poses of clause (i)(I), a health insurance
14 market specified in this clause is one of the
15 following:

16 “(I) The large group market
17 (other than plans described in sub-
18 clause (III)).

19 “(II) The small group market
20 (other than plans described in sub-
21 clause (III)).

22 “(III) In the case of a self-in-
23 sured group health plan, other self-in-
24 sured group health plans.

1 “(v) DEFINITIONS.—For purposes of
2 this subparagraph:

3 “(I) FIRST COVERAGE YEAR.—
4 The term ‘first coverage year’ means,
5 with respect to a group health plan or
6 group health insurance coverage of-
7 fered by a health insurance issuer and
8 an item or service for which coverage
9 is not offered in 2019 under such plan
10 or coverage, the first year after 2019
11 for which coverage for such item or
12 service is offered under such plan or
13 health insurance coverage.

14 “(II) FIRST SUFFICIENT INFOR-
15 MATION YEAR.—The term ‘first suffi-
16 cient information year’ means, with
17 respect to a group health plan or
18 group health insurance coverage of-
19 fered by a health insurance issuer—

20 “(aa) in the case of an item
21 or service for which the plan or
22 coverage does not have sufficient
23 information to calculate the me-
24 dian of the contracted rates de-
25 scribed in clause (i)(I) in 2019,

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

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

19 “(III) NEWLY COVERED ITEM OR
20 SERVICE.—The term ‘newly covered
21 item or service’ means, with respect to
22 a group health plan or health insur-
23 ance issuer offering group health in-
24 surance coverage, an item or service
25 for which coverage was not offered in

1 2019 under such plan or coverage, but
2 is offered under such plan or coverage
3 in a year after 2019.

4 “(F) NONPARTICIPATING EMERGENCY FA-
5 CILITY; PARTICIPATING EMERGENCY FACIL-
6 ITY.—

7 “(i) NONPARTICIPATING EMERGENCY
8 FACILITY.—The term ‘nonparticipating
9 emergency facility’ means, with respect to
10 an item or service and a group health plan
11 or group health insurance coverage offered
12 by a health insurance issuer, an emergency
13 department of a hospital, or an inde-
14 pendent freestanding emergency depart-
15 ment, that does not have a contractual re-
16 lationship directly or indirectly with the
17 plan or issuer, respectively, for furnishing
18 such item or service under the plan or cov-
19 erage, respectively.

20 “(ii) PARTICIPATING EMERGENCY FA-
21 CILITY.—The term ‘participating emer-
22 gency facility’ means, with respect to an
23 item or service and a group health plan or
24 group health insurance coverage offered by
25 a health insurance issuer, an emergency

1 department of a hospital, or an inde-
2 pendent freestanding emergency depart-
3 ment, that has a contractual relationship
4 directly or indirectly with the plan or
5 issuer, respectively, with respect to the fur-
6 nishing of such an item or service at such
7 facility.

8 “(G) NONPARTICIPATING PROVIDERS; PAR-
9 TICIPATING PROVIDERS.—

10 “(i) NONPARTICIPATING PROVIDER.—

11 The term ‘nonparticipating provider’
12 means, with respect to an item or service
13 and a group health plan or group health
14 insurance coverage offered by a health in-
15 surance issuer, a physician or other health
16 care provider who is acting within the
17 scope of practice of that provider’s license
18 or certification under applicable State law
19 and who does not have a contractual rela-
20 tionship with the plan or issuer, respec-
21 tively, for furnishing such item or service
22 under the plan or coverage, respectively.

23 “(ii) PARTICIPATING PROVIDER.—The
24 term ‘participating provider’ means, with
25 respect to an item or service and a group

1 health plan or group health insurance cov-
2 erage offered by a health insurance issuer,
3 a physician or other health care provider
4 who is acting within the scope of practice
5 of that provider's license or certification
6 under applicable State law and who has a
7 contractual relationship with the plan or
8 issuer, respectively, for furnishing such
9 item or service under the plan or coverage,
10 respectively.

11 “(H) RECOGNIZED AMOUNT.—The term
12 ‘recognized amount’ means, with respect to an
13 item or service furnished by a nonparticipating
14 provider or emergency facility during a year
15 and a group health plan or group health insur-
16 ance coverage offered by a health insurance
17 issuer—

18 “(i) subject to clause (iii), in the case
19 of such item or service furnished in a State
20 that has in effect a specified State law
21 with respect to such plan, coverage, or
22 issuer, respectively; such a nonpartici-
23 pating provider or emergency facility; and
24 such an item or service, the amount deter-
25 mined in accordance with such law;

1 “(ii) subject to clause (iii), in the case
2 of such item or service furnished in a State
3 that does not have in effect a specified
4 State law, with respect to such plan, cov-
5 erage, or issuer, respectively; such a non-
6 participating provider or emergency facil-
7 ity; and such an item or service, the
8 amount that is the qualifying payment
9 amount (as defined in subparagraph (E))
10 for such year and determined in accord-
11 ance with rulemaking described in para-
12 graph (2)) for such item or service; or

13 “(iii) in the case of such item or serv-
14 ice furnished in a State with an All-Payer
15 Model Agreement under section 1115A of
16 the Social Security Act, the amount that
17 the State approves under such system for
18 such item or service so furnished.

19 “(I) SPECIFIED STATE LAW.—The term
20 ‘specified State law’ means, with respect to a
21 State, an item or service furnished by a non-
22 participating provider or emergency facility dur-
23 ing a year and a group health plan or group
24 health insurance coverage offered by a health
25 insurance issuer, a State law that provides for

1 a method for determining the total amount pay-
2 able under such a plan, coverage, or issuer, re-
3 spectively (to the extent such State law applies
4 to such plan, coverage, or issuer, subject to sec-
5 tion 514) in the case of a participant or bene-
6 ficiary covered under such plan or coverage and
7 receiving such item or service from such a non-
8 participating provider or emergency facility.

9 “(J) STABILIZE.—The term ‘to stabilize’,
10 with respect to an emergency medical condition
11 (as defined in subparagraph (B)), has the
12 meaning give in section 1867(e)(3) of the Social
13 Security Act (42 U.S.C. 1395dd(e)(3)).

14 “(K) OUT-OF-NETWORK RATE.—The term
15 ‘out-of-network rate’ means, with respect to an
16 item or service furnished in a State during a
17 year to a participant, beneficiary, or enrollee of
18 a group health plan or group health insurance
19 coverage offered by a health insurance issuer
20 receiving such item or service from a non-
21 participating provider or facility—

22 “(i) subject to clause (iii), in the case
23 of such item or service furnished in a State
24 that has in effect a specified State law
25 with respect to such plan, coverage, or

1 issuer, respectively; such a nonpartici-
2 pating provider or emergency facility; and
3 such an item or service, the amount deter-
4 mined in accordance with such law;

5 “(ii) subject to clause (iii), in the case
6 such State does not have in effect such a
7 law with respect to such item or service,
8 plan, and provider or facility—

9 “(I) subject to subclause (II), if
10 the provider or facility (as applicable)
11 and such plan or coverage agree on an
12 amount of payment (including if
13 agreed on through open negotiations
14 under subsection (c)(1)) with respect
15 to such item or service, such agreed
16 on amount; or

17 “(II) if such provider or facility
18 (as applicable) and such plan or cov-
19 erage enter the independent dispute
20 resolution process under subsection
21 (c) and do not so agree before the
22 date on which a certified independent
23 entity (as defined in paragraph (4) of
24 such subsection) makes a determina-
25 tion with respect to such item or serv-

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

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

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

12 “(b) COVERAGE OF NON-EMERGENCY SERVICES
13 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
14 TAIN PARTICIPATING FACILITIES.—

15 “(1) IN GENERAL.—In the case of items or
16 services (other than emergency services to which
17 subsection (a) applies) for which any benefits are
18 provided or covered by a group health plan or health
19 insurance issuer offering group health insurance cov-
20 erage furnished to a participant or beneficiary of
21 such plan or coverage by a nonparticipating provider
22 (as defined in subsection (a)(3)(G)(i)) (and who,
23 with respect to such items and services, has not sat-
24 isfied the notice and consent criteria of section
25 2799B–2(d) of the Public Health Service Act) with

1 respect to a visit (as defined by the Secretary in ac-
2 cordance with paragraph (2)(B)) at a participating
3 health care facility (as defined in paragraph (2)(A)),
4 with respect to such plan or coverage, respectively,
5 the plan or coverage, respectively—

6 “(A) shall not impose on such participant
7 or beneficiary a cost-sharing requirement for
8 such items and services so furnished that is
9 greater than the cost-sharing requirement that
10 would apply under such plan or coverage, re-
11 spectively, had such items or services been fur-
12 nished by a participating provider (as defined in
13 subsection (a)(3)(G)(ii));

14 “(B) shall calculate such cost-sharing re-
15 quirement as if the total amount that would
16 have been charged for such items and services
17 by such participating provider were equal to the
18 recognized amount (as defined in subsection
19 (a)(3)(H)) for such items and services, plan or
20 coverage, and year;

21 “(C) shall pay directly, in accordance with
22 timing consistent with the requirements under
23 section 2799B–10 of the Public Health Service
24 Act and, if applicable, in accordance with the
25 timing requirement described in subsection

1 (c)(6), to such provider furnishing such items
2 and services to such participant, beneficiary, or
3 enrollee the amount by which the out-of-net-
4 work rate (as defined in subsection (a)(3)(K))
5 for such items and services exceeds the cost-
6 sharing amount imposed under the plan or cov-
7 erage, respectively, for such items and services
8 (as determined in accordance with subpara-
9 graphs (A) and (B)) and year; and

10 “(D) shall count toward any in-network
11 deductible and in-network out-of-pocket maxi-
12 mums (as applicable) applied under the plan or
13 coverage, respectively, any cost-sharing pay-
14 ments made by the participant, beneficiary, or
15 enrollee (and such in-network deductible and
16 out-of-pocket maximums shall be applied) with
17 respect to such items and services so furnished
18 in the same manner as if such cost-sharing pay-
19 ments were with respect to items and services
20 furnished by a participating provider.

21 “(2) DEFINITIONS.—In this section:

22 “(A) PARTICIPATING HEALTH CARE FACIL-
23 ITY.—

24 “(i) IN GENERAL.—The term ‘partici-
25 pating health care facility’ means, with re-

1 spect to an item or service and a group
2 health plan or health insurance issuer of-
3 fering group health insurance coverage, a
4 health care facility described in clause (ii)
5 that has a direct or indirect contractual re-
6 lationship with the plan or issuer, respec-
7 tively, with respect to the furnishing of
8 such an item or service at the facility.

9 “(ii) HEALTH CARE FACILITY DE-
10 SCRIBED.—A health care facility described
11 in this clause, with respect to a group
12 health plan or group health insurance cov-
13 erage, is each of the following:

14 “(I) A hospital (as defined in
15 1861(e) of the Social Security Act).

16 “(II) A hospital outpatient de-
17 partment.

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

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

24 “(V) Any other facility, specified
25 by the Secretary, that provides items

1 or services for which coverage is pro-
2 vided under the plan or coverage, re-
3 spectively.

4 “(B) VISIT.—The term ‘visit’ shall, with
5 respect to items and services furnished to an in-
6 dividual at a health care facility, include equip-
7 ment and devices, telemedicine services, imag-
8 ing services, laboratory services, preoperative
9 and postoperative services, and such other items
10 and services as the Secretary may specify, re-
11 gardless of whether or not the provider fur-
12 nishing such items or services is at the facility.

13 “(c) CERTAIN ACCESS FEES TO CERTAIN DATA-
14 BASES.—In the case of a sponsor of a group health plan
15 or health insurance issuer offering group health insurance
16 coverage that, pursuant to subsection (a)(3)(E)(iii), uses
17 a database described in such subsection to determine a
18 rate to apply under such subsection for an item or service
19 by reason of having insufficient information described in
20 such subsection with respect to such item or service, such
21 sponsor or issuer shall cover the cost for access to such
22 database.”.

23 (2) TRANSFER AMENDMENT.—Subpart B of
24 part 7 of title I of the Employee Retirement Income
25 Security Act of 1974 (29 U.S.C. 1185 et seq.), as

1 amended by paragraph (1), is further amended by
2 adding at the end the following:

3 **“SEC. 722. OTHER PATIENT PROTECTIONS.**

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

12 “(b) ACCESS TO PEDIATRIC CARE.—

13 “(1) PEDIATRIC CARE.—In the case of a person
14 who has a child who is a participant, beneficiary, or
15 enrollee under a group health plan, or group health
16 insurance coverage offered by a health insurance
17 issuer, if the plan or issuer requires or provides for
18 the designation of a participating primary care pro-
19 vider for the child, the plan or issuer shall permit
20 such person to designate a physician (allopathic or
21 osteopathic) who specializes in pediatrics as the
22 child’s primary care provider if such provider par-
23 ticipates in the network of the plan or issuer.

24 “(2) CONSTRUCTION.—Nothing in paragraph
25 (1) shall be construed to waive any exclusions of cov-

1 erage under the terms and conditions of the plan or
2 health insurance coverage with respect to coverage
3 of pediatric care.

4 “(c) PATIENT ACCESS TO OBSTETRICAL AND GYNE-
5 COLOGICAL CARE.—

6 “(1) GENERAL RIGHTS.—

7 “(A) DIRECT ACCESS.—A group health
8 plan, or health insurance issuer offering group
9 health insurance coverage, described in para-
10 graph (2) may not require authorization or re-
11 ferral by the plan, issuer, or any person (includ-
12 ing a primary care provider described in para-
13 graph (2)(B)) in the case of a female partici-
14 pant, beneficiary, or enrollee who seeks cov-
15 erage for obstetrical or gynecological care pro-
16 vided by a participating health care professional
17 who specializes in obstetrics or gynecology.
18 Such professional shall agree to otherwise ad-
19 here to such plan’s or issuer’s policies and pro-
20 cedures, including procedures regarding refer-
21 rals and obtaining prior authorization and pro-
22 viding services pursuant to a treatment plan (if
23 any) approved by the plan or issuer.

24 “(B) OBSTETRICAL AND GYNECOLOGICAL
25 CARE.—A group health plan or health insur-

1 ance issuer described in paragraph (2) shall
2 treat the provision of obstetrical and gynecolo-
3 gical care, and the ordering of related obstet-
4 rical and gynecological items and services, pur-
5 suant to the direct access described under sub-
6 paragraph (A), by a participating health care
7 professional who specializes in obstetrics or
8 gynecology as the authorization of the primary
9 care provider.

10 “(2) APPLICATION OF PARAGRAPH.—A group
11 health plan, or health insurance issuer offering
12 group health insurance coverage, described in this
13 paragraph is a group health plan or coverage that—

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

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

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

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

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

6 (3) CLERICAL AMENDMENT.—The table of con-
7 tents of the Employee Retirement Income Security
8 Act of 1974 is amended by inserting after the item
9 relating to section 714 the following:

“Sec. 715. Additional market reforms.
“Sec. 716. Preventing surprise medical bills.
“Sec. 722. Other patient protections.”.

10 (c) IRC AMENDMENTS.—

11 (1) IN GENERAL.—Subchapter B of chapter
12 100 of the Internal Revenue Code of 1986 is amend-
13 ed by adding at the end the following:

14 **“SEC. 9816. PREVENTING SURPRISE MEDICAL BILLS.**

15 “(a) COVERAGE OF EMERGENCY SERVICES.—

16 “(1) IN GENERAL.—If a group health plan pro-
17 vides or covers any benefits with respect to services
18 in an emergency department of a hospital or with re-
19 spect to emergency services in an independent free-
20 standing emergency department (as defined in para-
21 graph (3)(D)), the plan shall cover emergency serv-
22 ices (as defined in paragraph (3)(C))—

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

1 “(B) whether the health care provider fur-
2 nishing such services is a participating provider
3 or a participating emergency facility, as appli-
4 cable, with respect to such services;

5 “(C) in a manner so that, if such services
6 are provided to a participant or beneficiary by
7 a nonparticipating provider or a nonpartici-
8 pating emergency facility—

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

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

23 “(iii) such cost-sharing requirement is
24 calculated as if the total amount that
25 would have been charged for such services

1 by such participating provider or partici-
2 pating emergency facility were equal to the
3 recognized amount (as defined in para-
4 graph (3)(H)) for such services, plan, and
5 year;

6 “(iv) the group health plan pays di-
7 rectly to such provider or facility, respec-
8 tively (in a time and manner that ensures
9 such provider or facility can comply with
10 section 2799B–10 of the Public Health
11 Service Act and, if applicable, in accord-
12 ance with the timing requirement described
13 in subsection (c)(6)) the amount by which
14 the out-of-network rate (as defined in
15 paragraph (3)(K)) for such services ex-
16 ceeds the cost-sharing amount for such
17 services (as determined in accordance with
18 clauses (ii) and (iii)) and year; and

19 “(v) any cost-sharing payments made
20 by the participant, beneficiary, or enrollee
21 with respect to such emergency services so
22 furnished shall be counted toward any in-
23 network deductible or out-of-pocket maxi-
24 mums applied under the plan (and such in-
25 network deductible and out-of-pocket maxi-

1 mums shall be applied) in the same man-
2 ner as if such cost-sharing payments were
3 made with respect to emergency services
4 furnished by a participating provider or a
5 participating emergency facility; and

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

15 “(2) AUDIT PROCESS AND REGULATIONS FOR
16 QUALIFYING PAYMENT AMOUNTS.—

17 “(A) AUDIT PROCESS.—

18 “(i) IN GENERAL.—Not later than
19 July 1, 2021, the Secretary, in consulta-
20 tion with the Secretary of Health and
21 Human Services and the Secretary of
22 Labor, shall establish through rulemaking
23 a process, in accordance with clause (ii),
24 under which group health plans are au-

1 dited by the Secretary or applicable State
2 authority to ensure that—

3 “(I) such plans are in compliance
4 with the requirement of applying a
5 qualifying payment amount under this
6 section; and

7 “(II) such qualifying payment
8 amount so applied satisfies the defini-
9 tion under paragraph (3)(E) with re-
10 spect to the year involved, including
11 with respect to a group health plan
12 described in clause (ii) of such para-
13 graph (3)(E).

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

17 “(I) shall conduct audits de-
18 scribed in such clause, with respect to
19 a year (beginning with 2022), of a
20 sample with respect to such year of
21 claims data from not more than 25
22 group health plans; and

23 “(II) may audit any group health
24 plan if the Secretary has received any
25 complaint about such plan or cov-

1 erage, respectively, that involves the
2 compliance of the plan with either of
3 the requirements described in sub-
4 clauses (I) and (II) of such clause.

5 “(iii) REPORTS.—Beginning for 2022,
6 the Secretary shall annually submit to
7 Congress a report on the number of plans
8 and issuers with respect to which audits
9 were conducted during such year pursuant
10 to this subparagraph.

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

16 “(i) the methodology the group health
17 plan shall use to determine the qualifying
18 payment amount, differentiating by large
19 group market and small group market;

20 “(ii) the information such plan or
21 issuer, respectively, shall share with the
22 nonparticipating provider or nonpartici-
23 pating facility, as applicable, when making
24 such a determination;

1 “(iii) the geographic regions applied
2 for purposes of this subparagraph, taking
3 into account access to items and services in
4 rural and underserved areas, including
5 health professional shortage areas, as de-
6 fined in section 332 of the Public Health
7 Service Act; and

8 “(iv) a process to receive complaints
9 of violations of the requirements described
10 in subclauses (I) and (II) of subparagraph
11 (A)(i) by group health plans.

12 Such rulemaking shall take into account pay-
13 ments that are made by such plan that are not
14 on a fee-for-service basis. Such methodology
15 may account for relevant payment adjustments
16 that take into account quality or facility type
17 (including higher acuity settings and the case-
18 mix of various facility types) that are otherwise
19 taken into account for purposes of determining
20 payment amounts with respect to participating
21 facilities. In carrying out clause (iii), the Sec-
22 retary shall consult with the National Associa-
23 tion of Insurance Commissioners to establish
24 the geographic regions under such clause and
25 shall periodically update such regions, as appro-

1 priate, taking into account the findings of the
2 report submitted under section 109(a) of the
3 No Surprises Act.

4 “(3) DEFINITIONS.—In this subchapter:

5 “(A) EMERGENCY DEPARTMENT OF A HOS-
6 PITAL.—The term ‘emergency department of a
7 hospital’ includes a hospital outpatient depart-
8 ment that provides emergency services (as de-
9 fined in subparagraph (C)(i)).

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

21 “(C) EMERGENCY SERVICES.—

22 “(i) IN GENERAL.—The term ‘emer-
23 gency services’, with respect to an emer-
24 gency medical condition, means—

1 “(I) a medical screening exam-
2 ination (as required under section
3 1867 of the Social Security Act, or as
4 would be required under such section
5 if such section applied to an inde-
6 pendent freestanding emergency de-
7 partment) that is within the capability
8 of the emergency department of a hos-
9 pital or of an independent free-
10 standing emergency department, as
11 applicable, including ancillary services
12 routinely available to the emergency
13 department to evaluate such emer-
14 gency medical condition; and

15 “(II) within the capabilities of
16 the staff and facilities available at the
17 hospital or the independent free-
18 standing emergency department, as
19 applicable, such further medical exam-
20 ination and treatment as are required
21 under section 1867 of such Act, or as
22 would be required under such section
23 if such section applied to an inde-
24 pendent freestanding emergency de-
25 partment, to stabilize the patient (re-

1 regardless of the department of the hos-
2 pital in which such further examina-
3 tion or treatment is furnished).

4 “(ii) INCLUSION OF ADDITIONAL
5 SERVICES.—

6 “(I) IN GENERAL.—For purposes
7 of this subsection and section 2799B-
8 1 of the Public Health Service Act, in
9 the case of a participant, beneficiary,
10 or enrollee in a group health plan who
11 is furnished services described in
12 clause (i) with respect to an emer-
13 gency medical condition, the term
14 ‘emergency services’ shall include, un-
15 less each of the conditions described
16 in subclause (II) are met, in addition
17 to the items and services described in
18 clause (i), items and services—

19 “(aa) for which benefits are
20 provided or covered under the
21 plan; and

22 “(bb) that are furnished by
23 a nonparticipating provider or
24 nonparticipating emergency facil-
25 ity (regardless of the department

1 of the hospital in which such
2 items or services are furnished)
3 after the participant, beneficiary,
4 or enrollee is stabilized and as
5 part of outpatient observation or
6 an inpatient or outpatient stay
7 with respect to the visit in which
8 the services described in clause
9 (i) are furnished.

10 “(II) CONDITIONS.—For pur-
11 poses of subclause (I), the conditions
12 described in this subclause, with re-
13 spect to a participant, beneficiary, or
14 enrollee who is stabilized and fur-
15 nished additional items and services
16 described in subclause (I) after such
17 stabilization by a provider or facility
18 described in subclause (I), are the fol-
19 lowing;

20 “(aa) Such a provider or fa-
21 cility determines such individual
22 is able to travel using nonmedical
23 transportation or nonemergency
24 medical transportation.

1 “(bb) Such provider fur-
2 nishing such additional items and
3 services satisfies the notice and
4 consent criteria of section
5 2799B–2(d) with respect to such
6 items and services.

7 “(cc) Such an individual is
8 in a condition to receive (as de-
9 termined in accordance with
10 guidelines issued by the Sec-
11 retary pursuant to rulemaking)
12 the information described in sec-
13 tion 2799B–2 and to provide in-
14 formed consent under such sec-
15 tion, in accordance with applica-
16 ble State law.

17 “(dd) Such other conditions,
18 as specified by the Secretary,
19 such as conditions relating to co-
20 ordinating care transitions to
21 participating providers and facili-
22 ties.

23 “(D) INDEPENDENT FREESTANDING
24 EMERGENCY DEPARTMENT.—The term ‘inde-

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

3 “(i) is geographically separate and
4 distinct and licensed separately from a hos-
5 pital under applicable State law; and

6 “(ii) provides any of the emergency
7 services (as defined in subparagraph
8 (C)(i)).

9 “(E) QUALIFYING PAYMENT AMOUNT.—

10 “(i) IN GENERAL.—The term ‘quali-
11 fying payment amount’ means, subject to
12 clauses (ii) and (iii), with respect to a
13 sponsor of a group health plan—

14 “(I) for an item or service fur-
15 nished during 2022, the median of the
16 contracted rates recognized by the
17 plan (determined with respect to all
18 such plans of such sponsor that are
19 offered within the same insurance
20 market (specified in subclause (I),
21 (II), or (III) of clause (iv)) as the
22 plan) as the total maximum payment
23 (including the cost-sharing amount
24 imposed for such item or service and
25 the amount to be paid by the plan)

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

16 “(II) for an item or service fur-
17 nished during 2023 or a subsequent
18 year, the qualifying payment amount
19 determined under this clause for such
20 an item or service furnished in the
21 previous year, increased by the per-
22 centage increase in the consumer price
23 index for all urban consumers (United
24 States city average) over such pre-
25 vious year.

1 “(ii) NEW PLANS AND COVERAGE.—

2 The term ‘qualifying payment amount’
3 means, with respect to a sponsor of a
4 group health plan in a geographic region in
5 which such sponsor, respectively, did not
6 offer any group health plan or health in-
7 surance coverage during 2019—

8 “(I) for the first year in which
9 such group health plan is offered in
10 such region, a rate (determined in ac-
11 cordance with a methodology estab-
12 lished by the Secretary) for items and
13 services that are covered by such plan
14 and furnished during such first year;
15 and

16 “(II) for each subsequent year
17 such group health plan is offered in
18 such region, the qualifying payment
19 amount determined under this clause
20 for such items and services furnished
21 in the previous year, increased by the
22 percentage increase in the consumer
23 price index for all urban consumers
24 (United States city average) over such
25 previous year.

1 “(iii) INSUFFICIENT INFORMATION;
2 NEWLY COVERED ITEMS AND SERVICES.—
3 In the case of a sponsor of a group health
4 plan that does not have sufficient informa-
5 tion to calculate the median of the con-
6 tracted rates described in clause (i)(I) in
7 2019 (or, in the case of a newly covered
8 item or service (as defined in clause
9 (v)(III)), in the first coverage year (as de-
10 fined in clause (v)(I)) for such item or
11 service with respect to such plan) for an
12 item or service (including with respect to
13 provider type, or amount, of claims for
14 items or services (as determined by the
15 Secretary) provided in a particular geo-
16 graphic region (other than in a case with
17 respect to which clause (ii) applies)) the
18 term ‘qualifying payment amount’—

19 “(I) for an item or service fur-
20 nished during 2022 (or, in the case of
21 a newly covered item or service, dur-
22 ing the first coverage year for such
23 item or service with respect to such
24 plan), means such rate for such item
25 or service determined by the sponsor

1 through use of any database that is
2 determined, in accordance with rule-
3 making described in paragraph
4 (2)(B), to not have any conflicts of in-
5 terest and to have sufficient informa-
6 tion reflecting allowed amounts paid
7 to a health care provider or facility for
8 relevant services furnished in the ap-
9 plicable geographic region (such as a
10 State all-payer claims database);

11 “(II) for an item or service fur-
12 nished in a subsequent year (before
13 the first sufficient information year
14 (as defined in clause (v)(II)) for such
15 item or service with respect to such
16 plan), means the rate determined
17 under subclause (I) or this subclause,
18 as applicable, for such item or service
19 for the year previous to such subse-
20 quent year, increased by the percent-
21 age increase in the consumer price
22 index for all urban consumers (United
23 States city average) over such pre-
24 vious year;

1 “(III) for an item or service fur-
2 nished in the first sufficient informa-
3 tion year for such item or service with
4 respect to such plan, has the meaning
5 given the term qualifying payment
6 amount in clause (i)(I), except that in
7 applying such clause to such item or
8 service, the reference to ‘furnished
9 during 2022’ shall be treated as a ref-
10 erence to furnished during such first
11 sufficient information year, the ref-
12 erence to ‘on January 31, 2019’ shall
13 be treated as a reference to in such
14 sufficient information year, and the
15 increase described in such clause shall
16 not be applied; and

17 “(IV) for an item or service fur-
18 nished in any year subsequent to the
19 first sufficient information year for
20 such item or service with respect to
21 such plan, has the meaning given such
22 term in clause (i)(II), except that in
23 applying such clause to such item or
24 service, the reference to ‘furnished
25 during 2023 or a subsequent year’

1 shall be treated as a reference to fur-
2 nished during the year after such first
3 sufficient information year or a subse-
4 quent year.

5 “(iv) INSURANCE MARKET.—For pur-
6 poses of clause (i)(I), a health insurance
7 market specified in this clause is one of the
8 following:

9 “(I) The large group market
10 (other than plans described in sub-
11 clause (III)).

12 “(II) The small group market
13 (other than plans described in sub-
14 clause (III)).

15 “(III) In the case of a self-in-
16 sured group health plan, other self-in-
17 sured group health plans.

18 “(v) DEFINITIONS.—For purposes of
19 this subparagraph:

20 “(I) FIRST COVERAGE YEAR.—
21 The term ‘first coverage year’ means,
22 with respect to a group health plan
23 and an item or service for which cov-
24 erage is not offered in 2019 under
25 such plan or coverage, the first year

1 after 2019 for which coverage for
2 such item or service is offered under
3 such plan.

4 “(II) FIRST SUFFICIENT INFOR-
5 MATION YEAR.—The term ‘first suffi-
6 cient information year’ means, with
7 respect to a group health plan—

8 “(aa) in the case of an item
9 or service for which the plan does
10 not have sufficient information to
11 calculate the median of the con-
12 tracted rates described in clause
13 (i)(I) in 2019, the first year sub-
14 sequent to 2022 for which such
15 sponsor has such sufficient infor-
16 mation to calculate the median of
17 such contracted rates in the year
18 previous to such first subsequent
19 year; and

20 “(bb) in the case of a newly
21 covered item or service, the first
22 year subsequent to the first cov-
23 erage year for such item or serv-
24 ice with respect to such plan for
25 which the sponsor has sufficient

1 information to calculate the me-
2 dian of the contracted rates de-
3 scribed in clause (i)(I) in the
4 year previous to such first subse-
5 quent year.

6 “(III) NEWLY COVERED ITEM OR
7 SERVICE.—The term ‘newly covered
8 item or service’ means, with respect to
9 a group health plan, an item or serv-
10 ice for which coverage was not offered
11 in 2019 under such plan or coverage,
12 but is offered under such plan or cov-
13 erage in a year after 2019.

14 “(F) NONPARTICIPATING EMERGENCY FA-
15 CILITY; PARTICIPATING EMERGENCY FACIL-
16 ITY.—

17 “(i) NONPARTICIPATING EMERGENCY
18 FACILITY.—The term ‘nonparticipating
19 emergency facility’ means, with respect to
20 an item or service and a group health plan,
21 an emergency department of a hospital, or
22 an independent freestanding emergency de-
23 partment, that does not have a contractual
24 relationship directly or indirectly with the

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

3 “(ii) PARTICIPATING EMERGENCY FA-
4 CILITY.—The term ‘participating emer-
5 gency facility’ means, with respect to an
6 item or service and a group health plan, an
7 emergency department of a hospital, or an
8 independent freestanding emergency de-
9 partment, that has a contractual relation-
10 ship directly or indirectly with the plan,
11 with respect to the furnishing of such an
12 item or service at such facility.

13 “(G) NONPARTICIPATING PROVIDERS; PAR-
14 TICIPATING PROVIDERS.—

15 “(i) NONPARTICIPATING PROVIDER.—
16 The term ‘nonparticipating provider’
17 means, with respect to an item or service
18 and a group health plan, a physician or
19 other health care provider who is acting
20 within the scope of practice of that pro-
21 vider’s license or certification under appli-
22 cable State law and who does not have a
23 contractual relationship with the plan or
24 issuer, respectively, for furnishing such
25 item or service under the plan.

1 “(ii) PARTICIPATING PROVIDER.—The
2 term ‘participating provider’ means, with
3 respect to an item or service and a group
4 health plan, a physician or other health
5 care provider who is acting within the
6 scope of practice of that provider’s license
7 or certification under applicable State law
8 and who has a contractual relationship
9 with the plan for furnishing such item or
10 service under the plan.

11 “(H) RECOGNIZED AMOUNT.—The term
12 ‘recognized amount’ means, with respect to an
13 item or service furnished by a nonparticipating
14 provider or emergency facility during a year
15 and a group health plan—

16 “(i) subject to clause (iii), in the case
17 of such item or service furnished in a State
18 that has in effect a specified State law
19 with respect to such plan; such a non-
20 participating provider or emergency facil-
21 ity; and such an item or service, the
22 amount determined in accordance with
23 such law;

24 “(ii) subject to clause (iii), in the case
25 of such item or service furnished in a State

1 that does not have in effect a specified
2 State law, with respect to such plan; such
3 a nonparticipating provider or emergency
4 facility; and such an item or service, the
5 amount that is the qualifying payment
6 amount (as defined in subparagraph (E))
7 for such year and determined in accord-
8 ance with rulemaking described in para-
9 graph (2)(B)) for such item or service; or

10 “(iii) in the case of such item or serv-
11 ice furnished in a State with an All-Payer
12 Model Agreement under section 1115A of
13 the Social Security Act, the amount that
14 the State approves under such system for
15 such item or service so furnished.

16 “(I) SPECIFIED STATE LAW.—The term
17 ‘specified State law’ means, with respect to a
18 State, an item or service furnished by a non-
19 participating provider or emergency facility dur-
20 ing a year and a group health plan, a State law
21 that provides for a method for determining the
22 total amount payable under such a plan (to the
23 extent such State law applies to such plan, sub-
24 ject to section 514) in the case of a participant
25 or beneficiary covered under such plan and re-

1 ceiving such item or service from such a non-
2 participating provider or emergency facility.

3 “(J) STABILIZE.—The term ‘to stabilize’,
4 with respect to an emergency medical condition
5 (as defined in subparagraph (B)), has the
6 meaning give in section 1867(e)(3) of the Social
7 Security Act (42 U.S.C. 1395dd(e)(3)).

8 “(K) OUT-OF-NETWORK RATE.—The term
9 ‘out-of-network rate’ means, with respect to an
10 item or service furnished in a State during a
11 year to a participant, beneficiary, or enrollee of
12 a group health plan receiving such item or serv-
13 ice from a nonparticipating provider or facil-
14 ity—

15 “(i) subject to clause (iii), in the case
16 of such item or service furnished in a State
17 that has in effect a specified State law
18 with respect to such plan; such a non-
19 participating provider or emergency facil-
20 ity; and such an item or service, the
21 amount determined in accordance with
22 such law;

23 “(ii) subject to clause (iii), in the case
24 such State does not have in effect such a

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

3 “(I) subject to subclause (II), if
4 the provider or facility (as applicable)
5 and such plan or coverage agree on an
6 amount of payment (including if
7 agreed on through open negotiations
8 under subsection (c)(1)) with respect
9 to such item or service, such agreed
10 on amount; or

11 “(II) if such provider or facility
12 (as applicable) and such plan or cov-
13 erage enter the independent dispute
14 resolution process under subsection
15 (c) and do not so agree before the
16 date on which a certified independent
17 entity (as defined in paragraph (4) of
18 such subsection) makes a determina-
19 tion with respect to such item or serv-
20 ice under such subsection, the amount
21 of such determination; or

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

1 such system for such item or service so
2 furnished.

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

6 “(b) COVERAGE OF NON-EMERGENCY SERVICES
7 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-
8 TAIN PARTICIPATING FACILITIES.—

9 “(1) IN GENERAL.—In the case of items or
10 services (other than emergency services to which
11 subsection (a) applies) for which any benefits are
12 provided or covered by a group health plan furnished
13 to a participant or beneficiary of such plan by a
14 nonparticipating provider (as defined in subsection
15 (a)(3)(G)(i)) (and who, with respect to such items
16 and services, has not satisfied the notice and consent
17 criteria of section 2799B–2(d) of the Public Health
18 Service Act) with respect to a visit (as defined by
19 the Secretary in accordance with paragraph (2)(B))
20 at a participating health care facility (as defined in
21 paragraph (2)(A)), with respect to such plan, the
22 plan—

23 “(A) shall not impose on such participant
24 or beneficiary a cost-sharing requirement for
25 such items and services so furnished that is

1 greater than the cost-sharing requirement that
2 would apply under such plan had such items or
3 services been furnished by a participating pro-
4 vider (as defined in subsection (a)(3)(G)(ii));

5 “(B) shall calculate such cost-sharing re-
6 quirement as if the total amount that would
7 have been charged for such items and services
8 by such participating provider were equal to the
9 recognized amount (as defined in subsection
10 (a)(3)(H)) for such items and services, plan,
11 and year;

12 “(C) shall pay directly, in accordance with
13 timing consistent with the requirements under
14 section 2799B–10 of the Public Health Service
15 Act and, if applicable, in accordance with the
16 timing requirement described in subsection
17 (c)(6), to such provider furnishing such items
18 and services to such participant or beneficiary
19 the amount by which the out-of-network rate
20 (as defined in subsection (a)(3)(K)) for such
21 items and services exceeds the cost-sharing
22 amount imposed under the plan for such items
23 and services (as determined in accordance with
24 subparagraphs (A) and (B)) and year; and

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

12 “(2) DEFINITIONS.—In this section:

13 “(A) PARTICIPATING HEALTH CARE FACIL-
14 ITY.—

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

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

1 health plan or health insurance coverage
2 offered in the group or individual market,
3 is each of the following:

4 “(I) A hospital (as defined in
5 1861(e) of the Social Security Act).

6 “(II) A hospital outpatient de-
7 partment.

8 “(III) A critical access hospital
9 (as defined in section 1861(mm)(1) of
10 such Act).

11 “(IV) An ambulatory surgical
12 center described in section
13 1833(i)(1)(A) of such Act.

14 “(V) Any other facility, specified
15 by the Secretary, that provides items
16 or services for which coverage is pro-
17 vided under the plan or coverage, re-
18 spectively.

19 “(B) VISIT.—The term ‘visit’ shall, with
20 respect to items and services furnished to an in-
21 dividual at a health care facility, include equip-
22 ment and devices, telemedicine services, imag-
23 ing services, laboratory services, preoperative
24 and postoperative services, and such other items
25 and services as the Secretary may specify, re-

1 regardless of whether or not the provider fur-
2 nishing such items or services is at the facility.

3 “(c) CERTAIN ACCESS FEES TO CERTAIN DATA-
4 BASES.—In the case of a sponsor of a group health plan
5 that, pursuant to subsection (a)(3)(E)(iii), uses a data-
6 base described in such subsection to determine a rate to
7 apply under such subsection for an item or service by rea-
8 son of having insufficient information described in such
9 subsection with respect to such item or service, such spon-
10 sor shall cover the cost for access to such database.”.

11 (2) TRANSFER AMENDMENT.—Subchapter B of
12 chapter 100 of the Internal Revenue Code of 1986,
13 as amended by paragraph (1), is further amended by
14 adding at the end the following:

15 **“SEC. 9822. OTHER PATIENT PROTECTIONS.**

16 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If
17 a group health plan requires or provides for designation
18 by a participant, beneficiary, or enrollee of a participating
19 primary care provider, then the plan shall permit each
20 participant, beneficiary, and enrollee to designate any par-
21 ticipating primary care provider who is available to accept
22 such individual.

23 “(b) ACCESS TO PEDIATRIC CARE.—

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

1 enrollee under a group health plan if the plan re-
2 quires or provides for the designation of a partici-
3 pating primary care provider for the child, the plan
4 shall permit such person to designate a physician
5 (allopathic or osteopathic) who specializes in pediat-
6 rics as the child’s primary care provider if such pro-
7 vider participates in the network of the plan.

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

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

14 “(1) GENERAL RIGHTS.—

15 “(A) DIRECT ACCESS.—A group health
16 plan described in paragraph (2) may not re-
17 quire authorization or referral by the plan,
18 issuer, or any person (including a primary care
19 provider described in paragraph (2)(B)) in the
20 case of a female participant, beneficiary, or en-
21 rollee who seeks coverage for obstetrical or gyn-
22 eological care provided by a participating
23 health care professional who specializes in ob-
24 stetrics or gynecology. Such professional shall
25 agree to otherwise adhere to such plan’s policies

1 and procedures, including procedures regarding
2 referrals and obtaining prior authorization and
3 providing services pursuant to a treatment plan
4 (if any) approved by the plan.

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

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

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

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

23 “(3) CONSTRUCTION.—Nothing in paragraph
24 (1) shall be construed to—

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

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

10 (3) CLERICAL AMENDMENT.—The table of sections
11 for subchapter B of chapter 100 of the Internal
12 Revenue Code of 1986 is amended by adding at
13 the end the following new item:

“Sec. 9815. Additional market reforms.

“Sec. 9816. Preventing surprise medical bills.

“Sec. 9822. Other patient protections.”.

14 (d) ADDITIONAL APPLICATION PROVISIONS.—

15 (1) APPLICATION TO FEHB.—

16 (A) IN GENERAL.—Section 8902 of title 5,
17 United States Code, is amended by adding at
18 the end the following new subsection:

19 “(p) Each contract under this chapter shall require
20 the carrier to comply with requirements described in the
21 provisions of sections 2799A–1, 2799A–2, and 2799A–7
22 of the Public Health Service Act, sections 716, 717, and
23 722 of the Employee Retirement Income Security Act of
24 1974, and sections 9816, 9817, and 9822 of the Internal

1 Revenue Code of 1986 (as applicable) in the same manner
2 as such provisions apply to a group health plan or health
3 insurance issuer offering group or individual health insur-
4 ance coverage, as described in such sections. The provi-
5 sions of sections 2799B-1, 2799B-2, 2799B-3, 2799B-
6 5, and 2799B-11 of the Public Health Service Act shall
7 apply to a health care provider and facility and an air am-
8 bulance provider described in such respective sections with
9 respect to an enrollee in a health benefits plan under this
10 chapter in the same manner as such provisions apply to
11 such a provider and facility with respect to an enrollee
12 in a group health plan or group or individual health insur-
13 ance coverage offered by a health insurance issuer, as de-
14 scribed in such sections.”.

15 (B) EFFECTIVE DATE.—The amendment
16 made by this paragraph shall apply with respect
17 to contracts entered into or renewed for con-
18 tract years beginning on or after January 1,
19 2022.

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

24 “(5) APPLICATION OF ADDITIONAL PROVI-
25 SIONS.—Sections 2799A-1, 2799A-2, and 2799A-7

1 of the Public Health Service Act shall apply to
2 grandfathered health plans for plan years beginning
3 on or after January 1, 2022.”.

4 (3) RULE OF CONSTRUCTION.—Nothing in this
5 title, including the amendments made by this title
6 may be construed as modifying, reducing, or elimi-
7 nating—

8 (A) the protections under section 222 of
9 the Indian Health Care Improvement Act (25
10 U.S.C. 1621u) and under subpart I of part 136
11 of title 42, Code of Federal Regulations (or any
12 successor regulation), against payment liability
13 for a patient who receives contract health serv-
14 ices that are authorized by the Indian Health
15 Service; or

16 (B) the requirements under section
17 1866(a)(1)(U) of the Social Security Act (42
18 U.S.C. 1395cc(a)(1)(U)).

19 (e) EFFECTIVE DATE.—The amendments made by
20 this section (except as specified under subsection
21 (d)(1)(B)) shall apply with respect to plan years beginning
22 on or after January 1, 2022.

1 **SEC. 103. DETERMINATION OF OUT-OF-NETWORK RATES TO**
2 **BE PAID BY HEALTH PLANS; INDEPENDENT**
3 **DISPUTE RESOLUTION PROCESS.**

4 (a) PHSA.—Section 2799A–1, as added by section
5 102, is amended—

6 (1) by redesignating subsection (c) as sub-
7 section (d); and

8 (2) by inserting after subsection (b) the fol-
9 lowing new subsection:

10 “(c) DETERMINATION OF OUT-OF-NETWORK RATES
11 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
12 RESOLUTION PROCESS.—

13 “(1) DETERMINATION THROUGH OPEN NEGO-
14 TIATION.—

15 “(A) IN GENERAL.—With respect to an
16 item or service furnished in a year by a non-
17 participating provider or a nonparticipating fa-
18 cility, with respect to a group health plan or
19 health insurance issuer offering group or indi-
20 vidual health insurance coverage, in a State de-
21 scribed in subsection (a)(3)(K)(ii) with respect
22 to such plan or coverage and provider or facil-
23 ity, and for which a payment is required to be
24 made by the plan or coverage pursuant to sub-
25 section (a)(1) or (b)(1), the provider or facility
26 (as applicable) or plan or coverage may, during

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

17 “(B) ACCESSING INDEPENDENT DISPUTE
18 RESOLUTION PROCESS IN CASE OF FAILED NE-
19 GOTIATIONS.—In the case of open negotiations
20 pursuant to subparagraph (A), with respect to
21 an item or service, that do not result in a deter-
22 mination of an amount of payment for such
23 item or service by the last day of the open nego-
24 tiation period described in such subparagraph
25 with respect to such item or service, the pro-

1 vider or facility (as applicable) or group health
2 plan or health insurance issuer offering group
3 or individual health insurance coverage that was
4 party to such negotiations may, during the 2-
5 day period beginning on the day after such
6 open negotiation period, initiate the inde-
7 pendent dispute resolution process under para-
8 graph (2) with respect to such item or service.
9 The independent dispute resolution process
10 shall be initiated by a party pursuant to the
11 previous sentence by submission to the other
12 party and to the Secretary of a notification
13 (containing such information as specified by the
14 Secretary) and for purposes of this subsection,
15 the date of initiation of such process shall be
16 the date of such submission or such other date
17 specified by the Secretary pursuant to regula-
18 tions that is not later than the date of receipt
19 of such notification by both the other party and
20 the Secretary.

21 “(2) INDEPENDENT DISPUTE RESOLUTION
22 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
23 GOTIATIONS.—

24 “(A) ESTABLISHMENT.—Not later than 1
25 year after the date of the enactment of this

1 subsection, the Secretary, jointly with the Sec-
2 retary of Labor and the Secretary of the Treas-
3 ury, shall establish by regulation one inde-
4 pendent dispute resolution process (referred to
5 in this subsection as the ‘IDR process’) under
6 which, in the case of an item or service with re-
7 spect to which a provider or facility (as applica-
8 ble) or group health plan or health insurance
9 issuer offering group or individual health insur-
10 ance coverage submits a notification under
11 paragraph (1)(B) (in this subsection referred to
12 as a ‘qualified IDR item or service’), a certified
13 IDR entity under paragraph (4) determines,
14 subject to subparagraph (B) and in accordance
15 with the succeeding provisions of this sub-
16 section, the amount of payment under the plan
17 or coverage for such item or service furnished
18 by such provider or facility.

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

1 such determination under paragraph (4) makes
2 such determination under paragraph (5), such
3 amount shall be treated for purposes of sub-
4 section (a)(3)(K)(ii) as the amount agreed to by
5 such parties for such item or service. In the
6 case of an agreement described in the previous
7 sentence, the independent dispute resolution
8 process shall provide for a method to determine
9 how to allocate between the parties to such de-
10 termination the payment of the compensation of
11 the entity selected with respect to such deter-
12 mination.

13 “(C) CLARIFICATION.—A nonparticipating
14 provider may not, with respect to an item or
15 service furnished by such provider, submit a no-
16 tification under paragraph (1)(B) if such pro-
17 vider is exempt from the requirement under
18 subsection (a) of section 2799B–2 with respect
19 to such item or service pursuant to subsection
20 (b) of such section.

21 “(3) TREATMENT OF BATCHING OF ITEMS AND
22 SERVICES.—

23 “(A) IN GENERAL.—Under the IDR proc-
24 ess, the Secretary shall specify criteria under
25 which multiple qualified IDR dispute items and

1 services are permitted to be considered jointly
2 as part of a single determination by an entity
3 for purposes of encouraging the efficiency (in-
4 cluding minimizing costs) of the mediated dis-
5 pute process. Such items and services may be
6 so considered only if—

7 “(i) such items and services to be in-
8 cluded in such determination are furnished
9 by the same provider or facility;

10 “(ii) payment for such items and serv-
11 ices is required to be made by the same
12 health plan;

13 “(iii) are related to the treatment of a
14 similar condition; and

15 “(iv) such items and services were
16 furnished during the 30 day period fol-
17 lowing the date on which the first item or
18 service included with respect to such deter-
19 mination was furnished or an alternative
20 period as determined by Secretary, for use
21 in limited situations, such as by the con-
22 sent of the parties or in the case of low-
23 volume items and services, to encourage
24 procedural efficiency and minimize health
25 plan and provider administrative costs.

1 “(B) TREATMENT OF BUNDLED PAY-
2 MENTS.—In carrying out subparagraph (A), the
3 Secretary shall provide that, in the case of
4 items and services which are included by a pro-
5 vider or facility as part of a bundled payment,
6 such items and services included in such bun-
7 dled payment may be part of a single deter-
8 mination under this subsection.

9 “(4) CERTIFICATION AND SELECTION OF IDR
10 ENTITIES.—

11 “(A) IN GENERAL.—The Secretary, in con-
12 sultation with the Secretary of Labor and Sec-
13 retary of the Treasury, shall establish a process
14 to certify (including to recertify) entities under
15 this paragraph. Such process shall ensure that
16 an entity so certified—

17 “(i) has (directly or through contracts
18 or other arrangements) sufficient medical,
19 legal, and other expertise and sufficient
20 staffing to make determinations described
21 in paragraph (5) on a timely basis;

22 “(ii) is not—

23 “(I) a group health plan or
24 health insurance issuer offering group

1 or individual health insurance cov-
2 erage, provider, or facility;

3 “(II) an affiliate or a subsidiary
4 of such a group health plan or health
5 insurance issuer, provider, or facility;
6 or

7 “(III) an affiliate or subsidiary of
8 a professional or trade association of
9 such group health plans or health in-
10 surance issuers or of providers or fa-
11 cilities;

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

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

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

22 “(vi) does not under the IDR process
23 carry out any determination with respect
24 to which the entity would not pursuant to

1 subclause (I), (II), or (III) of subpara-
2 graph (F)(i) 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 group health plan or health in-
21 surance issuer offering group or individual
22 health insurance coverage may petition for a de-
23 nial of a certification or a revocation of a cer-
24 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 (5).

9 “(F) SELECTION OF CERTIFIED IDR ENTI-
10 TY.—The Secretary shall, with respect to the
11 determination of the amount of payment under
12 this subsection of an item or service, provide for
13 a method—

14 “(i) that allows for the group health
15 plan or health insurance issuer offering
16 group or individual health insurance cov-
17 erage and the nonparticipating provider or
18 the nonparticipating emergency facility (as
19 applicable) involved in a notification under
20 paragraph (1)(B) to jointly select, not later
21 than the last day of the 3-business day pe-
22 riod following the date of the initiation of
23 the process with respect to such item or
24 service, for purposes of making such deter-

1 mination, an entity certified under this
2 paragraph that—

3 “(I) is not a party to such deter-
4 mination or an employee or agent of
5 such a party;

6 “(II) does not have a material fa-
7 miliar, financial, or professional rela-
8 tionship with such a party; and

9 “(III) does not otherwise have a
10 conflict of interest with such a party
11 (as determined by the Secretary); and

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

17 “(I) select such an entity that
18 satisfies subclauses (I) through (III)
19 of item (i)); and

20 “(II) provide notification of such
21 selection to the provider or facility (as
22 applicable) and the plan or issuer (as
23 applicable) party to such determina-
24 tion.

1 An entity selected pursuant to the previous sentence to
2 make a determination described in such sentence shall be
3 referred to in this subsection as the ‘certified IDR entity’
4 with respect to such determination.

5 “(5) PAYMENT DETERMINATION.—

6 “(A) IN GENERAL.—Not later than 30
7 days after the date of selection of the certified
8 IDR entity, with respect to a qualified IDR
9 item or service, the certified independent entity
10 with respect to a determination under this sub-
11 section for such item or service shall—

12 “(i) taking into account the consider-
13 ations specified in subparagraph (C), select
14 one of the offers submitted under subpara-
15 graph (B) to be the amount of payment for
16 such item or service determined under this
17 subsection for purposes of subsection
18 (a)(1) or (b)(1), as applicable; and

19 “(ii) notify the provider or facility and
20 the group health plan or health insurance
21 issuer offering group or individual health
22 insurance coverage party to such deter-
23 mination of the offer selected under clause
24 (i).

1 “(B) SUBMISSION OF OFFERS.—Not later
2 than 10 days after the date of selection of the
3 certified IDR entity with respect to a deter-
4 mination for a qualified IDR item or service,
5 the provider or facility and the group health
6 plan or health insurance issuer offering group
7 or individual health insurance coverage party to
8 such determination—

9 “(i) shall each submit to the certified
10 independent entity with respect to such de-
11 termination—

12 “(I) an offer for a payment
13 amount for such item or service fur-
14 nished by such provider or facility;
15 and

16 “(II) such information as re-
17 quested by the certified IDR entity re-
18 lating to such offer; and

19 “(ii) may each submit to the certified
20 independent entity with respect to such de-
21 termination any information relating to
22 such offer submitted by either party, in-
23 cluding information relating to any cir-
24 cumstance described in subparagraph
25 (C)(ii).

1 “(C) CONSIDERATIONS IN DETERMINA-
2 TION.—

3 “(i) IN GENERAL.—In determining
4 which offer is the payment to be applied
5 pursuant to this paragraph, the certified
6 IDR entity, with respect to the determina-
7 tion for a qualified IDR item or service
8 shall consider—

9 “(I) the offers under subpara-
10 graph (B)(i);

11 “(II) the qualifying payment
12 amounts (as defined in subsection
13 (a)(3)(E)) for the applicable year for
14 items or services that are comparable
15 to the qualified IDR item or service
16 and that are furnished in the same
17 geographic region (as defined by the
18 Secretary for purposes of such sub-
19 section) as such qualified IDR item or
20 service; and

21 “(III) information on any cir-
22 cumstance described in clause (ii),
23 such information requested in sub-
24 paragraph (B)(i)(II), and any addi-

1 tional information provided in sub-
2 paragraph (B)(ii).

3 “(ii) ADDITIONAL CIRCUMSTANCES.—

4 For purposes of clause (i)(II), the cir-
5 cumstances described in this clause are,
6 with respect to a qualified IDR item or
7 service of a nonparticipating provider, non-
8 participating emergency facility, group
9 health plan, or health insurance issuer of
10 group or individual health insurance cov-
11 erage the following:

12 “(I) The level of training, experi-
13 ence, and quality and outcomes meas-
14 urements of the provider or facility
15 that furnished such item or service
16 (such as those endorsed by the con-
17 sensus-based entity authorized in sec-
18 tion 1890 of the Social Security Act).

19 “(II) The market share held by
20 the out-of-network health care pro-
21 vider or facility or that of the plan or
22 issuer in the geographic region in
23 which the item or service was pro-
24 vided.

1 “(III) The acuity of the indi-
2 vidual receiving such item or service
3 or the complexity of furnishing such
4 item or service to such individual.

5 “(IV) The teaching status, case
6 mix, and scope of services of the non-
7 participating facility that furnished
8 such item or service.

9 “(V) Demonstrations of good
10 faith efforts (or lack of good faith ef-
11 forts) made by the nonparticipating
12 provider or nonparticipating facility or
13 the plan or issuer to enter into net-
14 work agreements and, if applicable,
15 contracted rates between the provider
16 or facility, as applicable, and the plan
17 or issuer, as applicable, during the
18 previous 4 plan years.

19 “(D) PROHIBITION ON CONSIDERATION OF
20 BILLED CHARGES.—In determining which offer
21 is the payment to be applied with respect to
22 qualified IDR items and services furnished by a
23 provider or facility, the certified IDR entity
24 with respect to a determination shall not con-
25 sider usual and customary charges or the

1 amount that would have been billed by such
2 provider or facility with respect to such items
3 and services had the provisions of section
4 2799B–1 or 2799B–2 (as applicable) not ap-
5 plied.

6 “(E) EFFECTS OF DETERMINATION.—

7 “(i) IN GENERAL.—A determination
8 of a certified IDR entity under subpara-
9 graph (A)—

10 “(I) shall be binding; and

11 “(II) shall not be subject to judi-
12 cial review, except in a case described
13 in any of paragraphs (1) through (4)
14 of section 10(a) of title 9, United
15 States Code.

16 “(ii) SUSPENSION OF CERTAIN SUBSE-
17 QUENT IDR REQUESTS.—In the case of a
18 determination of a certified IDR entity
19 under subparagraph (A), with respect to
20 an initial notification submitted under
21 paragraph (1)(B) with respect to qualified
22 IDR items and services and the two par-
23 ties involved with such notification, the
24 party that submitted such notification may
25 not submit during the 90-day period fol-

1 lowing such determination a subsequent
2 notification under such paragraph involv-
3 ing the same other party to such notifica-
4 tion with respect to such an item or service
5 that was the subject of such initial notifi-
6 cation.

7 “(iii) SUBSEQUENT SUBMISSION OF
8 REQUESTS PERMITTED.—In the case of a
9 notification that pursuant to clause (ii) is
10 not permitted to be submitted under para-
11 graph (1)(B) during a 90-day period speci-
12 fied in such clause, if the end of the open
13 negotiation period specified in paragraph
14 (1)(A), that but for this clause would oth-
15 erwise apply with respect to such notifica-
16 tion, occurs during such 90-day period,
17 such paragraph (1)(B) shall be applied as
18 if the reference in such paragraph to the
19 2-day period beginning on the day after
20 such open negotiation period were instead
21 a reference to the 30-day period beginning
22 on the day after the last day of such 90-
23 day period.

24 “(iv) REPORT.—Not later than 4
25 years after the date of implementation of

1 clause (ii), the Secretary, Secretary of
2 Labor, and Secretary of the Treasury shall
3 examine the impact of the application of
4 such clause and whether the application of
5 such clause delays payment determina-
6 tions, impacts early, alternative resolution
7 of claims (such as through open negotia-
8 tions), and shall submit to Congress a re-
9 port on whether any group health plans or
10 health insurance issuers offering group or
11 individual health insurance coverage or
12 types of such plans or coverage have a pat-
13 tern or practice of routine denial, low pay-
14 ment, or down-coding of claims, or other-
15 wise abuse the 90-day period described in
16 such clause, including recommendations on
17 ways to discourage such a pattern or prac-
18 tice.

19 “(F) COSTS OF INDEPENDENT DISPUTE
20 RESOLUTION PROCESS.—In the case of a notifi-
21 cation under paragraph (1)(B) submitted by a
22 nonparticipating provider, nonparticipating
23 emergency facility, group health plan, or health
24 insurance issuer offering group or individual

1 health insurance coverage and submitted to a
2 certified IDR entity—

3 “(i) if such entity makes a determina-
4 tion with respect to such notification under
5 subparagraph (A), the party whose offer is
6 not chosen under such subparagraph shall
7 be responsible for paying all fees charged
8 by such entity; and

9 “(ii) if the parties reach a settlement
10 with respect to such notification prior to
11 such a determination, each party shall pay
12 half of all fees charged by such entity, un-
13 less the parties otherwise agree.

14 “(6) TIMING OF PAYMENT.—Payment required
15 pursuant to subsection (a)(1) or (b)(1), with respect
16 to a qualified IDR item or service for which a deter-
17 mination is made under paragraph (5)(A) or with
18 respect to an item or service for which a payment
19 amount is determined under open negotiations under
20 paragraph (1), shall be made directly to the non-
21 participating provider or facility not later than 30
22 days after the date on which such determination is
23 made.

24 “(7) PUBLICATION OF INFORMATION RELATING
25 TO THE IDR PROCESS.—

1 “(A) PUBLICATION OF INFORMATION.—
2 For each calendar quarter in 2022 and each
3 calendar quarter in a subsequent year, the Sec-
4 retary shall make available on the public
5 website of the Department of Health and
6 Human Services—

7 “(i) the number of notifications sub-
8 mitted under paragraph (1)(B) during
9 such calendar quarter;

10 “(ii) the size of the provider practices
11 and the size of the facilities submitting no-
12 tifications under paragraph (1)(B) during
13 such calendar quarter;

14 “(iii) the number of such notifications
15 with respect to which a determination was
16 made under paragraph (5)(A);

17 “(iv) the information described in sub-
18 paragraph (B) with respect to each notifi-
19 cation with respect to which such a deter-
20 mination was so made;

21 “(v) the number of times the payment
22 amount determined (or agreed to) under
23 this subsection exceeds the qualifying pay-
24 ment amount, specified by items and serv-
25 ices;

1 “(vi) the amount of expenditures
2 made by the Secretary during such cal-
3 endar quarter to carry out the IDR proc-
4 ess;

5 “(vii) the total amount of fees paid
6 under paragraph (7) during such calendar
7 quarter; and

8 “(viii) the total amount of compensa-
9 tion paid to certified IDR entities under
10 paragraph (5)(F) during such calendar
11 quarter.

12 “(B) INFORMATION.—For purposes of sub-
13 paragraph (A), the information described in
14 this subparagraph is, with respect to a notifica-
15 tion under paragraph (1)(B) by a nonpartici-
16 pating provider, nonparticipating emergency fa-
17 cility, group health plan, or health insurance
18 issuer offering group or individual health insur-
19 ance coverage—

20 “(i) a description of each item and
21 service included with respect to such notifi-
22 cation;

23 “(ii) the geography in which the items
24 and services with respect to such notifica-
25 tion were provided;

1 “(iii) the amount of the offer sub-
2 mitted under paragraph (5)(B) by the
3 group health plan or health insurance
4 issuer (as applicable) and by the non-
5 participating provider or nonparticipating
6 emergency facility (as applicable) expressed
7 as a percentage of the qualifying payment
8 amount;

9 “(iv) whether the offer selected by the
10 certified IDR entity under paragraph (5)
11 to be the payment applied was the offer
12 submitted by such plan or issuer (as appli-
13 cable) or by such provider or facility (as
14 applicable) and the amount of such offer
15 so selected expressed as a percentage of
16 the qualifying payment amount;

17 “(v) the category and practice spe-
18 cialty of each such provider or facility in-
19 volved in furnishing such items and serv-
20 ices;

21 “(vi) the identity of the health plan or
22 health insurance issuer, provider, or facil-
23 ity, with respect to the notification;

24 “(vii) the length of time in making
25 each determination;

1 “(viii) the compensation paid to the
2 certified IDR entity with respect to the
3 settlement or determination; and

4 “(ix) any other information specified
5 by the Secretary.

6 “(C) IDR ENTITY REQUIREMENTS.—For
7 2022 and each subsequent year, an IDR entity,
8 as a condition of certification as an IDR entity,
9 shall submit to the Secretary such information
10 as the Secretary determines necessary to carry
11 out the provisions of this subsection.

12 “(D) CLARIFICATION.—The Secretary
13 shall ensure the public reporting under this
14 paragraph does not contain information that
15 would disclose privileged or confidential infor-
16 mation of a group health plan or health insur-
17 ance issuer offering group or individual health
18 insurance coverage or of a provider or facility.

19 “(8) ADMINISTRATIVE FEE.—

20 “(A) IN GENERAL.—Each party to a deter-
21 mination under paragraph (5) to which an enti-
22 ty is selected under paragraph (3) in a year
23 shall pay to the Secretary, at such time and in
24 such manner as specified by the Secretary, a
25 fee for participating in the IDR 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 IDR process.

11 “(9) WAIVER AUTHORITY.—The Secretary may
12 modify any deadline or other timing required speci-
13 fied under this subsection (other than under para-
14 graph (6)) in cases of extenuating circumstances, as
15 specified by the Secretary.”.

16 (b) ERISA.—Section 716 of the Employee Retire-
17 ment Income Security Act of 1974, as added by section
18 102, is amended—

19 (1) by redesignating subsection (c) as sub-
20 section (d); and

21 (2) by inserting after subsection (b) the fol-
22 lowing new subsection:

23 “(c) DETERMINATION OF OUT-OF-NETWORK RATES
24 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
25 RESOLUTION PROCESS.—

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 group health plan or
7 health insurance issuer offering group health
8 insurance coverage, in a State described in sub-
9 section (a)(3)(K)(ii) with respect to such plan
10 or coverage and provider or facility, and for
11 which a payment is required to be made by the
12 plan or coverage pursuant to subsection (a)(1)
13 or (b)(1), the provider or facility (as applicable)
14 or plan or coverage may, during the 30-day pe-
15 riod beginning on the day the provider or facil-
16 ity receives a response from the plan or cov-
17 erage regarding a claim for payment for such
18 item or service, initiate open negotiations under
19 this paragraph between such provider or facility
20 and plan or coverage for purposes of deter-
21 mining, during the open negotiation period, an
22 amount agreed on by such provider or facility,
23 respectively, and such plan or coverage for pay-
24 ment (including any cost-sharing) for such item
25 or service. For purposes of this subsection, the

1 open negotiation period, with respect to an item
2 or service, is the 30-day period beginning on
3 the date of initiation of the negotiations with
4 respect to such item or service.

5 “(B) ACCESSING INDEPENDENT DISPUTE
6 RESOLUTION PROCESS IN CASE OF FAILED NE-
7 GOTIATIONS.—In the case of open negotiations
8 pursuant to subparagraph (A), with respect to
9 an item or service, that do not result in a deter-
10 mination of an amount of payment for such
11 item or service by the last day of the open nego-
12 tiation period described in such subparagraph
13 with respect to such item or service, the pro-
14 vider or facility (as applicable) or group health
15 plan or health insurance issuer offering group
16 health insurance coverage that was party to
17 such negotiations may, during the 2-day period
18 beginning on the day after such open negotia-
19 tion period, initiate the independent dispute res-
20 olution process under paragraph (2) with re-
21 spect to such item or service. The independent
22 dispute resolution process shall be initiated by
23 a party pursuant to the previous sentence by
24 submission to the other party and to the Sec-
25 retary of a notification (containing such infor-

1 mation as specified by the Secretary) and for
2 purposes of this subsection, the date of initi-
3 ation of such process shall be the date of such
4 submission or such other date specified by the
5 Secretary pursuant to regulations that is not
6 later than the date of receipt of such notifica-
7 tion by both the other party and the Secretary.

8 “(2) INDEPENDENT DISPUTE RESOLUTION
9 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
10 GOTIATIONS.—

11 “(A) ESTABLISHMENT.—Not later than 1
12 year after the date of the enactment of this
13 subsection, the Secretary, jointly with the Sec-
14 retary of Labor and the Secretary of the Treas-
15 ury, shall establish by regulation one inde-
16 pendent dispute resolution process (referred to
17 in this subsection as the ‘IDR process’) under
18 which, in the case of an item or service with re-
19 spect to which a provider or facility (as applica-
20 ble) or group health plan or health insurance
21 issuer offering group health insurance coverage
22 submits a notification under paragraph (1)(B)
23 (in this subsection referred to as a ‘qualified
24 IDR item or service’), a certified IDR entity
25 under paragraph (4) determines, subject to sub-

1 paragraph (B) and in accordance with the suc-
2 ceeding provisions of this subsection, the
3 amount of payment under the plan or coverage
4 for such item or service furnished by such pro-
5 vider or facility.

6 “(B) AUTHORITY TO CONTINUE NEGOTIA-
7 TIONS.—Under the independent dispute resolu-
8 tion process, in the case that the parties to a
9 determination for a qualified IDR item or serv-
10 ice agree on a payment amount for such item
11 or service during such process but before the
12 date on which the entity selected with respect to
13 such determination under paragraph (4) makes
14 such determination under paragraph (5), such
15 amount shall be treated for purposes of sub-
16 section (a)(3)(K)(ii) as the amount agreed to by
17 such parties for such item or service. In the
18 case of an agreement described in the previous
19 sentence, the independent dispute resolution
20 process shall provide for a method to determine
21 how to allocate between the parties to such de-
22 termination the payment of the compensation of
23 the entity selected with respect to such deter-
24 mination.

1 “(C) CLARIFICATION.—A nonparticipating
2 provider may not, with respect to an item or
3 service furnished by such provider, submit a no-
4 tification under paragraph (1)(B) if such pro-
5 vider is exempt from the requirement under
6 subsection (a) of section 2799B–2 with respect
7 to such item or service pursuant to subsection
8 (b) of such section.

9 “(3) TREATMENT OF BATCHING OF ITEMS AND
10 SERVICES.—

11 “(A) IN GENERAL.—Under the IDR proc-
12 ess, the Secretary shall specify criteria under
13 which multiple qualified IDR dispute items and
14 services are permitted to be considered jointly
15 as part of a single determination by an entity
16 for purposes of encouraging the efficiency (in-
17 cluding minimizing costs) of the mediated dis-
18 pute process. Such items and services may be
19 so considered only if—

20 “(i) such items and services to be in-
21 cluded in such determination are furnished
22 by the same provider or facility;

23 “(ii) payment for such items and serv-
24 ices is required to be made by the same
25 health plan;

1 “(iii) are related to the treatment of a
2 similar condition; and

3 “(iv) such items and services were
4 furnished during the 30 day period fol-
5 lowing the date on which the first item or
6 service included with respect to such deter-
7 mination was furnished or an alternative
8 period as determined by Secretary, for use
9 in limited situations, such as by the con-
10 sent of the parties or in the case of low-
11 volume items and services, to encourage
12 procedural efficiency and minimize health
13 plan and provider administrative costs.

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

22 “(4) CERTIFICATION AND SELECTION OF IDR
23 ENTITIES.—

24 “(A) IN GENERAL.—The Secretary, in con-
25 sultation with the Secretary of Labor and Sec-

1 retary of the Treasury, shall establish a process
2 to certify (including to recertify) entities under
3 this paragraph. Such process shall ensure that
4 an entity so certified—

5 “(i) has (directly or through contracts
6 or other arrangements) sufficient medical,
7 legal, and other expertise and sufficient
8 staffing to make determinations described
9 in paragraph (5) on a timely basis;

10 “(ii) is not—

11 “(I) a group health plan or
12 health insurance issuer offering group
13 health insurance coverage, provider,
14 or facility;

15 “(II) an affiliate or a subsidiary
16 of such a group health plan or health
17 insurance issuer, provider, or facility;
18 or

19 “(III) an affiliate or subsidiary of
20 a professional or trade association of
21 such group health plans or health in-
22 surance issuers or of providers or fa-
23 cilities;

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

4 “(iv) meets appropriate indicators of
5 fiscal integrity;

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

11 “(vi) does not under the IDR process
12 carry out any determination with respect
13 to which the entity would not pursuant to
14 subclause (I), (II), or (III) of subpara-
15 graph (F)(i) be eligible for selection; and

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

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

24 “(C) REVOCATION.—A certification of an
25 entity under this paragraph may be revoked

1 under the process described in subparagraph
2 (A) if the entity has a pattern or practice of
3 noncompliance with any of the requirements de-
4 scribed in such subparagraph.

5 “(D) PETITION FOR DENIAL OR WITH-
6 DRAWAL.—The process described in subpara-
7 graph (A) shall ensure that an individual, pro-
8 vider, facility, or group health plan or health in-
9 surance issuer offering group health insurance
10 coverage may petition for a denial of a certifi-
11 cation or a revocation of a certification with re-
12 spect to an entity under this paragraph for fail-
13 ure of meeting a requirement of this subsection.

14 “(E) SUFFICIENT NUMBER OF ENTI-
15 TIES.—The process described in subparagraph
16 (A) shall ensure that a sufficient number of en-
17 tities are certified under this paragraph to en-
18 sure the timely and efficient provision of deter-
19 minations described in paragraph (5).

20 “(F) SELECTION OF CERTIFIED IDR ENTI-
21 TY.—The Secretary shall, with respect to the
22 determination of the amount of payment under
23 this subsection of an item or service, provide for
24 a method—

1 “(i) that allows for the group health
2 plan or health insurance issuer offering
3 group health insurance coverage and the
4 nonparticipating provider or the non-
5 participating emergency facility (as appli-
6 cable) involved in a notification under
7 paragraph (1)(B) to jointly select, not later
8 than the last day of the 3-business day pe-
9 riod following the date of the initiation of
10 the process with respect to such item or
11 service, for purposes of making such deter-
12 mination, an entity certified under this
13 paragraph that—

14 “(I) is not a party to such deter-
15 mination or an employee or agent of
16 such a party;

17 “(II) does not have a material fa-
18 milial, financial, or professional rela-
19 tionship with such a party; and

20 “(III) does not otherwise have a
21 conflict of interest with such a party
22 (as determined by the Secretary); and

23 “(ii) that requires, in the case such
24 parties do not make such selection by such
25 last day, the Secretary to, not later than 6

1 business days after such date of initi-
2 ation—

3 “(I) select such an entity that
4 satisfies subclauses (I) through (III)
5 of item (i)); and

6 “(II) provide notification of such
7 selection to the provider or facility (as
8 applicable) and the plan or issuer (as
9 applicable) party to such determina-
10 tion.

11 An entity selected pursuant to the previous sentence to
12 make a determination described in such sentence shall be
13 referred to in this subsection as the ‘certified IDR entity’
14 with respect to such determination.

15 “(5) PAYMENT DETERMINATION.—

16 “(A) IN GENERAL.—Not later than 30
17 days after the date of selection of the certified
18 IDR entity, with respect to a qualified IDR
19 item or service, the certified independent entity
20 with respect to a determination under this sub-
21 section for such item or service shall—

22 “(i) taking into account the consider-
23 ations specified in subparagraph (C), select
24 one of the offers submitted under subpara-
25 graph (B) to be the amount of payment for

1 such item or service determined under this
2 subsection for purposes of subsection
3 (a)(1) or (b)(1), as applicable; and

4 “(ii) notify the provider or facility and
5 the group health plan or health insurance
6 issuer offering group health insurance cov-
7 erage party to such determination of the
8 offer selected under clause (i).

9 “(B) SUBMISSION OF OFFERS.—Not later
10 than 10 days after the date of selection of the
11 certified IDR entity with respect to a deter-
12 mination for a qualified IDR item or service,
13 the provider or facility and the group health
14 plan or health insurance issuer offering group
15 health insurance coverage party to such deter-
16 mination—

17 “(i) shall each submit to the certified
18 independent entity with respect to such de-
19 termination—

20 “(I) an offer for a payment
21 amount for such item or service fur-
22 nished by such provider or facility;
23 and

1 “(II) such information as re-
2 requested by the certified IDR entity re-
3 lating to such offer; and

4 “(ii) may each submit to the certified
5 independent entity with respect to such de-
6 termination any information relating to
7 such offer submitted by either party, in-
8 cluding information relating to any cir-
9 cumstance described in subparagraph
10 (C)(ii).

11 “(C) CONSIDERATIONS IN DETERMINA-
12 TION.—

13 “(i) IN GENERAL.—In determining
14 which offer is the payment to be applied
15 pursuant to this paragraph, the certified
16 IDR entity, with respect to the determina-
17 tion for a qualified IDR item or service
18 shall consider—

19 “(I) the offers under subpara-
20 graph (B)(i);

21 “(II) the qualifying payment
22 amounts (as defined in subsection
23 (a)(3)(E)) for the applicable year for
24 items or services that are comparable
25 to the qualified IDR item or service

1 and that are furnished in the same
2 geographic region (as defined by the
3 Secretary for purposes of such sub-
4 section) as such qualified IDR item or
5 service; and

6 “(III) information on any cir-
7 cumstance described in clause (ii),
8 such information requested in sub-
9 paragraph (B)(i)(II), and any addi-
10 tional information provided in sub-
11 paragraph (B)(ii).

12 “(ii) ADDITIONAL CIRCUMSTANCES.—
13 For purposes of clause (i)(II), the cir-
14 cumstances described in this clause are,
15 with respect to a qualified IDR item or
16 service of a nonparticipating provider, non-
17 participating emergency facility, group
18 health plan, or health insurance issuer of
19 group health insurance coverage the fol-
20 lowing:

21 “(I) The level of training, experi-
22 ence, and quality and outcomes meas-
23 urements of the provider or facility
24 that furnished such item or service
25 (such as those endorsed by the con-

1 sensus-based entity authorized in sec-
2 tion 1890 of the Social Security Act).

3 “(II) The market share held by
4 the out-of-network health care pro-
5 vider or facility or that of the plan or
6 issuer in the geographic region in
7 which the item or service was pro-
8 vided.

9 “(III) The acuity of the indi-
10 vidual receiving such item or service
11 or the complexity of furnishing such
12 item or service to such individual.

13 “(IV) The teaching status, case
14 mix, and scope of services of the non-
15 participating facility that furnished
16 such item or service.

17 “(V) Demonstrations of good
18 faith efforts (or lack of good faith ef-
19 forts) made by the nonparticipating
20 provider or nonparticipating facility or
21 the plan or issuer to enter into net-
22 work agreements and, if applicable,
23 contracted rates between the provider
24 or facility, as applicable, and the plan

1 or issuer, as applicable, during the
2 previous 4 plan years.

3 “(D) PROHIBITION ON CONSIDERATION OF
4 BILLED CHARGES.—In determining which offer
5 is the payment to be applied with respect to
6 qualified IDR items and services furnished by a
7 provider or facility, the certified IDR entity
8 with respect to a determination shall not con-
9 sider usual and customary charges or the
10 amount that would have been billed by such
11 provider or facility with respect to such items
12 and services had the provisions of section
13 2799B–1 or 2799B–2 (as applicable) not ap-
14 plied.

15 “(E) EFFECTS OF DETERMINATION.—

16 “(i) IN GENERAL.—A determination
17 of a certified IDR entity under subpara-
18 graph (A)—

19 “(I) shall be binding; and

20 “(II) shall not be subject to judi-
21 cial review, except in a case described
22 in any of paragraphs (1) through (4)
23 of section 10(a) of title 9, United
24 States Code.

1 “(ii) SUSPENSION OF CERTAIN SUBSE-
2 QUENT IDR REQUESTS.—In the case of a
3 determination of a certified IDR entity
4 under subparagraph (A), with respect to
5 an initial notification submitted under
6 paragraph (1)(B) with respect to qualified
7 IDR items and services and the two par-
8 ties involved with such notification, the
9 party that submitted such notification may
10 not submit during the 90-day period fol-
11 lowing such determination a subsequent
12 notification under such paragraph involv-
13 ing the same other party to such notifica-
14 tion with respect to such an item or service
15 that was the subject of such initial notifi-
16 cation.

17 “(iii) SUBSEQUENT SUBMISSION OF
18 REQUESTS PERMITTED.—In the case of a
19 notification that pursuant to clause (ii) is
20 not permitted to be submitted under para-
21 graph (1)(B) during a 90-day period speci-
22 fied in such clause, if the end of the open
23 negotiation period specified in paragraph
24 (1)(A), that but for this clause would oth-
25 erwise apply with respect to such notifica-

1 tion, occurs during such 90-day period,
2 such paragraph (1)(B) shall be applied as
3 if the reference in such paragraph to the
4 2-day period beginning on the day after
5 such open negotiation period were instead
6 a reference to the 30-day period beginning
7 on the day after the last day of such 90-
8 day period.

9 “(iv) REPORT.—Not later than 4
10 years after the date of implementation of
11 clause (ii), the Secretary, Secretary of
12 Health and Human Services, and Sec-
13 retary of the Treasury shall examine the
14 impact of the application of such clause
15 and whether the application of such clause
16 delays payment determinations, impacts
17 early, alternative resolution of claims (such
18 as through open negotiations), and shall
19 submit to Congress a report on whether
20 any group health plans or health insurance
21 issuers offering group health insurance
22 coverage or types of such plans or coverage
23 have a pattern or practice of routine de-
24 nial, low payment, or down-coding of
25 claims, or otherwise abuse the 90-day pe-

1 riod described in such clause, including
2 recommendations on ways to discourage
3 such a pattern or practice.

4 “(F) COSTS OF INDEPENDENT DISPUTE
5 RESOLUTION PROCESS.—In the case of a notifi-
6 cation under paragraph (1)(B) submitted by a
7 nonparticipating provider, nonparticipating
8 emergency facility, group health plan, or health
9 insurance issuer offering group health insur-
10 ance coverage and submitted to a certified IDR
11 entity—

12 “(i) if such entity makes a determina-
13 tion with respect to such notification under
14 subparagraph (A), the party whose offer is
15 not chosen under such subparagraph shall
16 be responsible for paying all fees charged
17 by such entity; and

18 “(ii) if the parties reach a settlement
19 with respect to such notification prior to
20 such a determination, each party shall pay
21 half of all fees charged by such entity, un-
22 less the parties otherwise agree.

23 “(6) TIMING OF PAYMENT.—Payment required
24 pursuant to subsection (a)(1) or (b)(1), with respect
25 to a qualified IDR item or service for which a deter-

1 mination is made under paragraph (5)(A) or with
2 respect to an item or service for which a payment
3 amount is determined under open negotiations under
4 paragraph (1), shall be made directly to the non-
5 participating provider or facility not later than 30
6 days after the date on which such determination is
7 made.

8 “(7) PUBLICATION OF INFORMATION RELATING
9 TO THE IDR PROCESS.—

10 “(A) PUBLICATION OF INFORMATION.—

11 For each calendar quarter in 2022 and each
12 calendar quarter in a subsequent year, the Sec-
13 retary shall make available on the public
14 website of the Department of Health and
15 Human Services—

16 “(i) the number of notifications sub-
17 mitted under paragraph (1)(B) during
18 such calendar quarter;

19 “(ii) the size of the provider practices
20 and the size of the facilities submitting no-
21 tifications under paragraph (1)(B) during
22 such calendar quarter;

23 “(iii) the number of such notifications
24 with respect to which a determination was
25 made under paragraph (5)(A);

1 “(iv) the information described in sub-
2 paragraph (B) with respect to each notifi-
3 cation with respect to which such a deter-
4 mination was so made;

5 “(v) the number of times the payment
6 amount determined (or agreed to) under
7 this subsection exceeds the qualifying pay-
8 ment amount, specified by items and serv-
9 ices;

10 “(vi) the amount of expenditures
11 made by the Secretary during such cal-
12 endar quarter to carry out the IDR proc-
13 ess;

14 “(vii) the total amount of fees paid
15 under paragraph (7) during such calendar
16 quarter; and

17 “(viii) the total amount of compensa-
18 tion paid to certified IDR entities under
19 paragraph (5)(F) during such calendar
20 quarter.

21 “(B) INFORMATION.—For purposes of sub-
22 paragraph (A), the information described in
23 this subparagraph is, with respect to a notifica-
24 tion under paragraph (1)(B) by a nonpartici-
25 pating provider, nonparticipating emergency fa-

1 cility, group health plan, or health insurance
2 issuer offering group health insurance cov-
3 erage—

4 “(i) a description of each item and
5 service included with respect to such notifi-
6 cation;

7 “(ii) the geography in which the items
8 and services with respect to such notifica-
9 tion were provided;

10 “(iii) the amount of the offer sub-
11 mitted under paragraph (5)(B) by the
12 group health plan or health insurance
13 issuer (as applicable) and by the non-
14 participating provider or nonparticipating
15 emergency facility (as applicable) expressed
16 as a percentage of the qualifying payment
17 amount;

18 “(iv) whether the offer selected by the
19 certified IDR entity under paragraph (5)
20 to be the payment applied was the offer
21 submitted by such plan or issuer (as appli-
22 cable) or by such provider or facility (as
23 applicable) and the amount of such offer
24 so selected expressed as a percentage of
25 the qualifying payment amount;

1 “(v) the category and practice spe-
2 cialty of each such provider or facility in-
3 volved in furnishing such items and serv-
4 ices;

5 “(vi) the identity of the health plan or
6 health insurance issuer, provider, or facil-
7 ity, with respect to the notification;

8 “(vii) the length of time in making
9 each determination;

10 “(viii) the compensation paid to the
11 certified IDR entity with respect to the
12 settlement or determination; and

13 “(ix) any other information specified
14 by the Secretary.

15 “(C) IDR ENTITY REQUIREMENTS.—For
16 2022 and each subsequent year, an IDR entity,
17 as a condition of certification as an IDR entity,
18 shall submit to the Secretary such information
19 as the Secretary determines necessary to carry
20 out the provisions of this subsection.

21 “(D) CLARIFICATION.—The Secretary
22 shall ensure the public reporting under this
23 paragraph does not contain information that
24 would disclose privileged or confidential infor-
25 mation of a group health plan or health insur-

1 ance issuer offering group or individual health
2 insurance coverage or of a provider or facility.

3 “(8) ADMINISTRATIVE FEE.—

4 “(A) IN GENERAL.—Each party to a deter-
5 mination under paragraph (5) to which an enti-
6 ty is selected under paragraph (3) in a year
7 shall pay to the Secretary, at such time and in
8 such manner as specified by the Secretary, a
9 fee for participating in the IDR process with re-
10 spect to such determination in an amount de-
11 scribed in subparagraph (B) for such year.

12 “(B) AMOUNT OF FEE.—The amount de-
13 scribed in this subparagraph for a year is an
14 amount established by the Secretary in a man-
15 ner such that the total amount of fees paid
16 under this paragraph for such year is estimated
17 to be equal to the amount of expenditures esti-
18 mated to be made by the Secretary for such
19 year in carrying out the IDR process.

20 “(9) WAIVER AUTHORITY.—The Secretary may
21 modify any deadline or other timing required speci-
22 fied under this subsection (other than under para-
23 graph (6)) in cases of extenuating circumstances, as
24 specified by the Secretary.”.

1 (c) IRC.—Section 9816 of the Internal Revenue Code
2 of 1986, as added by section 102, is amended—

3 (1) by redesignating subsection (c) as sub-
4 section (d); and

5 (2) by inserting after subsection (b) the fol-
6 lowing new subsection:

7 “(c) DETERMINATION OF OUT-OF-NETWORK RATES
8 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
9 RESOLUTION PROCESS.—

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

12 “(A) IN GENERAL.—With respect to an
13 item or service furnished in a year by a non-
14 participating provider or a nonparticipating fa-
15 cility, with respect to a group health plan, in a
16 State described in subsection (a)(3)(K)(ii) with
17 respect to such plan and provider or facility,
18 and for which a payment is required to be made
19 by the plan pursuant to subsection (a)(1) or
20 (b)(1), the provider or facility (as applicable) or
21 plan may, during the 30-day period beginning
22 on the day the provider or facility receives a re-
23 sponse from the plan regarding a claim for pay-
24 ment for such item or service, initiate open ne-
25 gotiations under this paragraph between such

1 provider or facility and plan for purposes of de-
2 termining, during the open negotiation period,
3 an amount agreed on by such provider or facil-
4 ity, respectively, and such plan for payment (in-
5 cluding any cost-sharing) for such item or serv-
6 ice. For purposes of this subsection, the open
7 negotiation period, with respect to an item or
8 service, is the 30-day period beginning on the
9 date of initiation of the negotiations with re-
10 spect to such item or service.

11 “(B) ACCESSING INDEPENDENT DISPUTE
12 RESOLUTION PROCESS IN CASE OF FAILED NE-
13 GOTIATIONS.—In the case of open negotiations
14 pursuant to subparagraph (A), with respect to
15 an item or service, that do not result in a deter-
16 mination of an amount of payment for such
17 item or service by the last day of the open nego-
18 tiation period described in such subparagraph
19 with respect to such item or service, the pro-
20 vider or facility (as applicable) or group health
21 plan that was party to such negotiations may,
22 during the 2-day period beginning on the day
23 after such open negotiation period, initiate the
24 independent dispute resolution process under
25 paragraph (2) with respect to such item or

1 service. The independent dispute resolution
2 process shall be initiated by a party pursuant to
3 the previous sentence by submission to the
4 other party and to the Secretary of a notifica-
5 tion (containing such information as specified
6 by the Secretary) and for purposes of this sub-
7 section, the date of initiation of such process
8 shall be the date of such submission or such
9 other date specified by the Secretary pursuant
10 to regulations that is not later than the date of
11 receipt of such notification by both the other
12 party and the Secretary.

13 “(2) INDEPENDENT DISPUTE RESOLUTION
14 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
15 GOTIATIONS.—

16 “(A) ESTABLISHMENT.—Not later than 1
17 year after the date of the enactment of this
18 subsection, the Secretary, jointly with the Sec-
19 retary of Labor and the Secretary of the Treas-
20 ury, shall establish by regulation one inde-
21 pendent dispute resolution process (referred to
22 in this subsection as the ‘IDR process’) under
23 which, in the case of an item or service with re-
24 spect to which a provider or facility (as applica-
25 ble) or group health plan submits a notification

1 under paragraph (1)(B) (in this subsection re-
2 ferred to as a ‘qualified IDR item or service’),
3 a certified IDR entity under paragraph (4) de-
4 termines, subject to subparagraph (B) and in
5 accordance with the succeeding provisions of
6 this subsection, the amount of payment under
7 the plan for such item or service furnished by
8 such provider or facility.

9 “(B) AUTHORITY TO CONTINUE NEGOTIA-
10 TIONS.—Under the independent dispute resolu-
11 tion process, in the case that the parties to a
12 determination for a qualified IDR item or serv-
13 ice agree on a payment amount for such item
14 or service during such process but before the
15 date on which the entity selected with respect to
16 such determination under paragraph (4) makes
17 such determination under paragraph (5), such
18 amount shall be treated for purposes of sub-
19 section (a)(3)(K)(ii) as the amount agreed to by
20 such parties for such item or service. In the
21 case of an agreement described in the previous
22 sentence, the independent dispute resolution
23 process shall provide for a method to determine
24 how to allocate between the parties to such de-
25 termination the payment of the compensation of

1 the entity selected with respect to such deter-
2 mination.

3 “(C) CLARIFICATION.—A nonparticipating
4 provider may not, with respect to an item or
5 service furnished by such provider, submit a no-
6 tification under paragraph (1)(B) if such pro-
7 vider is exempt from the requirement under
8 subsection (a) of section 2799B–2 with respect
9 to such item or service pursuant to subsection
10 (b) of such section.

11 “(3) TREATMENT OF BATCHING OF ITEMS AND
12 SERVICES.—

13 “(A) IN GENERAL.—Under the IDR proc-
14 ess, the Secretary shall specify criteria under
15 which multiple qualified IDR dispute items and
16 services are permitted to be considered jointly
17 as part of a single determination by an entity
18 for purposes of encouraging the efficiency (in-
19 cluding minimizing costs) of the mediated dis-
20 pute process. Such items and services may be
21 so considered only if—

22 “(i) such items and services to be in-
23 cluded in such determination are furnished
24 by the same provider or facility;

1 “(ii) payment for such items and serv-
2 ices is required to be made by the same
3 health plan;

4 “(iii) are related to the treatment of a
5 similar condition; and

6 “(iv) such items and services were
7 furnished during the 30 day period fol-
8 lowing the date on which the first item or
9 service included with respect to such deter-
10 mination was furnished or an alternative
11 period as determined by Secretary, for use
12 in limited situations, such as by the con-
13 sent of the parties or in the case of low-
14 volume items and services, to encourage
15 procedural efficiency and minimize health
16 plan and provider administrative costs.

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

1 “(4) CERTIFICATION AND SELECTION OF IDR
2 ENTITIES.—

3 “(A) IN GENERAL.—The Secretary, in con-
4 sultation with the Secretary of Labor and Sec-
5 retary of the Treasury, shall establish a process
6 to certify (including to recertify) entities under
7 this paragraph. Such process shall ensure that
8 an entity so certified—

9 “(i) has (directly or through contracts
10 or other arrangements) sufficient medical,
11 legal, and other expertise and sufficient
12 staffing to make determinations described
13 in paragraph (5) on a timely basis;

14 “(ii) is not—

15 “(I) a group health plan, pro-
16 vider, or facility;

17 “(II) an affiliate or a subsidiary
18 of such a group health plan, provider,
19 or facility; or

20 “(III) an affiliate or subsidiary of
21 a professional or trade association of
22 such group health plans or of pro-
23 viders or facilities;

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

4 “(iv) meets appropriate indicators of
5 fiscal integrity;

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

11 “(vi) does not under the IDR process
12 carry out any determination with respect
13 to which the entity would not pursuant to
14 subclause (I), (II), or (III) of subpara-
15 graph (F)(i) be eligible for selection; and

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

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

24 “(C) REVOCATION.—A certification of an
25 entity under this paragraph may be revoked

1 under the process described in subparagraph
2 (A) if the entity has a pattern or practice of
3 noncompliance with any of the requirements de-
4 scribed in such subparagraph.

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

13 “(E) SUFFICIENT NUMBER OF ENTI-
14 TIES.—The process described in subparagraph
15 (A) shall ensure that a sufficient number of en-
16 tities are certified under this paragraph to en-
17 sure the timely and efficient provision of deter-
18 minations described in paragraph (5).

19 “(F) SELECTION OF CERTIFIED IDR ENTI-
20 TY.—The Secretary shall, with respect to the
21 determination of the amount of payment under
22 this subsection of an item or service, provide for
23 a method—

24 “(i) that allows for the group health
25 plan and the nonparticipating provider or

1 the nonparticipating emergency facility (as
2 applicable) involved in a notification under
3 paragraph (1)(B) to jointly select, not later
4 than the last day of the 3-business day pe-
5 riod following the date of the initiation of
6 the process with respect to such item or
7 service, for purposes of making such deter-
8 mination, an entity certified under this
9 paragraph that—

10 “(I) is not a party to such deter-
11 mination or an employee or agent of
12 such a party;

13 “(II) does not have a material fa-
14 milial, financial, or professional rela-
15 tionship with such a party; and

16 “(III) does not otherwise have a
17 conflict of interest with such a party
18 (as determined by the Secretary); and

19 “(ii) that requires, in the case such
20 parties do not make such selection by such
21 last day, the Secretary to, not later than 6
22 business days after such date of initi-
23 ation—

1 “(I) select such an entity that
2 satisfies subclauses (I) through (III)
3 of item (i)); and

4 “(II) provide notification of such
5 selection to the provider or facility (as
6 applicable) and the plan or issuer (as
7 applicable) party to such determina-
8 tion.

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

13 “(5) PAYMENT DETERMINATION.—

14 “(A) IN GENERAL.—Not later than 30
15 days after the date of selection of the certified
16 IDR entity, with respect to a qualified IDR
17 item or service, the certified independent entity
18 with respect to a determination under this sub-
19 section for such item or service shall—

20 “(i) taking into account the consider-
21 ations specified in subparagraph (C), select
22 one of the offers submitted under subpara-
23 graph (B) to be the amount of payment for
24 such item or service determined under this

1 subsection for purposes of subsection
2 (a)(1) or (b)(1), as applicable; and

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

7 “(B) SUBMISSION OF OFFERS.—Not later
8 than 10 days after the date of selection of the
9 certified IDR entity with respect to a determina-
10 tion for a qualified IDR item or service, the
11 provider or facility and the group health plan
12 party to such determination—

13 “(i) shall each submit to the certified
14 independent entity with respect to such de-
15 termination—

16 “(I) an offer for a payment
17 amount for such item or service fur-
18 nished by such provider or facility;
19 and

20 “(II) such information as re-
21 quested by the certified IDR entity re-
22 lating to such offer; and

23 “(ii) may each submit to the certified
24 independent entity with respect to such de-
25 termination any information relating to

1 such offer submitted by either party, in-
2 cluding information relating to any cir-
3 cumstance described in subparagraph
4 (C)(ii).

5 “(C) CONSIDERATIONS IN DETERMINA-
6 TION.—

7 “(i) IN GENERAL.—In determining
8 which offer is the payment to be applied
9 pursuant to this paragraph, the certified
10 IDR entity, with respect to the determina-
11 tion for a qualified IDR item or service
12 shall consider—

13 “(I) the offers under subpara-
14 graph (B)(i);

15 “(II) the qualifying payment
16 amounts (as defined in subsection
17 (a)(3)(E)) for the applicable year for
18 items or services that are comparable
19 to the qualified IDR item or service
20 and that are furnished in the same
21 geographic region (as defined by the
22 Secretary for purposes of such sub-
23 section) as such qualified IDR item or
24 service; and

1 “(III) information on any cir-
2 cumstance described in clause (ii),
3 such information requested in sub-
4 paragraph (B)(i)(II), and any addi-
5 tional information provided in sub-
6 paragraph (B)(ii).

7 “(ii) ADDITIONAL CIRCUMSTANCES.—
8 For purposes of clause (i)(II), the cir-
9 cumstances described in this clause are,
10 with respect to a qualified IDR item or
11 service of a nonparticipating provider, non-
12 participating emergency facility, or group
13 health plan, the following:

14 “(I) The level of training, experi-
15 ence, and quality and outcomes meas-
16 urements of the provider or facility
17 that furnished such item or service
18 (such as those endorsed by the con-
19 sensus-based entity authorized in sec-
20 tion 1890 of the Social Security Act).

21 “(II) The market share held by
22 the out-of-network health care pro-
23 vider or facility or that of the plan or
24 issuer in the geographic region in

1 which the item or service was pro-
2 vided.

3 “(III) The acuity of the indi-
4 vidual receiving such item or service
5 or the complexity of furnishing such
6 item or service to such individual.

7 “(IV) The teaching status, case
8 mix, and scope of services of the non-
9 participating facility that furnished
10 such item or service.

11 “(V) Demonstrations of good
12 faith efforts (or lack of good faith ef-
13 forts) made by the nonparticipating
14 provider or nonparticipating facility or
15 the plan or issuer to enter into net-
16 work agreements and, if applicable,
17 contracted rates between the provider
18 or facility, as applicable, and the plan
19 or issuer, as applicable, during the
20 previous 4 plan years.

21 “(D) PROHIBITION ON CONSIDERATION OF
22 BILLED CHARGES.—In determining which offer
23 is the payment to be applied with respect to
24 qualified IDR items and services furnished by a
25 provider or facility, the certified IDR entity

1 with respect to a determination shall not con-
2 sider usual and customary charges or the
3 amount that would have been billed by such
4 provider or facility with respect to such items
5 and services had the provisions of section
6 2799B-1 or 2799B-2 (as applicable) not ap-
7 plied.

8 “(E) EFFECTS OF DETERMINATION.—

9 “(i) IN GENERAL.—A determination
10 of a certified IDR entity under subpara-
11 graph (A)—

12 “(I) shall be binding; and

13 “(II) shall not be subject to judi-
14 cial review, except in a case described
15 in any of paragraphs (1) through (4)
16 of section 10(a) of title 9, United
17 States Code.

18 “(ii) SUSPENSION OF CERTAIN SUBSE-
19 QUENT IDR REQUESTS.—In the case of a
20 determination of a certified IDR entity
21 under subparagraph (A), with respect to
22 an initial notification submitted under
23 paragraph (1)(B) with respect to qualified
24 IDR items and services and the two par-
25 ties involved with such notification, the

1 party that submitted such notification may
2 not submit during the 90-day period fol-
3 lowing such determination a subsequent
4 notification under such paragraph involv-
5 ing the same other party to such notifica-
6 tion with respect to such an item or service
7 that was the subject of such initial notifi-
8 cation.

9 “(iii) SUBSEQUENT SUBMISSION OF
10 REQUESTS PERMITTED.—In the case of a
11 notification that pursuant to clause (ii) is
12 not permitted to be submitted under para-
13 graph (1)(B) during a 90-day period speci-
14 fied in such clause, if the end of the open
15 negotiation period specified in paragraph
16 (1)(A), that but for this clause would oth-
17 erwise apply with respect to such notifica-
18 tion, occurs during such 90-day period,
19 such paragraph (1)(B) shall be applied as
20 if the reference in such paragraph to the
21 2-day period beginning on the day after
22 such open negotiation period were instead
23 a reference to the 30-day period beginning
24 on the day after the last day of such 90-
25 day period.

1 “(iv) REPORT.—Not later than 4
2 years after the date of implementation of
3 clause (ii), the the Secretary, Secretary of
4 Labor, and Secretary of Health and
5 Human Services shall examine the impact
6 of the application of such clause and
7 whether the application of such clause
8 delays payment determinations, impacts
9 early, alternative resolution of claims (such
10 as through open negotiations), and shall
11 submit to Congress a report on whether
12 any group health plans or types of such
13 plans have a pattern or practice of routine
14 denial, low payment, or down-coding of
15 claims, or otherwise abuse the 90-day pe-
16 riod described in such clause, including
17 recommendations on ways to discourage
18 such a pattern or practice.

19 “(F) COSTS OF INDEPENDENT DISPUTE
20 RESOLUTION PROCESS.—In the case of a notifi-
21 cation under paragraph (1)(B) submitted by a
22 nonparticipating provider, nonparticipating
23 emergency facility, or group health plan and
24 submitted to a certified IDR entity—

1 “(i) if such entity makes a determina-
2 tion with respect to such notification under
3 subparagraph (A), the party whose offer is
4 not chosen under such subparagraph shall
5 be responsible for paying all fees charged
6 by such entity; and

7 “(ii) if the parties reach a settlement
8 with respect to such notification prior to
9 such a determination, each party shall pay
10 half of all fees charged by such entity, un-
11 less the parties otherwise agree.

12 “(6) TIMING OF PAYMENT.—Payment required
13 pursuant to subsection (a)(1) or (b)(1), with respect
14 to a qualified IDR item or service for which a deter-
15 mination is made under paragraph (5)(A) or with
16 respect to an item or service for which a payment
17 amount is determined under open negotiations under
18 paragraph (1), shall be made directly to the non-
19 participating provider or facility not later than 30
20 days after the date on which such determination is
21 made.

22 “(7) PUBLICATION OF INFORMATION RELATING
23 TO THE IDR PROCESS.—

24 “(A) PUBLICATION OF INFORMATION.—

25 For each calendar quarter in 2022 and each

1 calendar quarter in a subsequent year, the Sec-
2 retary shall make available on the public
3 website of the Department of Health and
4 Human Services—

5 “(i) the number of notifications sub-
6 mitted under paragraph (1)(B) during
7 such calendar quarter;

8 “(ii) the size of the provider practices
9 and the size of the facilities submitting no-
10 tifications under paragraph (1)(B) during
11 such calendar quarter;

12 “(iii) the number of such notifications
13 with respect to which a determination was
14 made under paragraph (5)(A);

15 “(iv) the information described in sub-
16 paragraph (B) with respect to each notifi-
17 cation with respect to which such a deter-
18 mination was so made;

19 “(v) the number of times the payment
20 amount determined (or agreed to) under
21 this subsection exceeds the qualifying pay-
22 ment amount, specified by items and serv-
23 ices;

24 “(vi) the amount of expenditures
25 made by the Secretary during such cal-

1 endar quarter to carry out the IDR proc-
2 ess;

3 “(vii) the total amount of fees paid
4 under paragraph (7) during such calendar
5 quarter; and

6 “(viii) the total amount of compensa-
7 tion paid to certified IDR entities under
8 paragraph (5)(F) during such calendar
9 quarter.

10 “(B) INFORMATION.—For purposes of sub-
11 paragraph (A), the information described in
12 this subparagraph is, with respect to a notifica-
13 tion under paragraph (1)(B) by a nonpartici-
14 pating provider, nonparticipating emergency fa-
15 cility, or group health plan—

16 “(i) a description of each item and
17 service included with respect to such notifi-
18 cation;

19 “(ii) the geography in which the items
20 and services with respect to such notifica-
21 tion were provided;

22 “(iii) the amount of the offer sub-
23 mitted under paragraph (5)(B) by the
24 group health plan and by the nonpartici-
25 pating provider or nonparticipating emer-

1 gency facility (as applicable) expressed as
2 a percentage of the qualifying payment
3 amount;

4 “(iv) whether the offer selected by the
5 certified IDR entity under paragraph (5)
6 to be the payment applied was the offer
7 submitted by such plan or by such provider
8 or facility (as applicable) and the amount
9 of such offer so selected expressed as a
10 percentage of the qualifying payment
11 amount;

12 “(v) the category and practice spe-
13 cialty of each such provider or facility in-
14 volved in furnishing such items and serv-
15 ices;

16 “(vi) the identity of the group health
17 plan, provider, or facility, with respect to
18 the notification;

19 “(vii) the length of time in making
20 each determination;

21 “(viii) the compensation paid to the
22 certified IDR entity with respect to the
23 settlement or determination; and

24 “(ix) any other information specified
25 by the Secretary.

1 “(C) IDR ENTITY REQUIREMENTS.—For
2 2022 and each subsequent year, an IDR entity,
3 as a condition of certification as an IDR entity,
4 shall submit to the Secretary such information
5 as the Secretary determines necessary to carry
6 out the provisions of this subsection.

7 “(D) CLARIFICATION.—The Secretary
8 shall ensure the public reporting under this
9 paragraph does not contain information that
10 would disclose privileged or confidential infor-
11 mation of a group health plan or health insur-
12 ance issuer offering group or individual health
13 insurance coverage or of a provider or facility.

14 “(8) ADMINISTRATIVE FEE.—

15 “(A) IN GENERAL.—Each party to a deter-
16 mination under paragraph (5) to which an enti-
17 ty is selected under paragraph (3) in a year
18 shall pay to the Secretary, at such time and in
19 such manner as specified by the Secretary, a
20 fee for participating in the IDR process with re-
21 spect to such determination in an amount de-
22 scribed in subparagraph (B) for such year.

23 “(B) AMOUNT OF FEE.—The amount de-
24 scribed in this subparagraph for a year is an
25 amount established by the Secretary in a man-

1 ner such that the total amount of fees paid
2 under this paragraph for such year is estimated
3 to be equal to the amount of expenditures esti-
4 mated to be made by the Secretary for such
5 year in carrying out the IDR process.

6 “(9) WAIVER AUTHORITY.—The Secretary may
7 modify any deadline or other timing required speci-
8 fied under this subsection (other than under para-
9 graph (6)) in cases of extenuating circumstances, as
10 specified by the Secretary.”.

11 **SEC. 104. HEALTH CARE PROVIDER REQUIREMENTS RE-**
12 **GARDING SURPRISE MEDICAL BILLING.**

13 (a) IN GENERAL.—Title XXVII of the Public Health
14 Service Act (42 U.S.C. 300gg et seq.) is amended by in-
15 serting after part D, as added by section 102, the fol-
16 lowing:

17 **“PART E—HEALTH CARE PROVIDER**
18 **REQUIREMENTS**

19 **“SEC. 2799B-1. BALANCE BILLING IN CASES OF EMERGENCY**
20 **SERVICES.**

21 “(a) IN GENERAL.—In the case of a participant, ben-
22 eficiary, or enrollee with benefits under a group health
23 plan or group or individual health insurance coverage of-
24 fered by a health insurance issuer and who is furnished
25 during a plan year beginning on or after January 1, 2022,

1 emergency services (for which benefits are provided under
2 the plan or coverage) with respect to an emergency med-
3 ical condition with respect to a visit at an emergency de-
4 partment of a hospital or an independent freestanding
5 emergency department—

6 “(1) in the case that the hospital or inde-
7 pendent freestanding emergency department is a
8 nonparticipating emergency facility, the emergency
9 department of a hospital or independent free-
10 standing emergency department shall not hold the
11 participant, beneficiary, or enrollee liable for a pay-
12 ment amount for such emergency services so fur-
13 nished that is more than the cost-sharing require-
14 ment for such services (as determined in accordance
15 with clauses (ii) and (iii) of section 2799A-
16 1(a)(1)(C), of section 9816(a)(1)(C) of the Internal
17 Revenue Code of 1986, and of section 716(a)(1)(C)
18 of the Employee Retirement Income Security Act of
19 1974, as applicable); and

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

1 condition and visit for which the individual receives
2 emergency services at the hospital or emergency de-
3 partment that is more than the cost-sharing require-
4 ment for such services furnished by the provider (as
5 determined in accordance with clauses (ii) and (iii)
6 of section 2799A-1(a)(1)(C), of section
7 9816(a)(1)(C) of the Internal Revenue Code of
8 1986, and of section 716(a)(1)(C) of the Employee
9 Retirement Income Security Act of 1974, as applica-
10 ble).

11 “(b) DEFINITION.—In this section, the term ‘visit’
12 shall have such meaning as applied to such term for pur-
13 poses of section 2799A-1(b).

14 **“SEC. 2799B-2. BALANCE BILLING IN CASES OF NON-EMER-**
15 **GENCY SERVICES PERFORMED BY NON-**
16 **PARTICIPATING PROVIDERS AT CERTAIN**
17 **PARTICIPATING FACILITIES.**

18 “(a) IN GENERAL.—Subject to subsection (b), in the
19 case of a participant, beneficiary, or enrollee with benefits
20 under a group health plan or group or individual health
21 insurance coverage offered by a health insurance issuer
22 and who is furnished during a plan year beginning on or
23 after January 1, 2022, items or services (other than emer-
24 gency services to which section 2799B-1 applies) for
25 which benefits are provided under the plan or coverage

1 at a participating health care facility by a nonparticipating
2 provider, such provider shall not bill, and shall not hold
3 liable, such participant, beneficiary, or enrollee for a pay-
4 ment amount for such an item or service furnished by such
5 provider with respect to a visit at such facility that is more
6 than the cost-sharing requirement for such item or service
7 (as determined in accordance with subparagraphs (A) and
8 (B) of section 2799A–1(b)(1) of section 9816(b)(1) of the
9 Internal Revenue Code of 1986, and of section 716(b)(1)
10 of the Employee Retirement Income Security Act of 1974,
11 as applicable).

12 “(b) EXCEPTION.—

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

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

1 “(A) subject to paragraph (3), items and
2 services related to emergency medicine, anesthesi-
3 ology, pathology, radiology, and neonatology,
4 whether or not provided by a physician or non-
5 physician practitioner, and items and services
6 provided by assistant surgeons, hospitalists, and
7 intensivists;

8 “(B) subject to paragraph (3), diagnostic
9 services (including radiology and laboratory
10 services);

11 “(C) items and services provided by such
12 other specialty practitioners, as the Secretary
13 specifies through rulemaking; and

14 “(D) items and services provided by a non-
15 participating provider if there is no partici-
16 pating provider who can furnish such item or
17 service at such facility.

18 “(3) EXCEPTION.—The Secretary may, through
19 rulemaking, establish a list (and update such list pe-
20 riodically) of advanced diagnostic laboratory tests,
21 which shall not be included as an ancillary service
22 described in paragraph (2) and with respect to
23 which subsection (a) would apply.

24 “(e) CLARIFICATION.—In the case of a nonpartici-
25 pating provider that satisfies the notice and consent cri-

1 teria of subsection (d) with respect to an item or service
2 (referred to in this subsection as a ‘covered item or serv-
3 ice’), such notice and consent criteria may not be con-
4 strued as applying with respect to any item or service that
5 is furnished as a result of unforeseen, urgent medical
6 needs that arise at the time such covered item or service
7 is furnished. For purposes of the previous sentence, a cov-
8 ered item or service shall not include an ancillary service
9 described in subsection (b)(2).

10 “(d) NOTICE AND CONSENT TO BE TREATED BY A
11 NONPARTICIPATING PROVIDER OR NONPARTICIPATING
12 FACILITY.—

13 “(1) IN GENERAL.—A nonparticipating provider
14 or nonparticipating facility satisfies the notice and
15 consent criteria of this subsection, with respect to
16 items or services furnished by the provider or facility
17 to a participant, beneficiary, or enrollee of a group
18 health plan or group or individual health insurance
19 coverage offered by a health insurance issuer, if the
20 provider (or, if applicable, the participating health
21 care facility on behalf of such provider) or non-
22 participating facility—

23 “(A) in the case that the participant, bene-
24 ficiary, or enrollee makes an appointment to be
25 furnished such items or services at least 72

1 hours prior to the date on which the individual
2 is to be furnished such items or services, pro-
3 vides to the participant, beneficiary, or enrollee
4 (or to an authorized representative of the par-
5 ticipant, beneficiary, or enrollee) not later than
6 72 hours prior to the date on which the indi-
7 vidual is furnished such items or services (or, in
8 the case that the participant, beneficiary, or en-
9 rollee makes such an appointment within 72
10 hours of when such items or services are to be
11 furnished, provides to the participant, bene-
12 ficiary, or enrollee (or to an authorized rep-
13 resentative of the participant, beneficiary, or
14 enrollee) on such date the appointment is
15 made), a written notice in paper or electronic
16 form, as selected by the participant, beneficiary,
17 or enrollee, (and including electronic notifica-
18 tion, as practicable) specified by the Secretary,
19 not later than July 1, 2021, through guidance
20 (which shall be updated as determined nec-
21 essary by the Secretary) that—

22 “(i) contains the information required
23 under paragraph (2);

24 “(ii) clearly states that consent to re-
25 ceive such items and services from such

1 nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and

15 “(iii) is available in the 15 most common languages in the geographic region of the applicable facility;

18 “(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility; and

23 “(C) provides a signed copy of such consent to the participant, beneficiary, or enrollee

1 through mail or email (as selected by the par-
2 ticipant, beneficiary, or enrollee).

3 “(2) INFORMATION REQUIRED UNDER WRITTEN
4 NOTICE.—For purposes of paragraph (1)(A)(i), the
5 information described in this paragraph, with re-
6 spect to a nonparticipating provider or nonpartici-
7 pating facility and a participant, beneficiary, or en-
8 rollee of a group health plan or group or individual
9 health insurance coverage offered by a health insur-
10 ance issuer, is each of the following:

11 “(A) Notification, as applicable, that the
12 health care provider is a nonparticipating pro-
13 vider with respect to the health plan or the
14 health care facility is a nonparticipating facility
15 with respect to the health plan.

16 “(B) Notification of the good faith esti-
17 mated amount that such provider or facility
18 may charge the participant, beneficiary, or en-
19 rollee for such items and services involved, in-
20 cluding a notification that the provision of such
21 estimate or consent to be treated under para-
22 graph (3) does not constitute a contract with
23 respect to the charges estimated for such items
24 and services.

1 “(C) In the case of a participating facility
2 and a nonparticipating provider, a list of any
3 participating providers at the facility who are
4 able to furnish such items and services involved
5 and notification that the participant, bene-
6 ficiary, or enrollee may be referred, at their op-
7 tion, to such a participating provider.

8 “(D) Information about whether prior au-
9 thorization or other care management limita-
10 tions may be required in advance of receiving
11 such items or services at the facility.

12 “(3) CONSENT DESCRIBED TO BE TREATED BY
13 A NONPARTICIPATING PROVIDER OR NONPARTICI-
14 PATING FACILITY.—For purposes of paragraph
15 (1)(B), the consent described in this paragraph, with
16 respect to a participant, beneficiary, or enrollee of a
17 group health plan or group or individual health in-
18 surance coverage offered by a health insurance
19 issuer who is to be furnished items or services by a
20 nonparticipating provider or nonparticipating facil-
21 ity, is a document specified by the Secretary, in con-
22 sultation with the Secretary of Labor, through guid-
23 ance that shall be signed by the participant, bene-
24 ficiary, or enrollee before such items or services are
25 furnished and that —

1 “(A) acknowledges (in clear and under-
2 standable language) that the participant, bene-
3 ficiary, or enrollee has been—

4 “(i) provided with the written notice
5 under paragraph (1)(A);

6 “(ii) informed that the payment of
7 such charge by the participant, beneficiary,
8 or enrollee may not accrue toward meeting
9 any limitation that the plan or coverage
10 places on cost-sharing, including an expla-
11 nation that such payment may not apply to
12 an in-network deductible applied under the
13 plan or coverage; and

14 “(iii) provided the opportunity to re-
15 ceive the written notice under paragraph
16 (1)(A) in the form selected by the partici-
17 pant, beneficiary or enrollee; and

18 “(B) documents the date on which the par-
19 ticipant, beneficiary, or enrollee received the
20 written notice under paragraph (1)(A) and the
21 date on which the individual signed such con-
22 sent to be furnished such items or services by
23 such provider or facility.

24 “(4) RULE OF CONSTRUCTION.—The consent
25 described in paragraph (3), with respect to a partici-

1 participant, beneficiary, or enrollee of a group health plan
2 or group or individual health insurance coverage of-
3 fered by a health insurance issuer, shall constitute
4 only consent to the receipt of the information pro-
5 vided pursuant to this subsection and shall not con-
6 stitute a contractual agreement of the participant,
7 beneficiary, or enrollee to any estimated charge or
8 amount included in such information.

9 “(e) RETENTION OF CERTAIN DOCUMENTS.—A non-
10 participating facility (with respect to such facility or any
11 nonparticipating provider at such facility) or a partici-
12 pating facility (with respect to nonparticipating providers
13 at such facility) that obtains from a participant, bene-
14 ficiary, or enrollee of a group health plan or group or indi-
15 vidual health insurance coverage offered by a health insur-
16 ance issuer (or an authorized representative of such par-
17 ticipant, beneficiary, or enrollee) a written notice in ac-
18 cordance with subsection (d)(1)(A)(ii), with respect to fur-
19 nishing an item or service to such participant, beneficiary,
20 or enrollee, shall retain such notice for at least a 7-year
21 period after the date on which such item or service is so
22 furnished.

23 “(f) DEFINITIONS.—In this section:

24 “(1) The terms ‘nonparticipating provider’ and
25 ‘participating provider’ have the meanings given

1 such terms, respectively, in subsection (a)(3) of sec-
2 tion 2799A-1.

3 “(2) The term ‘participating health care facil-
4 ity’ has the meaning given such term in subsection
5 (b)(2) of section 2799A-1.

6 “(3) The term ‘nonparticipating facility’
7 means—

8 “(A) with respect to emergency services (as
9 defined in section 2799A-1(a)(3)(C)(i)) and a
10 group health plan or group or individual health
11 insurance coverage offered by a health insur-
12 ance issuer, an emergency department of a hos-
13 pital, or an independent freestanding emergency
14 department, that does not have a contractual
15 relationship with the plan or issuer, respec-
16 tively, with respect to the furnishing of such
17 services under the plan or coverage, respec-
18 tively; and

19 “(B) with respect to services described in
20 section 2799A-1(a)(3)(C)(ii) and a group
21 health plan or group or individual health insur-
22 ance coverage offered by a health insurance
23 issuer, a hospital or an independent free-
24 standing emergency department, that does not
25 have a contractual relationship with the plan or

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

4 “(4) The term ‘participating facility’ means—

5 “(A) with respect to emergency services (as
6 defined in clause (i) of section 2799A-
7 1(a)(3)(C)) that are not described in clause(ii)
8 of such section and a group health plan or
9 group or individual health insurance coverage
10 offered by a health insurance issuer, an emer-
11 gency department of a hospital, or an inde-
12 pendent freestanding emergency department,
13 that has a direct or indirect contractual rela-
14 tionship with the plan or issuer, respectively,
15 with respect to the furnishing of such services
16 under the plan or coverage, respectively; and

17 “(B) with respect to services that pursuant
18 to clause (ii) of section 2799A-1(a)(3)(C), of
19 section 9816(a)(3) of the Internal Revenue
20 Code of 1986, and of section 716(a)(3) of the
21 Employee Retirement Income Security Act of
22 1974, as applicable are included as emergency
23 services (as defined in clause (i) of such section
24 and a group health plan or group or individual
25 health insurance coverage offered by a health

1 insurance issuer, a hospital or an independent
2 freestanding emergency department, that has a
3 contractual relationship with the plan or cov-
4 erage, respectively, with respect to the fur-
5 nishing of such services under the plan or cov-
6 erage, respectively.

7 **“SEC. 2799B-3. PROVIDER REQUIREMENTS WITH RESPECT**
8 **TO DISCLOSURE ON PATIENT PROTECTIONS**
9 **AGAINST BALANCE BILLING.**

10 “Beginning not later than January 1, 2022, each
11 health care provider and health care facility shall make
12 publicly available, and (if applicable) post on a public
13 website of such provider or facility and provide to individ-
14 uals who are participants, beneficiaries, or enrollees of a
15 group health plan or group or individual health insurance
16 coverage offered by a health insurance issuer a one-page
17 notice (either postal or electronic mail, as specified by the
18 participant, beneficiary, or enrollee) in clear and under-
19 standable language containing information on—

20 “(1) the requirements and prohibitions of such
21 provider or facility under sections 2799B-1 and
22 2799B-2 (relating to prohibitions on balance billing
23 in certain circumstances);

24 “(2) any other applicable State law require-
25 ments on such provider or facility regarding the

1 amounts such provider or facility may, with respect
2 to an item or service, charge a participant, bene-
3 ficiary, or enrollee of a group health plan or group
4 or individual health insurance coverage offered by a
5 health insurance issuer with respect to which such
6 provider or facility does not have a contractual rela-
7 tionship for furnishing such item or service under
8 the plan or coverage, respectively, after receiving
9 payment from the plan or coverage, respectively, for
10 such item or service and any applicable cost-sharing
11 payment from such participant, beneficiary, or en-
12 rollee; and

13 “(3) information on contacting appropriate
14 State and Federal agencies in the case that an indi-
15 vidual believes that such provider or facility has vio-
16 lated any requirement described in paragraph (1) or
17 (2) with respect to such individual.

18 **“SEC. 2799B-4. ENFORCEMENT.**

19 “(a) STATE ENFORCEMENT.—

20 “(1) STATE AUTHORITY.—Each State may re-
21 quire a provider or health care facility (including a
22 provider of air ambulance services) subject to the re-
23 quirements (including as applied through section
24 2799B-11) of this part or, in the case of air ambu-

1 lance providers, section 2799B–5 to satisfy such re-
2 quirements applicable to the provider or facility.

3 “(2) FAILURE TO IMPLEMENT REQUIRE-
4 MENTS.—In the case of a determination by the Sec-
5 retary that a State has failed to substantially en-
6 force the requirements to which paragraph (1) ap-
7 plies with respect to applicable providers and facili-
8 ties in the State, the Secretary shall enforce such re-
9 quirements under subsection (b) insofar as they re-
10 late to violations of such requirements occurring in
11 such State.

12 “(3) NOTIFICATION OF APPLICABLE SEC-
13 RETARY.—A State may notify the Secretary of
14 Labor, Secretary of Health and Human Services, or
15 the Secretary of the Treasury, as applicable, of in-
16 stances of violations of sections 2799A–1, 2799A–2,
17 or 2799A–5 with respect to participants, bene-
18 ficiaries, or enrollees under a group health plan or
19 group or individual health insurance coverage, as ap-
20 plicable offered by a health insurance issuer and any
21 enforcement actions taken against providers or fa-
22 cilities as a result of such violations, including the
23 disposition of any such enforcement actions.

24 “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

1 “(1) IN GENERAL.—If a provider or facility is
2 found by the Secretary to be in violation of a re-
3 quirement to which subsection (a)(1) applies, the
4 Secretary may apply a civil monetary penalty with
5 respect to such provider or facility (including, as ap-
6 plicable, a provider of air ambulance services) in an
7 amount not to exceed \$10,000 per violation. The
8 provisions of subsections (c) (with the exception of
9 the first sentence of paragraph (1) of such sub-
10 section), (d), (e), (g), (h), (k), and (l) of section
11 1128A of the Social Security Act shall apply to a
12 civil monetary penalty or assessment under this sub-
13 section in the same manner as such provisions apply
14 to a penalty, assessment, or proceeding under sub-
15 section (a) of such section.

16 “(2) LIMITATION.—The provisions of para-
17 graph (1) shall apply to enforcement of a provision
18 (or provisions) specified in subsection (a)(1) only as
19 provided under subsection (a)(2).

20 “(3) COMPLAINT PROCESS.—The Secretary
21 shall, through rulemaking, establish a process to re-
22 ceive consumer complaints of violations of such pro-
23 visions and provide a response to such complaints
24 within 60 days of receipt of such complaints.

1 “(4) EXCEPTION.—The Secretary shall waive
2 the penalties described under paragraph (1) with re-
3 spect to a facility or provider (including a provider
4 of air ambulance services) who does not knowingly
5 violate, and should not have reasonably known it vio-
6 lated, section 2799B–1, 2799B–2, or 2799B–10 (or,
7 in the case of a provider of air ambulance services,
8 section 2799B–5) (including as such respective sec-
9 tion is applied through section 2799B–11) with re-
10 spect to a participant, beneficiary, or enrollee, if
11 such facility or practitioner, within 30 days of the
12 violation, withdraws the bill that was in violation of
13 such provision and reimburses the health plan or en-
14 rollee, as applicable, in an amount equal to the dif-
15 ference between the amount billed and the amount
16 allowed to be billed under the provision, plus inter-
17 est, at an interest rate determined by the Secretary.

18 “(5) HARDSHIP EXEMPTION.—The Secretary
19 may establish a hardship exemption to the penalties
20 under this subsection.

21 “(c) CONTINUED APPLICABILITY OF STATE LAW.—
22 The sections specified in subsection (a)(1) shall not be
23 construed to supersede any provision of State law which
24 establishes, implements, or continues in effect any require-
25 ment or prohibition except to the extent that such require-

1 ment or prohibition prevents the application of a require-
2 ment or prohibition of such a section.”.

3 (b) SECRETARY OF LABOR ENFORCEMENT.—

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

8 **“SEC. 522. COORDINATION OF ENFORCEMENT REGARDING**
9 **VIOLATIONS OF CERTAIN HEALTH CARE PRO-**
10 **VIDER REQUIREMENTS; COMPLAINT PROC-**
11 **ESS.**

12 “(a) INVESTIGATING VIOLATIONS.—Upon receiving a
13 notice from a State or the Secretary of Health and Human
14 Services of violations of sections 2799A–1 or 2799A–2 of
15 the Public Health Service Act, the Secretary of Labor
16 shall identify patterns of such violations with respect to
17 participants or beneficiaries under a group health plan or
18 group health insurance coverage offered by a health insur-
19 ance issuer and conduct an investigation pursuant to sec-
20 tion 504 where appropriate, as determined by the Sec-
21 retary. The Secretary shall coordinate with States and the
22 Secretary of Health and Human Services, in accordance
23 with section 506 and with section 104 of Health Insurance
24 Portability and Accountability Act of 1996, where appro-
25 priate, as determined by the Secretary, to ensure that ap-

1 appropriate measures have been taken to correct such viola-
2 tions retrospectively and prospectively with respect to par-
3 ticipants or beneficiaries under a group health plan or
4 group health insurance coverage offered by a health insur-
5 ance issuer.

6 “(b) COMPLAINT PROCESS.— Not later than January
7 1, 2022, the Secretary shall ensure a process under which
8 the Secretary—

9 “(1) may receive complaints from participants
10 and beneficiaries of group health plans or group
11 health insurance coverage offered by a health insur-
12 ance issuer relating to alleged violations of the sec-
13 tions specified in subsection (a); and

14 “(2) transmits such complaints to States or the
15 Secretary of Health and Human Services (as deter-
16 mined appropriate by the Secretary) for potential
17 enforcement actions.”.

18 (2) TECHNICAL AMENDMENT.—The table of
19 contents in section 1 of the Employee Retirement
20 Income Security Act of 1974 (29 U.S.C. 1001 et
21 seq.) is amended by inserting after the item relating
22 to section 521 the following new item:

“Sec. 522. Coordination of enforcement regarding violations of certain health
care provider requirements; complaint process.”.

1 **SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS.**

2 (a) GROUP HEALTH PLANS AND INDIVIDUAL AND
3 GROUP HEALTH INSURANCE COVERAGE.—

4 (1) PHSA AMENDMENTS.—Part D of title
5 XXVII of the Public Health Service Act, as added
6 and amended by section 102 and further amended
7 by the previous provisions of this title, is further
8 amended by inserting after section 2799A–1 the fol-
9 lowing:

10 **“SEC. 2799A–2. ENDING SURPRISE AIR AMBULANCE BILLS.**

11 “(a) IN GENERAL.—In the case of a participant, ben-
12 efiary, or enrollee who is in a group health plan or group
13 or individual health insurance coverage offered by a health
14 insurance issuer and who receives air ambulance services
15 from a nonparticipating provider (as defined in section
16 2799A–1(a)(3)(G)) with respect to such plan or coverage,
17 if such services would be covered if provided by a partici-
18 pating provider (as defined in such section) with respect
19 to such plan or coverage—

20 “(1) the cost-sharing requirement with respect
21 to such services shall be the same requirement that
22 would apply if such services were provided by such
23 a participating provider, and any coinsurance or de-
24 ductible shall be based on rates that would apply for
25 such services if they were furnished by such a par-
26 ticipating provider;

1 “(2) such cost-sharing amounts shall be count-
2 ed towards the in-network deductible and in-network
3 out-of-pocket maximum amount under the plan or
4 coverage for the plan year (and such in-network de-
5 ductible shall be applied) with respect to such items
6 and services so furnished in the same manner as if
7 such cost-sharing payments were with respect to
8 items and services furnished by a participating pro-
9 vider; and

10 “(3) the plan or coverage shall pay, in accord-
11 ance with, if applicable, subsection (b)(5)(F), di-
12 rectly to such provider furnishing such services to
13 such participant, beneficiary, or enrollee the amount
14 by which the out-of-network rate (as defined in sec-
15 tion 2799A-1(a)(3)(K)) for such services and year
16 involved exceeds the cost-sharing amount imposed
17 under the plan or coverage, respectively, for such
18 services (as determined in accordance with para-
19 graphs (1) and (2)).

20 “(b) DETERMINATION OF OUT-OF-NETWORK RATES
21 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
22 RESOLUTION PROCESS.—

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

1 “(A) IN GENERAL.—With respect to air
2 ambulance services furnished in a year by a
3 nonparticipating provider, with respect to a
4 group health plan or health insurance issuer of-
5 fering group or individual health insurance cov-
6 erage, in a State described in subsection section
7 2799A–1(a)(3)(K)(ii) with respect to such plan
8 or coverage and provider, and for which a pay-
9 ment is required to be made by the plan or cov-
10 erage pursuant to subsection (a)(3), the pro-
11 vider or plan or coverage may, during the 30-
12 day period beginning on the day the provider
13 receives a response from the plan or coverage
14 regarding a claim for payment for such service,
15 initiate open negotiations under this paragraph
16 between such provider and plan or coverage for
17 purposes of determining, during the open nego-
18 tiation period, an amount agreed on by such
19 provider, and such plan or coverage for pay-
20 ment (including any cost-sharing) for such serv-
21 ice. For purposes of this subsection, the open
22 negotiation period, with respect to air ambu-
23 lance services, is the 30-day period beginning
24 on the date of initiation of the negotiations with
25 respect to such services.

1 “(B) ACCESSING INDEPENDENT DISPUTE
2 RESOLUTION PROCESS IN CASE OF FAILED NE-
3 GOTIATIONS.—In the case of open negotiations
4 pursuant to subparagraph (A), with respect to
5 air ambulance services, that do not result in a
6 determination of an amount of payment for
7 such services by the last day of the open nego-
8 tiation period described in such subparagraph
9 with respect to such services, the provider or
10 group health plan or health insurance issuer of-
11 fering group or individual health insurance cov-
12 erage that was party to such negotiations may,
13 during the 2-day period beginning on the day
14 after such open negotiation period, initiate the
15 independent dispute resolution process under
16 paragraph (2) with respect to such item or
17 service. The independent dispute resolution
18 process shall be initiated by a party pursuant to
19 the previous sentence by submission to the
20 other party and to the Secretary of a notifica-
21 tion (containing such information as specified
22 by the Secretary) and for purposes of this sub-
23 section, the date of initiation of such process
24 shall be the date of such submission or such
25 other date specified by the Secretary pursuant

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

4 “(2) INDEPENDENT DISPUTE RESOLUTION
5 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
6 GOTIATIONS.—

7 “(A) ESTABLISHMENT.—Not later than 1
8 year after the date of the enactment of this
9 subsection, the Secretary, jointly with the Sec-
10 retary of Labor and the Secretary of the Treas-
11 ury, shall establish by regulation one inde-
12 pendent dispute resolution process (referred to
13 in this subsection as the ‘IDR process’) under
14 which, in the case of air ambulance services
15 with respect to which a provider or group
16 health plan or health insurance issuer offering
17 group or individual health insurance coverage
18 submits a notification under paragraph (1)(B)
19 (in this subsection referred to as a ‘qualified
20 IDR air ambulance services’), a certified IDR
21 entity under paragraph (4) determines, subject
22 to subparagraph (B) and in accordance with
23 the succeeding provisions of this subsection, the
24 amount of payment under the plan or coverage
25 for such services furnished by such provider.

1 “(B) AUTHORITY TO CONTINUE NEGOTIA-
2 TIONS.—Under the independent dispute resolu-
3 tion process, in the case that the parties to a
4 determination for qualified IDR air ambulance
5 services agree on a payment amount for such
6 services during such process but before the date
7 on which the entity selected with respect to
8 such determination under paragraph (4) makes
9 such determination under paragraph (5), such
10 amount shall be treated for purposes of section
11 2799A–1(a)(3)(K)(ii) as the amount agreed to
12 by such parties for such services. In the case of
13 an agreement described in the previous sen-
14 tence, the independent dispute resolution proc-
15 ess shall provide for a method to determine how
16 to allocate between the parties to such deter-
17 mination the payment of the compensation of
18 the entity selected with respect to such deter-
19 mination.

20 “(C) CLARIFICATION.—A nonparticipating
21 provider may not, with respect to an item or
22 service furnished by such provider, submit a no-
23 tification under paragraph (1)(B) if such pro-
24 vider is exempt from the requirement under
25 subsection (a) of section 2799B–2 with respect

1 to such item or service pursuant to subsection
2 (b) of such section.

3 “(3) TREATMENT OF BATCHING OF SERV-
4 ICES.—The provisions of section 2799A–1(c)(3)
5 shall apply with respect to a notification submitted
6 under this subsection with respect to air ambulance
7 services in the same manner and to the same extent
8 such provisions apply with respect to a notification
9 submitted under section 2799A–1(c) with respect to
10 items and services described in such section.

11 “(4) IDR ENTITIES.—

12 “(A) ELIGIBILITY.—An IDR entity cer-
13 tified under this subsection is an IDR entity
14 certified under section 2799A–1(c)(4).

15 “(B) SELECTION OF CERTIFIED IDR ENTI-
16 TY.—The provisions of subparagraph (F) of
17 section 2799A–1(c)(4) shall apply with respect
18 to selecting an IDR entity certified pursuant to
19 subparagraph (A) with respect to the deter-
20 mination of the amount of payment under this
21 subsection of air ambulance services in the
22 same manner as such provisions apply with re-
23 spect to selecting an IDR entity certified under
24 such section with respect to the determination
25 of the amount of payment under section

1 2799A–1(c) of an item or service. An entity se-
2 lected pursuant to the previous sentence to
3 make a determination described in such sen-
4 tence shall be referred to in this subsection as
5 the ‘certified IDR entity’ with respect to such
6 determination.

7 “(5) PAYMENT DETERMINATION.—

8 “(A) IN GENERAL.—Not later than 30
9 days after the date of selection of the certified
10 IDR entity, with respect to qualified IDR air
11 ambulance services, the certified independent
12 entity with respect to a determination under
13 this subsection for such services shall—

14 “(i) taking into account the consider-
15 ations specified in subparagraph (C), select
16 one of the offers submitted under subpara-
17 graph (B) to be the amount of payment for
18 such services determined under this sub-
19 section for purposes of subsection (a)(3);
20 and

21 “(ii) notify the provider or facility and
22 the group health plan or health insurance
23 issuer offering group or individual health
24 insurance coverage party to such deter-

1 mination of the offer selected under clause
2 (i).

3 “(B) SUBMISSION OF OFFERS.—Not later
4 than 10 days after the date of selection of the
5 certified IDR entity with respect to a deter-
6 mination for qualified IDR air ambulance serv-
7 ices, the provider and the group health plan or
8 health insurance issuer offering group or indi-
9 vidual health insurance coverage party to such
10 determination—

11 “(i) shall each submit to the certified
12 independent entity with respect to such de-
13 termination—

14 “(I) an offer for a payment
15 amount for such services furnished by
16 such provider; and

17 “(II) such information as re-
18 quested by the certified IDR entity re-
19 lating to such offer; and

20 “(ii) may each submit to the certified
21 independent entity with respect to such de-
22 termination any information relating to
23 such offer submitted by either party, in-
24 cluding information relating to any cir-

1 cumstance described in subparagraph
2 (C)(ii).

3 “(C) CONSIDERATIONS IN DETERMINA-
4 TION.—

5 “(i) IN GENERAL.—In determining
6 which offer is the payment to be applied
7 pursuant to this paragraph, the certified
8 IDR entity, with respect to the determina-
9 tion for a qualified IDR air ambulance
10 service shall consider—

11 “(I) the offers under subpara-
12 graph (B)(i);

13 “(II) the qualifying payment
14 amounts (as defined in subsection
15 (a)(3)(E)) for the applicable year for
16 items or services that are comparable
17 to the qualified IDR air ambulance
18 service and that are furnished in the
19 same geographic region (as defined by
20 the Secretary for purposes of such
21 subsection) as such qualified IDR air
22 ambulance service; and

23 “(III) information on any cir-
24 cumstance described in clause (ii),
25 such information requested in sub-

1 paragraph (B)(i)(II), and any addi-
2 tional information provided in sub-
3 paragraph (B)(ii).

4 “(ii) ADDITIONAL CIRCUMSTANCES.—
5 For purposes of clause (i)(II), the cir-
6 cumstances described in this clause are,
7 with respect to air ambulance services in-
8 cluded in the notification submitted under
9 paragraph (1)(A) of a nonparticipating
10 provider, group health plan, or health in-
11 surance issuer the following:

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

15 “(II) The acuity of the individual
16 receiving such services or the com-
17 plexity of furnishing such services to
18 such individual.

19 “(III) The training, experience,
20 and quality of the medical personnel
21 that furnished such services.

22 “(IV) Ambulance vehicle type, in-
23 cluding the clinical capability level of
24 such vehicle.

1 “(V) Population density of the
2 pick up location (such as urban, sub-
3 urban, rural, or frontier).

4 “(VI) Demonstrations of good
5 faith efforts (or lack of good faith ef-
6 forts) made by the nonparticipating
7 provider or nonparticipating facility or
8 the plan or issuer to enter into net-
9 work agreements and, if applicable,
10 contracted rates between the provider
11 and the plan or issuer, as applicable,
12 during the previous 4 plan years.

13 “(iii) PROHIBITION ON CONSIDER-
14 ATION OF BILLED CHARGES.—In deter-
15 mining which offer is the payment amount
16 to be applied with respect to qualified IDR
17 air ambulance services furnished by a pro-
18 vider, the certified IDR entity with respect
19 to such determination shall not consider
20 usual and customary charges or the
21 amount that would have been billed by
22 such provider with respect to such services
23 had the provisions of section 2799B–5 not
24 applied.

1 “(D) EFFECTS OF DETERMINATION.—The
2 provisions of section 2799A–1(c)(5)(D)) shall
3 apply with respect to a determination of a cer-
4 tified IDR entity under subparagraph (A), the
5 notification submitted with respect to such de-
6 termination, the services with respect to such
7 notification, and the parties to such notification
8 in the same manner as such provisions apply
9 with respect to a determination of a certified
10 IDR entity under section 2799A–1(c)(5)(D),
11 the notification submitted with respect to such
12 determination, the items and services with re-
13 spect to such notification, and the parties to
14 such notification.

15 “(E) COSTS OF INDEPENDENT DISPUTE
16 RESOLUTION PROCESS.—The provisions of sec-
17 tion 2799A–1(c)(5)(E) shall apply to a notifica-
18 tion made under this subsection, the parties to
19 such notification, and a determination under
20 subparagraph (A) in the same manner and to
21 the same extent such provisions apply to a noti-
22 fication under section 2799A–1(c), the parties
23 to such notification and a determination made
24 under section 2799A–1(c)(5)(A).

1 “(6) TIMING OF PAYMENT.—Payment required
2 pursuant to subsection (a)(3), with respect to quali-
3 fied IDR air ambulance services for which a deter-
4 mination is made under paragraph (5)(A) or with
5 respect to an air ambulance service for which a pay-
6 ment amount is determined under open negotiations
7 under paragraph (1), shall be made directly to the
8 nonparticipating provider not later than 30 days
9 after the date on which such determination is made.

10 “(7) PUBLICATION OF INFORMATION RELATING
11 TO THE IDR PROCESS.—

12 “(A) IN GENERAL.—For each calendar
13 quarter in 2022 and each calendar quarter in a
14 subsequent year, the Secretary shall publish on
15 the public website of the Department of Health
16 and Human Services—

17 “(i) the number of notifications sub-
18 mitted under the IDR process during such
19 calendar quarter;

20 “(ii) the number of such notifications
21 with respect to which a final determination
22 was made under paragraph (5)(A);

23 “(iii) the information described in
24 subparagraph (B) with respect to each no-

1 tification with respect to which such a de-
2 termination was so made.

3 “(iv) the number of times the pay-
4 ment amount determined (or agreed to)
5 under this subsection exceeds the quali-
6 fying payment amount;

7 “(v) the amount of expenditures made
8 by the Secretary during such calendar
9 quarter to carry out the IDR process;

10 “(vi) the total amount of fees paid
11 under paragraph (7) during such calendar
12 quarter; and

13 “(vii) the total amount of compensa-
14 tion paid to certified IDR entities under
15 paragraph (5)(E) during such calendar
16 quarter.

17 “(B) INFORMATION WITH RESPECT TO RE-
18 QUESTS.—For purposes of subparagraph (A),
19 the information described in this subparagraph
20 is, with respect to a notification under the IDR
21 process of a nonparticipating provider, group
22 health plan, or health insurance issuer offering
23 group or individual health insurance coverage—

24 “(i) a description of each air ambu-
25 lance service included in such notification;

1 “(ii) the geography in which the serv-
2 ices included in such notification were pro-
3 vided;

4 “(iii) the amount of the offer sub-
5 mitted under paragraph (2) by the group
6 health plan or health insurance issuer (as
7 applicable) and by the nonparticipating
8 provider expressed as a percentage of the
9 qualifying payment amount;

10 “(iv) whether the offer selected by the
11 certified IDR entity under paragraph (5)
12 to be the payment applied was the offer
13 submitted by such plan or issuer (as appli-
14 cable) or by such provider and the amount
15 of such offer so selected expressed as a
16 percentage of the qualifying payment
17 amount;

18 “(v) ambulance vehicle type, including
19 the clinical capability level of such vehicle;

20 “(vi) the identity of the group health
21 plan or health insurance issuer or air am-
22 bulance provider with respect to such noti-
23 fication;

24 “(vii) the length of time in making
25 each determination;

1 “(viii) the compensation paid to the
2 certified IDR entity with respect to the
3 settlement or determination; and

4 “(ix) any other information specified
5 by the Secretary.

6 “(C) IDR ENTITY REQUIREMENTS.—For
7 2022 and each subsequent year, an IDR entity,
8 as a condition of certification as an IDR entity,
9 shall submit to the Secretary such information
10 as the Secretary determines necessary for the
11 Secretary to carry out the provisions of this
12 paragraph.

13 “(D) CLARIFICATION.—The Secretary
14 shall ensure the public reporting under this
15 paragraph does not contain information that
16 would disclose privileged or confidential infor-
17 mation of a group health plan or health insur-
18 ance issuer offering group or individual health
19 insurance coverage or of a provider or facility.

20 “(8) ADMINISTRATIVE FEE.—

21 “(A) IN GENERAL.—Each party to a deter-
22 mination under paragraph (5) to which an enti-
23 ty is selected under paragraph (4) in a year
24 shall pay to the Secretary, at such time and in
25 such manner as specified by the Secretary, a

1 fee for participating in the IDR process with re-
2 spect to such determination in an amount de-
3 scribed in subparagraph (B) for such year.

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

12 “(9) WAIVER AUTHORITY.—The Secretary may
13 modify any deadline or other timing required speci-
14 fied under this subsection (other than under para-
15 graph (6)) in cases of extenuating circumstances, as
16 specified by the Secretary.

17 “(c) DEFINITION.—For purposes of this section, the
18 term ‘air ambulance service’ means medical transport by
19 helicopter or airplane for patients.”.

20 (2) ERISA AMENDMENT.—

21 (A) IN GENERAL.—Subpart B of part 7 of
22 title I of the Employee Retirement Income Se-
23 curity Act of 1974 (29 U.S.C. 1185 et seq.), as
24 amended by section 102(b) and further amend-
25 ed by the previous provisions of this title, is fur-

1 ther amended by inserting after section 716 the
2 following:

3 **“SEC. 717. ENDING SURPRISE AIR AMBULANCE BILLS.**

4 “(a) IN GENERAL.—In the case of a participant, ben-
5 ficiary, or enrollee who is in a group health plan or group
6 health insurance coverage offered by a health insurance
7 issuer and who receives air ambulance services from a non-
8 participating provider (as defined in section 716(a)(3)(G))
9 with respect to such plan or coverage, if such services
10 would be covered if provided by a participating provider
11 (as defined in such section) with respect to such plan or
12 coverage—

13 “(1) the cost-sharing requirement with respect
14 to such services shall be the same requirement that
15 would apply if such services were provided by such
16 a participating provider, and any coinsurance or de-
17 ductible shall be based on rates that would apply for
18 such services if they were furnished by such a par-
19 ticipating provider;

20 “(2) such cost-sharing amounts shall be count-
21 ed towards the in-network deductible and in-network
22 out-of-pocket maximum amount under the plan or
23 coverage for the plan year (and such in-network de-
24 ductible shall be applied) with respect to such items
25 and services so furnished in the same manner as if

1 such cost-sharing payments were with respect to
2 items and services furnished by a participating pro-
3 vider; and

4 “(3) the plan or coverage shall pay, in accord-
5 ance with, if applicable, subsection (b)(5)(F), di-
6 rectly to such provider furnishing such services to
7 such participant, beneficiary, or enrollee the amount
8 by which the out-of-network rate (as defined in sec-
9 tion 716(a)(3)(K)) for such services and year in-
10 volved exceeds the cost-sharing amount imposed
11 under the plan or coverage, respectively, for such
12 services (as determined in accordance with para-
13 graphs (1) and (2)).

14 “(b) DETERMINATION OF OUT-OF-NETWORK RATES
15 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
16 RESOLUTION PROCESS.—

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

19 “(A) IN GENERAL.—With respect to air
20 ambulance services furnished in a year by a
21 nonparticipating provider, with respect to a
22 group health plan or health insurance issuer of-
23 fering group health insurance coverage, in a
24 State described in subsection section
25 716(a)(3)(K)(ii) with respect to such plan or

1 coverage and provider, and for which a payment
2 is required to be made by the plan or coverage
3 pursuant to subsection (a)(3), the provider or
4 plan or coverage may, during the 30-day period
5 beginning on the day the provider receives a re-
6 sponse from the plan or coverage regarding a
7 claim for payment for such service, initiate open
8 negotiations under this paragraph between such
9 provider and plan or coverage for purposes of
10 determining, during the open negotiation pe-
11 riod, an amount agreed on by such provider,
12 and such plan or coverage for payment (includ-
13 ing any cost-sharing) for such service. For pur-
14 poses of this subsection, the open negotiation
15 period, with respect to air ambulance services,
16 is the 30-day period beginning on the date of
17 initiation of the negotiations with respect to
18 such services.

19 “(B) ACCESSING INDEPENDENT DISPUTE
20 RESOLUTION PROCESS IN CASE OF FAILED NE-
21 GOTIATIONS.—In the case of open negotiations
22 pursuant to subparagraph (A), with respect to
23 air ambulance services, that do not result in a
24 determination of an amount of payment for
25 such services by the last day of the open nego-

1 tiation period described in such subparagraph
2 with respect to such services, the provider or
3 group health plan or health insurance issuer of-
4 fering group health insurance coverage that was
5 party to such negotiations may, during the 2-
6 day period beginning on the day after such
7 open negotiation period, initiate the inde-
8 pendent dispute resolution process under para-
9 graph (2) with respect to such item or service.
10 The independent dispute resolution 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) INDEPENDENT DISPUTE RESOLUTION
23 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
24 GOTIATIONS.—

1 “(A) ESTABLISHMENT.—Not later than 1
2 year after the date of the enactment of this
3 subsection, the Secretary, jointly with the Sec-
4 retary of Health and Human Services and the
5 Secretary of the Treasury, shall establish by
6 regulation one independent dispute resolution
7 process (referred to in this subsection as the
8 ‘IDR process’) under which, in the case of air
9 ambulance services with respect to which a pro-
10 vider or group health plan or health insurance
11 issuer offering group health insurance coverage
12 submits a notification under paragraph (1)(B)
13 (in this subsection referred to as a ‘qualified
14 IDR air ambulance services’), a certified IDR
15 entity under paragraph (4) determines, subject
16 to subparagraph (B) and in accordance with
17 the succeeding provisions of this subsection, the
18 amount of payment under the plan or coverage
19 for such services furnished by such provider.

20 “(B) AUTHORITY TO CONTINUE NEGOTIA-
21 TIONS.—Under the independent dispute resolu-
22 tion process, in the case that the parties to a
23 determination for qualified IDR air ambulance
24 services agree on a payment amount for such
25 services during such process but before the date

1 on which the entity selected with respect to
2 such determination under paragraph (4) makes
3 such determination under paragraph (5), such
4 amount shall be treated for purposes of section
5 716(a)(3)(K)(ii) as the amount agreed to by
6 such parties for such services. In the case of an
7 agreement described in the previous sentence,
8 the independent dispute resolution process shall
9 provide for a method to determine how to allo-
10 cate between the parties to such determination
11 the payment of the compensation of the entity
12 selected with respect to such determination.

13 “(C) CLARIFICATION.—A nonparticipating
14 provider may not, with respect to an item or
15 service furnished by such provider, submit a no-
16 tification under paragraph (1)(B) if such pro-
17 vider is exempt from the requirement under
18 subsection (a) of section 2799B–2 of the Public
19 Health Service Act with respect to such item or
20 service pursuant to subsection (b) of such sec-
21 tion.

22 “(3) TREATMENT OF BATCHING OF SERV-
23 ICES.—The provisions of section 716(c)(3) shall
24 apply with respect to a notification submitted under
25 this subsection with respect to air ambulance serv-

1 ices in the same manner and to the same extent
2 such provisions apply with respect to a notification
3 submitted under section 716(c) with respect to items
4 and services described in such section.

5 “(4) IDR ENTITIES.—

6 “(A) ELIGIBILITY.—An IDR entity cer-
7 tified under this subsection is an IDR entity
8 certified under section 716(c)(4).

9 “(B) SELECTION OF CERTIFIED IDR ENTI-
10 TY.—The provisions of subparagraph (F) of
11 section 716(c)(4) shall apply with respect to se-
12 lecting an IDR entity certified pursuant to sub-
13 paragraph (A) with respect to the determina-
14 tion of the amount of payment under this sub-
15 section of air ambulance services in the same
16 manner as such provisions apply with respect to
17 selecting an IDR entity certified under such
18 section with respect to the determination of the
19 amount of payment under section 716(c) of an
20 item or service. An entity selected pursuant to
21 the previous sentence to make a determination
22 described in such sentence shall be referred to
23 in this subsection as the ‘certified IDR entity’
24 with respect to such determination.

25 “(5) PAYMENT DETERMINATION.—

1 “(A) IN GENERAL.—Not later than 30
2 days after the date of selection of the certified
3 IDR entity, with respect to qualified IDR air
4 ambulance services, the certified independent
5 entity with respect to a determination under
6 this subsection for such services shall—

7 “(i) taking into account the consider-
8 ations specified in subparagraph (C), select
9 one of the offers submitted under subpara-
10 graph (B) to be the amount of payment for
11 such services determined under this sub-
12 section for purposes of subsection (a)(3);
13 and

14 “(ii) notify the provider or facility and
15 the group health plan or health insurance
16 issuer offering group health insurance cov-
17 erage party to such determination of the
18 offer selected under clause (i).

19 “(B) SUBMISSION OF OFFERS.—Not later
20 than 10 days after the date of selection of the
21 certified IDR entity with respect to a deter-
22 mination for qualified IDR air ambulance serv-
23 ices, the provider and the group health plan or
24 health insurance issuer offering group health

1 insurance coverage party to such determina-
2 tion—

3 “(i) shall each submit to the certified
4 independent entity with respect to such de-
5 termination—

6 “(I) an offer for a payment
7 amount for such services furnished by
8 such provider; and

9 “(II) such information as re-
10 quested by the certified IDR entity re-
11 lating to such offer; and

12 “(ii) may each submit to the certified
13 independent entity with respect to such de-
14 termination any information relating to
15 such offer submitted by either party, in-
16 cluding information relating to any cir-
17 cumstance described in subparagraph
18 (C)(ii).

19 “(C) CONSIDERATIONS IN DETERMINA-
20 TION.—

21 “(i) IN GENERAL.—In determining
22 which offer is the payment to be applied
23 pursuant to this paragraph, the certified
24 IDR entity, with respect to the determina-

1 tion for a qualified IDR air ambulance
2 service shall consider—

3 “(I) the offers under subpara-
4 graph (B)(i);

5 “(II) the qualifying payment
6 amounts (as defined in subsection
7 (a)(3)(E)) for the applicable year for
8 items and services that are com-
9 parable to the qualified IDR air am-
10 bulance service and that are furnished
11 in the same geographic region (as de-
12 fined by the Secretary for purposes of
13 such subsection) as such qualified
14 IDR air ambulance service; and

15 “(III) information on any cir-
16 cumstance described in clause (ii),
17 such information requested in sub-
18 paragraph (B)(i)(II), and any addi-
19 tional information provided in sub-
20 paragraph (B)(ii).

21 “(ii) ADDITIONAL CIRCUMSTANCES.—
22 For purposes of clause (i)(II), the cir-
23 cumstances described in this clause are,
24 with respect to air ambulance services in-
25 cluded in the notification submitted under

1 paragraph (1)(A) of a nonparticipating
2 provider, group health plan, or health in-
3 surance issuer the following:

4 “(I) The quality and outcomes
5 measurements of the provider that
6 furnished such services.

7 “(II) The acuity of the individual
8 receiving such services or the com-
9 plexity of furnishing such services to
10 such individual.

11 “(III) The training, experience,
12 and quality of the medical personnel
13 that furnished such services.

14 “(IV) Ambulance vehicle type, in-
15 cluding the clinical capability level of
16 such vehicle.

17 “(V) Population density of the
18 pick up location (such as urban, sub-
19 urban, rural, or frontier).

20 “(VI) Demonstrations of good
21 faith efforts (or lack of good faith ef-
22 forts) made by the nonparticipating
23 provider or nonparticipating facility or
24 the plan or issuer to enter into net-
25 work agreements and, if applicable,

1 contracted rates between the provider
2 and the plan or issuer, as applicable,
3 during the previous 4 plan years.

4 “(iii) PROHIBITION ON CONSIDER-
5 ATION OF BILLED CHARGES.—In deter-
6 mining which offer is the payment amount
7 to be applied with respect to qualified IDR
8 air ambulance services furnished by a pro-
9 vider, the certified IDR entity with respect
10 to such determination shall not consider
11 usual and customary charges or the
12 amount that would have been billed by
13 such provider with respect to such services
14 had the provisions of section 2799B–5 of
15 the Public Health Service Act not applied.

16 “(D) EFFECTS OF DETERMINATION.—The
17 provisions of section 716(c)(5)(D)) shall apply
18 with respect to a determination of a certified
19 IDR entity under subparagraph (A), the notifi-
20 cation submitted with respect to such deter-
21 mination, the services with respect to such noti-
22 fication, and the parties to such notification in
23 the same manner as such provisions apply with
24 respect to a determination of a certified IDR
25 entity under section 716(c)(5)(D), the notifica-

1 tion submitted with respect to such determina-
2 tion, the items and services with respect to such
3 notification, and the parties to such notifica-
4 tion.

5 “(E) COSTS OF INDEPENDENT DISPUTE
6 RESOLUTION PROCESS.—The provisions of sec-
7 tion 716(c)(5)(E) shall apply to a notification
8 made under this subsection, the parties to such
9 notification, and a determination under sub-
10 paragraph (A) in the same manner and to the
11 same extent such provisions apply to a notifica-
12 tion under section 716(c), the parties to such
13 notification and a determination made under
14 section 716(c)(5)(A).

15 “(6) TIMING OF PAYMENT.—Payment required
16 pursuant to subsection (a)(3), with respect to quali-
17 fied IDR air ambulance services for which a deter-
18 mination is made under paragraph (5)(A) or with
19 respect to air ambulance services for which a pay-
20 ment amount is determined under open negotiations
21 under paragraph (1), shall be made directly to the
22 nonparticipating provider not later than 30 days
23 after the date on which such determination is made.

24 “(7) PUBLICATION OF INFORMATION RELATING
25 TO THE IDR PROCESS.—

1 “(A) IN GENERAL.—For each calendar
2 quarter in 2022 and each calendar quarter in a
3 subsequent year, the Secretary shall publish on
4 the public website of the Department of
5 Labor—

6 “(i) the number of notifications sub-
7 mitted under the IDR process during such
8 calendar quarter;

9 “(ii) the number of such notifications
10 with respect to which a final determination
11 was made under paragraph (5)(A);

12 “(iii) the information described in
13 subparagraph (B) with respect to each no-
14 tification with respect to which such a de-
15 termination was so made.

16 “(iv) the number of times the pay-
17 ment amount determined (or agreed to)
18 under this subsection exceeds the quali-
19 fying payment amount;

20 “(v) the amount of expenditures made
21 by the Secretary during such calendar
22 quarter to carry out the IDR process;

23 “(vi) the total amount of fees paid
24 under paragraph (7) during such calendar
25 quarter; and

1 “(vii) the total amount of compensa-
2 tion paid to certified IDR entities under
3 paragraph (5)(E)during such calendar
4 quarter.

5 “(B) INFORMATION WITH RESPECT TO RE-
6 QUESTS.—For purposes of subparagraph (A),
7 the information described in this subparagraph
8 is, with respect to a notification under the IDR
9 process of a nonparticipating provider, group
10 health plan, or health insurance issuer offering
11 group health insurance coverage—

12 “(i) a description of each air ambu-
13 lance service included in such notification;

14 “(ii) the geography in which the serv-
15 ices included in such notification were pro-
16 vided;

17 “(iii) the amount of the offer sub-
18 mitted under paragraph (2) by the group
19 health plan or health insurance issuer (as
20 applicable) and by the nonparticipating
21 provider expressed as a percentage of the
22 qualifying payment amount;

23 “(iv) whether the offer selected by the
24 certified IDR entity under paragraph (5)
25 to be the payment applied was the offer

1 submitted by such plan or issuer (as appli-
2 cable) or by such provider and the amount
3 of such offer so selected expressed as a
4 percentage of the qualifying payment
5 amount;

6 “(v) ambulance vehicle type, including
7 the clinical capability level of such vehicle;

8 “(vi) the identity of the group health
9 plan or health insurance issuer or air am-
10 bulance provider with respect to such noti-
11 fication;

12 “(vii) the length of time in making
13 each determination;

14 “(viii) the compensation paid to the
15 certified IDR entity with respect to the
16 settlement or determination; and

17 “(ix) any other information specified
18 by the Secretary.

19 “(C) IDR ENTITY REQUIREMENTS.—For
20 2022 and each subsequent year, an IDR entity,
21 as a condition of certification as an IDR entity,
22 shall submit to the Secretary such information
23 as the Secretary determines necessary for the
24 Secretary to carry out the provisions of this
25 paragraph.

1 “(D) CLARIFICATION.—The Secretary
2 shall ensure the public reporting under this
3 paragraph does not contain information that
4 would disclose privileged or confidential infor-
5 mation of a group health plan or health insur-
6 ance issuer offering group or individual health
7 insurance coverage or of a provider or facility.

8 “(8) ADMINISTRATIVE FEE.—

9 “(A) IN GENERAL.—Each party to a deter-
10 mination under paragraph (5) to which an enti-
11 ty is selected under paragraph (4) in a year
12 shall pay to the Secretary, at such time and in
13 such manner as specified by the Secretary, a
14 fee for participating in the IDR 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 IDR process.

1 “(9) WAIVER AUTHORITY.—The Secretary may
2 modify any deadline or other timing required speci-
3 fied under this subsection (other than under para-
4 graph (6)) in cases of extenuating circumstances, as
5 specified by the Secretary.

6 “(c) DEFINITION.—For purposes of this section:

7 “(1) AIR AMBULANCE SERVICES.—The term
8 ‘air ambulance service’ means medical transport by
9 helicopter or airplane for patients.

10 “(2) QUALIFYING PAYMENT AMOUNT.—The
11 term ‘qualifying payment amount’ has the meaning
12 given such term in section 716(b)(3).

13 “(3) NONPARTICIPATING PROVIDER.—The term
14 ‘nonparticipating provider’ has the meaning given
15 such term in section 716(b)(3).”.

16 (3) IRC AMENDMENTS.—

17 (A) IN GENERAL.—Subchapter B of chap-
18 ter 100 of the Internal Revenue Code of 1986,
19 as amended by section 102(c) and further
20 amended by the previous provisions of this title,
21 is further amended by inserting after section
22 9816 the following:

23 **“SEC. 9817. ENDING SURPRISE AIR AMBULANCE BILLS.**

24 “(a) IN GENERAL.—In the case of a participant, ben-
25 eficiary, or enrollee in a group health plan who receives

1 air ambulance services from a nonparticipating provider
2 (as defined in section 9816(a)(3)(G)) with respect to such
3 plan, if such services would be covered if provided by a
4 participating provider (as defined in such section) with re-
5 spect to such plan—

6 “(1) the cost-sharing requirement with respect
7 to such services shall be the same requirement that
8 would apply if such services were provided by such
9 a participating provider, and any coinsurance or de-
10 ductible shall be based on rates that would apply for
11 such services if they were furnished by such a par-
12 ticipating provider;

13 “(2) such cost-sharing amounts shall be count-
14 ed towards the in-network deductible and in-network
15 out-of-pocket maximum amount under the plan for
16 the plan year (and such in-network deductible shall
17 be applied) with respect to such items and services
18 so furnished in the same manner as if such cost-
19 sharing payments were with respect to items and
20 services furnished by a participating provider; and

21 “(3) the plan shall pay, in accordance with, if
22 applicable, subsection (b)(5)(F), directly to such pro-
23 vider furnishing such services to such participant,
24 beneficiary, or enrollee at least the amount by which
25 the recognized amount (as defined in and deter-

1 mined pursuant to section 9816(a)(3)(H)(ii) for
2 such services and year involved exceeds the cost-
3 sharing amount imposed under the plan for such
4 services (as determined in accordance with para-
5 graphs (1) and (2)).

6 “(b) DETERMINATION OF OUT-OF-NETWORK RATES
7 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
8 RESOLUTION PROCESS.—

9 “(1) DETERMINATION THROUGH OPEN NEGOTIATION.—
10 TATION.—

11 “(A) IN GENERAL.—With respect to air
12 ambulance services furnished in a year by a
13 nonparticipating provider, with respect to a
14 group health plan, in a State described in sub-
15 section section 9816(a)(3)(K)(ii) with respect to
16 such plan and provider, and for which a pay-
17 ment is required to be made by the plan pursu-
18 ant to subsection (a)(3), the provider or plan
19 may, during the 30-day period beginning on the
20 day the provider receives a response from the
21 plan regarding a claim for payment for such
22 service, initiate open negotiations under this
23 paragraph between such provider and plan for
24 purposes of determining, during the open nego-
25 tiation period, an amount agreed on by such

1 provider, and such plan for payment (including
2 any cost-sharing) for such service. For purposes
3 of this subsection, the open negotiation period,
4 with respect to air ambulance services, is the
5 30-day period beginning on the date of initi-
6 ation of the negotiations with respect to such
7 services.

8 “(B) ACCESSING INDEPENDENT DISPUTE
9 RESOLUTION PROCESS IN CASE OF FAILED NE-
10 GOTIATIONS.—In the case of open negotiations
11 pursuant to subparagraph (A), with respect to
12 air ambulance services, that do not result in a
13 determination of an amount of payment for
14 such services by the last day of the open nego-
15 tiation period described in such subparagraph
16 with respect to such services, the provider or
17 group health plan that was party to such nego-
18 tiations may, during the 2-day period beginning
19 on the day after such open negotiation period,
20 initiate the independent dispute resolution proc-
21 ess under paragraph (2) with respect to such
22 services. The independent dispute resolution
23 process shall be initiated by a party pursuant to
24 the previous sentence by submission to the
25 other party and to the Secretary of a notifica-

1 tion (containing such information as specified
2 by the Secretary) and for purposes of this sub-
3 section, the date of initiation of such process
4 shall be the date of such submission or such
5 other date specified by the Secretary pursuant
6 to regulations that is not later than the date of
7 receipt of such notification by both the other
8 party and the Secretary.

9 “(2) INDEPENDENT DISPUTE RESOLUTION
10 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
11 GOTIATIONS.—

12 “(A) ESTABLISHMENT.—Not later than 1
13 year after the date of the enactment of this
14 subsection, the Secretary, jointly with the Sec-
15 retary of Health and Human Services and the
16 Secretary of Labor, shall establish by regulation
17 one independent dispute resolution process (re-
18 ferred to in this subsection as the ‘IDR proc-
19 ess’) under which, in the case of air ambulance
20 services with respect to which a provider or
21 group health plan submits a notification under
22 paragraph (1)(B) (in this subsection referred to
23 as a ‘qualified IDR air ambulance services’), a
24 certified IDR entity under paragraph (4) deter-
25 mines, subject to subparagraph (B) and in ac-

1 cordance with the succeeding provisions of this
2 subsection, the amount of payment under the
3 plan for such services furnished by such pro-
4 vider.

5 “(B) AUTHORITY TO CONTINUE NEGOTIA-
6 TIONS.—Under the independent dispute resolu-
7 tion process, in the case that the parties to a
8 determination for qualified IDR air ambulance
9 services agree on a payment amount for such
10 services during such process but before the date
11 on which the entity selected with respect to
12 such determination under paragraph (4) makes
13 such determination under paragraph (5), such
14 amount shall be treated for purposes of section
15 9816(a)(3)(K)(ii) as the amount agreed to by
16 such parties for such services. In the case of an
17 agreement described in the previous sentence,
18 the independent dispute resolution process shall
19 provide for a method to determine how to allo-
20 cate between the parties to such determination
21 the payment of the compensation of the entity
22 selected with respect to such determination.

23 “(C) CLARIFICATION.—A nonparticipating
24 provider may not, with respect to an item or
25 service furnished by such provider, submit a no-

1 tification under paragraph (1)(B) if such pro-
2 vider is exempt from the requirement under
3 subsection (a) of section 2799B-2 of the Public
4 Health Service Act with respect to such item or
5 service pursuant to subsection (b) of such sec-
6 tion.

7 “(3) TREATMENT OF BATCHING OF SERV-
8 ICES.—The provisions of section 9816(c)(3) shall
9 apply with respect to a notification submitted under
10 this subsection with respect to air ambulance serv-
11 ices in the same manner and to the same extent
12 such provisions apply with respect to a notification
13 submitted under section 9816(c) with respect to
14 items and services described in such section.

15 “(4) IDR ENTITIES.—

16 “(A) ELIGIBILITY.—An IDR entity cer-
17 tified under this subsection is an IDR entity
18 certified under section 9816(c)(4).

19 “(B) SELECTION OF CERTIFIED IDR ENTI-
20 TY.—The provisions of subparagraph (F) of
21 section 9816(c)(4) shall apply with respect to
22 selecting an IDR entity certified pursuant to
23 subparagraph (A) with respect to the deter-
24 mination of the amount of payment under this
25 subsection of air ambulance services in the

1 same manner as such provisions apply with re-
2 spect to selecting an IDR entity certified under
3 such section with respect to the determination
4 of the amount of payment under section
5 9816(c) of an item or service. An entity selected
6 pursuant to the previous sentence to make a de-
7 termination described in such sentence shall be
8 referred to in this subsection as the ‘certified
9 IDR entity’ with respect to such determination.

10 “(5) PAYMENT DETERMINATION.—

11 “(A) IN GENERAL.—Not later than 30
12 days after the date of selection of the certified
13 IDR entity, with respect to qualified IDR air
14 ambulance services, the certified independent
15 entity with respect to a determination under
16 this subsection for such services shall—

17 “(i) taking into account the consider-
18 ations specified in subparagraph (C), select
19 one of the offers submitted under subpara-
20 graph (B) to be the amount of payment for
21 such services determined under this sub-
22 section for purposes of subsection (a)(3);
23 and

24 “(ii) notify the provider or facility and
25 the group health plan party to such deter-

1 mination of the offer selected under clause
2 (i).

3 “(B) SUBMISSION OF OFFERS.—Not later
4 than 10 days after the date of selection of the
5 certified IDR entity with respect to a deter-
6 mination for qualified IDR air ambulance serv-
7 ices, the provider and the group health plan
8 party to such determination—

9 “(i) shall each submit to the certified
10 independent entity with respect to such de-
11 termination—

12 “(I) an offer for a payment
13 amount for such services furnished by
14 such provider; and

15 “(II) such information as re-
16 quested by the certified IDR entity re-
17 lating to such offer; and

18 “(ii) may each submit to the certified
19 independent entity with respect to such de-
20 termination any information relating to
21 such offer submitted by either party, in-
22 cluding information relating to any cir-
23 cumstance described in subparagraph
24 (C)(ii).

1 “(C) CONSIDERATIONS IN DETERMINA-
2 TION.—

3 “(i) IN GENERAL.—In determining
4 which offer is the payment to be applied
5 pursuant to this paragraph, the certified
6 IDR entity, with respect to the determina-
7 tion for a qualified IDR air ambulance
8 service shall consider—

9 “(I) the offers under subpara-
10 graph (B)(i);

11 “(II) the qualifying payment
12 amounts (as defined in subsection
13 (a)(3)(E)) for the applicable year for
14 items or services that are comparable
15 to the qualified IDR air ambulance
16 service and that are furnished in the
17 same geographic region (as defined by
18 the Secretary for purposes of such
19 subsection) as such qualified IDR air
20 ambulance service; and

21 “(III) information on any cir-
22 cumstance described in clause (ii),
23 such information requested in sub-
24 paragraph (B)(i)(II), and any addi-

1 tional information provided in sub-
2 paragraph (B)(ii).

3 “(ii) ADDITIONAL CIRCUMSTANCES.—

4 For purposes of clause (i)(II), the cir-
5 cumstances described in this clause are,
6 with respect to air ambulance services in-
7 cluded in the notification submitted under
8 paragraph (1)(A) of a nonparticipating
9 provider, or group health plan the fol-
10 lowing:

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

14 “(II) The acuity of the individual
15 receiving such services or the com-
16 plexity of furnishing such services to
17 such individual.

18 “(III) The training, experience,
19 and quality of the medical personnel
20 that furnished such services.

21 “(IV) Ambulance vehicle type, in-
22 cluding the clinical capability level of
23 such vehicle.

1 “(V) Population density of the
2 pick up location (such as urban, sub-
3 urban, rural, or frontier).

4 “(VI) Demonstrations of good
5 faith efforts (or lack of good faith ef-
6 forts) made by the nonparticipating
7 provider or nonparticipating facility or
8 the plan to enter into network agree-
9 ments and, if applicable, contracted
10 rates between the provider and the
11 plan during the previous 4 plan years.

12 “(iii) PROHIBITION ON CONSIDER-
13 ATION OF BILLED CHARGES.—In deter-
14 mining which offer is the payment amount
15 to be applied with respect to qualified IDR
16 air ambulance services furnished by a pro-
17 vider, the certified IDR entity with respect
18 to such determination shall not consider
19 usual and customary charges or the
20 amount that would have been billed by
21 such provider with respect to such services
22 had the provisions of section 2799B–5 of
23 the Public Health Service Act not applied.

24 “(D) EFFECTS OF DETERMINATION.—The
25 provisions of section 9816(c)(5)(D)) shall apply

1 with respect to a determination of a certified
2 IDR entity under subparagraph (A), the notifi-
3 cation submitted with respect to such deter-
4 mination, the services with respect to such noti-
5 fication, and the parties to such notification in
6 the same manner as such provisions apply with
7 respect to a determination of a certified IDR
8 entity under section 9816(c)(5)(D), the notifi-
9 cation submitted with respect to such deter-
10 mination, the items and services with respect to
11 such notification, and the parties to such notifi-
12 cation.

13 “(E) COSTS OF INDEPENDENT DISPUTE
14 RESOLUTION PROCESS.—The provisions of sec-
15 tion 9816(c)(5)(E) shall apply to a notification
16 made under this subsection, the parties to such
17 notification, and a determination under sub-
18 paragraph (A) in the same manner and to the
19 same extent such provisions apply to a notifica-
20 tion under section 9816(c), the parties to such
21 notification and a determination made under
22 section 9816(c)(5)(A).

23 “(6) TIMING OF PAYMENT.—Payment required
24 pursuant to subsection (a)(3), with respect to quali-
25 fied IDR air ambulance services for which a deter-

1 mination is made under paragraph (5)(A) or with
2 respect to air ambulance services for which a pay-
3 ment amount is determined under open negotiations
4 under paragraph (1), shall be made directly to the
5 nonparticipating provider not later than 30 days
6 after the date on which such determination is made.

7 “(7) PUBLICATION OF INFORMATION RELATING
8 TO THE IDR PROCESS.—

9 “(A) IN GENERAL.—For each calendar
10 quarter in 2022 and each calendar quarter in a
11 subsequent year, the Secretary shall publish on
12 the public website of the Department of the
13 Treasury—

14 “(i) the number of notifications sub-
15 mitted under the IDR process during such
16 calendar quarter;

17 “(ii) the number of such notifications
18 with respect to which a final determination
19 was made under paragraph (5)(A);

20 “(iii) the information described in
21 subparagraph (B) with respect to each no-
22 tification with respect to which such a de-
23 termination was so made.

24 “(iv) the number of times the pay-
25 ment amount determined (or agreed to)

1 under this subsection exceeds the quali-
2 fying payment amount;

3 “(v) the amount of expenditures made
4 by the Secretary during such calendar
5 quarter to carry out the IDR process;

6 “(vi) the total amount of fees paid
7 under paragraph (7) during such calendar
8 quarter; and

9 “(vii) the total amount of compensa-
10 tion paid to certified IDR entities under
11 paragraph (5)(E) during such calendar
12 quarter.

13 “(B) INFORMATION WITH RESPECT TO RE-
14 QUESTS.—For purposes of subparagraph (A),
15 the information described in this subparagraph
16 is, with respect to a notification under the IDR
17 process of a nonparticipating provider, or group
18 health plan—

19 “(i) a description of each air ambu-
20 lance service included in such notification;

21 “(ii) the geography in which the serv-
22 ices included in such notification were pro-
23 vided;

24 “(iii) the amount of the offer sub-
25 mitted under paragraph (2) by the group

1 health plan and by the nonparticipating
2 provider expressed as a percentage of the
3 qualifying payment amount;

4 “(iv) whether the offer selected by the
5 certified IDR entity under paragraph (5)
6 to be the payment applied was the offer
7 submitted by such plan or issuer (as appli-
8 cable) or by such provider and the amount
9 of such offer so selected expressed as a
10 percentage of the qualifying payment
11 amount;

12 “(v) ambulance vehicle type, including
13 the clinical capability level of such vehicle;

14 “(vi) the identity of the group health
15 plan or health insurance issuer or air am-
16 bulance provider with respect to such noti-
17 fication;

18 “(vii) the length of time in making
19 each determination;

20 “(viii) the compensation paid to the
21 certified IDR entity with respect to the
22 settlement or determination; and

23 “(ix) any other information specified
24 by the Secretary.

1 “(C) IDR ENTITY REQUIREMENTS.—For
2 2022 and each subsequent year, an IDR entity,
3 as a condition of certification as an IDR entity,
4 shall submit to the Secretary such information
5 as the Secretary determines necessary for the
6 Secretary to carry out the provisions of this
7 paragraph.

8 “(D) CLARIFICATION.—The Secretary
9 shall ensure the public reporting under this
10 paragraph does not contain information that
11 would disclose privileged or confidential infor-
12 mation of a group health plan or health insur-
13 ance issuer offering group or individual health
14 insurance coverage or of a provider or facility.

15 “(8) ADMINISTRATIVE FEE.—

16 “(A) IN GENERAL.—Each party to a deter-
17 mination under paragraph (5) to which an enti-
18 ty is selected under paragraph (4) in a year
19 shall pay to the Secretary, at such time and in
20 such manner as specified by the Secretary, a
21 fee for participating in the IDR process with re-
22 spect to such determination in an amount de-
23 scribed in subparagraph (B) for such year.

24 “(B) AMOUNT OF FEE.—The amount de-
25 scribed in this subparagraph for a year is an

1 amount established by the Secretary in a man-
2 ner such that the total amount of fees paid
3 under this paragraph for such year is estimated
4 to be equal to the amount of expenditures esti-
5 mated to be made by the Secretary for such
6 year in carrying out the IDR process.

7 “(9) WAIVER AUTHORITY.—The Secretary may
8 modify any deadline or other timing required speci-
9 fied under this subsection (other than under para-
10 graph (6)) in cases of extenuating circumstances, as
11 specified by the Secretary.

12 “(c) DEFINITIONS.—For purposes of this section:

13 “(1) AIR AMBULANCE SERVICES.—The term
14 ‘air ambulance service’ means medical transport by
15 helicopter or airplane for patients.

16 “(2) QUALIFYING PAYMENT AMOUNT.—The
17 term ‘qualifying payment amount’ has the meaning
18 given such term in section 9816(b)(3).

19 “(3) NONPARTICIPATING PROVIDER.—The term
20 ‘nonparticipating provider’ has the meaning given
21 such term in section 9816(b)(3).”.

22 (B) CLERICAL AMENDMENT.—The table of
23 sections for subchapter B of chapter 100 of the
24 Internal Revenue Code of 1986, as amended by
25 section 102(c)(3), is further amended by insert-

1 ing after the item relating to section 9816 the
2 following new item:

“Sec. 9817. Ending surprise air ambulance bills.”.

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 (b) **AIR AMBULANCE PROVIDER BALANCE BILL-**
7 **ING.**—Part E of title XXVII of the Public Health Service
8 Act, as added and amended by section 104, is further
9 amended by adding at the end the following new section:
10 **“SEC. 2799B-5. AIR AMBULANCE SERVICES.**

11 “In the case of a participant, beneficiary, or enrollee
12 with benefits under a group health plan or group or indi-
13 vidual health insurance coverage offered by a health insur-
14 ance issuer and who is furnished on or after January 1,
15 2022, air ambulance services (for which benefits are avail-
16 able under such plan or coverage) from a nonparticipating
17 provider (as defined in section 2799A-1(a)(3)(G)) with re-
18 spect to such plan or coverage, such provider shall not bill,
19 and shall not hold liable, such participant, beneficiary, or
20 enrollee for a payment amount for such service furnished
21 by such provider that is more than the cost-sharing
22 amount for such service (as determined in accordance with
23 paragraphs (1) and (2) of section 2799A-2(a), section
24 717(a) of the Employee Retirement Income Security Act

1 of 1974, or section 9817(a) of the Internal Revenue Code
2 of 1986, as applicable).”.

3 **SEC. 106. REPORTING REQUIREMENTS REGARDING AIR AM-**
4 **BULANCE SERVICES.**

5 (a) REPORTING REQUIREMENTS FOR PROVIDERS OF
6 AIR AMBULANCE SERVICES.—

7 (1) IN GENERAL.—A provider of air ambulance
8 services shall submit to the Secretary of Health and
9 Human Services and the Secretary of Transpor-
10 tation—

11 (A) not later than the date that is 90 days
12 after the last day of the first plan year begin-
13 ning on or after the date on which a final rule
14 is promulgated pursuant to the rulemaking de-
15 scribed in subsection (d), the information de-
16 scribed in paragraph (2) with respect to such
17 plan year; and

18 (B) not later than the date that is 90 days
19 after the last day of the plan year immediately
20 succeeding the plan year described in subpara-
21 graph (A), such information with respect to
22 such immediately succeeding plan year.

23 (2) INFORMATION DESCRIBED.—For purposes
24 of paragraph (1), information described in this para-

1 graph, with respect to a provider of air ambulance
2 services, is each of the following:

3 (A) Cost data, as determined appropriate
4 by the Secretary of Health and Human Serv-
5 ices, in consultation with the Secretary of
6 Transportation, for air ambulance services fur-
7 nished by such provider, separated to the max-
8 imum extent possible by air transportation costs
9 associated with furnishing such air ambulance
10 services and costs of medical services and sup-
11 plies associated with furnishing such air ambu-
12 lance services.

13 (B) The number and location of all air am-
14 bulance bases operated by such provider.

15 (C) The number and type of aircraft oper-
16 ated by such provider.

17 (D) The number of air ambulance trans-
18 ports, disaggregated by payor mix, including—

19 (i)(I) group health plans;

20 (II) health insurance issuers; and

21 (III) State and Federal Government
22 payors; and

23 (ii) uninsured individuals.

24 (E) The number of claims of such provider
25 that have been denied payment by a group

1 health plan or health insurance issuer and the
2 reasons for any such denials.

3 (F) The number of emergency and non-
4 emergency air ambulance transports,
5 disaggregated by air ambulance base and type
6 of aircraft.

7 (G) Such other information regarding air
8 ambulance services as the Secretary of Health
9 and Human Services may specify.

10 (b) REPORTING REQUIREMENTS FOR GROUP
11 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

12 (1) PHSA.—Part D of title XXVII of the Pub-
13 lic Health Service Act, as added by section
14 102(a)(1), is amended by adding after section
15 2799A–7, as added by section 102(a)(2)(A) of this
16 Act, the following new section:

17 **“SEC. 2799A–8. AIR AMBULANCE REPORT REQUIREMENTS.**

18 “(a) IN GENERAL.—Each group health plan and
19 health insurance issuer offering group or individual health
20 insurance coverage shall submit to the Secretary—

21 “(1) not later than the date that is 90 days
22 after the last day of the first plan year beginning on
23 or after the date on which a final rule is promul-
24 gated pursuant to the rulemaking described in sec-
25 tion 106(d) of the No Surprises Act, the information

1 described in subsection (b) with respect to such plan
2 year; and

3 “(2) not later than the date that is 90 days
4 after the last day of the plan year immediately suc-
5 ceeding the plan year described in paragraph (1),
6 such information with respect to such immediately
7 succeeding plan year.

8 “(b) INFORMATION DESCRIBED.—For purposes of
9 subsection (a), information described in this subsection,
10 with respect to a group health plan or a health insurance
11 issuer offering group or individual health insurance cov-
12 erage, is each of the following:

13 “(1) Claims data for air ambulance services
14 furnished by providers of such services,
15 disaggregated by each of the following factors:

16 “(A) Whether such services were furnished
17 on an emergent or nonemergent basis.

18 “(B) Whether the provider of such services
19 is part of a hospital-owned or sponsored pro-
20 gram, municipality-sponsored program, hospital
21 independent partnership (hybrid) program,
22 independent program, or tribally operated pro-
23 gram in Alaska.

1 “(C) Whether the transport in which the
2 services were furnished originated in a rural or
3 urban area.

4 “(D) The type of aircraft (such as rotor
5 transport or fixed wing transport) used to fur-
6 nish such services.

7 “(E) Whether the provider of such services
8 has a contract with the plan or issuer, as appli-
9 cable, to furnish such services under the plan or
10 coverage, respectively.

11 “(2) Such other information regarding pro-
12 viders of air ambulance services as the Secretary
13 may specify.”.

14 (2) ERISA.—

15 (A) IN GENERAL.—Subpart B of part 7 of
16 title I of the Employee Retirement Income Se-
17 curity Act of 1974 (29 U.S.C. 1185 et seq.) is
18 amended by adding after section 722, as added
19 by section 102(b)(2)(A) of this Act, the fol-
20 lowing new section:

21 **“SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.**

22 “(a) IN GENERAL.—Each group health plan and
23 health insurance issuer offering group health insurance
24 coverage shall submit to the Secretary—

1 “(1) not later than the date that is 90 days
2 after the last day of the first plan year beginning on
3 or after the date on which a final rule is promul-
4 gated pursuant to the rulemaking described in sec-
5 tion 106(d) of the No Surprises Act, the information
6 described in subsection (b) with respect to such plan
7 year; and

8 “(2) not later than the date that is 90 days
9 after the last day of the plan year immediately suc-
10 ceeding the plan year described in paragraph (1),
11 such information with respect to such immediately
12 succeeding plan year.

13 “(b) INFORMATION DESCRIBED.—For purposes of
14 subsection (a), information described in this subsection,
15 with respect to a group health plan or a health insurance
16 issuer offering group health insurance coverage, is each
17 of the following:

18 “(1) Claims data for air ambulance services
19 furnished by providers of such services,
20 disaggregated by each of the following factors:

21 “(A) Whether such services were furnished
22 on an emergent or nonemergent basis.

23 “(B) Whether the provider of such services
24 is part of a hospital-owned or sponsored pro-
25 gram, municipality-sponsored program, hospital

1 independent partnership (hybrid) program,
2 independent program, or tribally operated pro-
3 gram in Alaska.

4 “(C) Whether the transport in which the
5 services were furnished originated in a rural or
6 urban area.

7 “(D) The type of aircraft (such as rotor
8 transport or fixed wing transport) used to fur-
9 nish such services.

10 “(E) Whether the provider of such services
11 has a contract with the plan or issuer, as appli-
12 cable, to furnish such services under the plan or
13 coverage, respectively.

14 “(2) Such other information regarding pro-
15 viders of air ambulance services as the Secretary
16 may specify.”.

17 (B) CLERICAL AMENDMENT.—The table of
18 contents of the Employee Retirement Income
19 Security Act of 1974 is amended by adding
20 after the item relating to section 722, as added
21 by section 102(b) the following:

“Sec. 723. Air ambulance report requirements.”.

22 (3) IRC.—

23 (A) IN GENERAL.—Subchapter B of chap-
24 ter 100 of the Internal Revenue Code of 1986
25 is amended by adding after section 9822, as

1 added by section 102(c)(2)(A) of this Act, the
2 following new section:

3 **“SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.**

4 “(a) IN GENERAL.—Each group health plan shall
5 submit to the Secretary—

6 “(1) not later than the date that is 90 days
7 after the last day of the first plan year beginning on
8 or after the date on which a final rule is promul-
9 gated pursuant to the rulemaking described in sec-
10 tion 106(d) of the No Surprises Act, the information
11 described in subsection (b) with respect to such plan
12 year; and

13 “(2) not later than the date that is 90 days
14 after the last day of the plan year immediately suc-
15 ceeding the plan year described in paragraph (1),
16 such information with respect to such immediately
17 succeeding plan year.

18 “(b) INFORMATION DESCRIBED.—For purposes of
19 subsection (a), information described in this subsection,
20 with respect to a group health plan is each of the fol-
21 lowing:

22 “(1) Claims data for air ambulance services
23 furnished by providers of such services,
24 disaggregated by each of the following factors:

1 “(A) Whether such services were furnished
2 on an emergent or nonemergent basis.

3 “(B) Whether the provider of such services
4 is part of a hospital-owned or sponsored pro-
5 gram, municipality-sponsored program, hospital
6 independent partnership (hybrid) program,
7 independent program, or tribally operated pro-
8 gram in Alaska.

9 “(C) Whether the transport in which the
10 services were furnished originated in a rural or
11 urban area.

12 “(D) The type of aircraft (such as rotor
13 transport or fixed wing transport) used to fur-
14 nish such services.

15 “(E) Whether the provider of such services
16 has a contract with the plan or issuer, as appli-
17 cable, to furnish such services under the plan or
18 coverage, respectively.

19 “(2) Such other information regarding pro-
20 viders of air ambulance services as the Secretary
21 may specify.”.

22 (B) CLERICAL AMENDMENT.—The table of
23 sections for subchapter B of chapter 100 of the
24 Internal Revenue Code of 1986 is amended by
25 adding after the item relating to section 9822,

1 as added by section 102(c), the following new
2 item:

“Sec. 9823. Air ambulance report requirements.”.

3 (c) PUBLICATION OF COMPREHENSIVE REPORT.—

4 (1) IN GENERAL.—Not later than the date that
5 is one year after the date described in subsection
6 (a)(2) of section 2799A–8 of the Public Health
7 Service Act, of section 723 of the Employee Retirement
8 Income Security Act of 1974, and of section
9 9823 of the Internal Revenue Code of 1986, as such
10 sections are added by subsection (b), the Secretary
11 of Health and Human Services, in consultation with
12 the Secretary of Transportation (referred to in this
13 section as the “Secretaries”), shall develop, and
14 make publicly available (subject to paragraph (3)), a
15 comprehensive report summarizing the information
16 submitted under subsection (a) and the amendments
17 made by subsection (b) and including each of the
18 following:

19 (A) The percentage of providers of air am-
20 bulance services that are part of a hospital-
21 owned or sponsored program, municipality-
22 sponsored program, hospital-independent part-
23 nership (hybrid) program, or independent pro-
24 gram.

1 (B) An assessment of the extent of com-
2 petition among providers of air ambulance serv-
3 ices on the basis of price and services offered,
4 and any changes in such competition over time.

5 (C) An assessment of the average charges
6 for air ambulance services, amounts paid by
7 group health plans and health insurance issuers
8 offering group or individual health insurance
9 coverage to providers of air ambulance services
10 for furnishing such services, and amounts paid
11 out-of-pocket by consumers, and any changes in
12 such amounts paid over time.

13 (D) An assessment of the presence of air
14 ambulance bases in, or with the capability to
15 serve, rural areas, and the relative growth in air
16 ambulance bases in rural and urban areas over
17 time.

18 (E) Any evidence of gaps in rural access to
19 providers of air ambulance services.

20 (F) The percentage of providers of air am-
21 bulance services that have contracts with group
22 health plans or health insurance issuers offering
23 group or individual health insurance coverage to
24 furnish such services under such plans or cov-
25 erage, respectively.

1 (G) An assessment of whether there are in-
2 stances of unfair, deceptive, or predatory prac-
3 tices by providers of air ambulance services in
4 collecting payments from patients to whom such
5 services are furnished, such as referral of such
6 patients to collections, lawsuits, and liens or
7 wage garnishment actions.

8 (H) An assessment of whether there are,
9 within the air ambulance industry, instances of
10 unreasonable industry concentration, excessive
11 market domination, or other conditions that
12 would allow at least one provider of air ambu-
13 lance services to unreasonably increase prices or
14 exclude competition in air ambulance services in
15 a given geographic region.

16 (I) An assessment of the frequency of pa-
17 tient balance billing, patient referrals to collec-
18 tions, lawsuits to collect balance bills, and liens
19 or wage garnishment actions by providers of air
20 ambulance services as part of a collections proc-
21 ess across hospital-owned or sponsored pro-
22 grams, municipality-sponsored programs, hos-
23 pital-independent partnership (hybrid) pro-
24 grams, tribally operated programs in Alaska, or
25 independent programs, providers of air ambu-

1 lance services operated by public agencies (such
2 as a State or county health department), and
3 other independent providers of air ambulance
4 services.

5 (J) An assessment of the frequency of
6 claims appeals made by providers of air ambu-
7 lance services to group health plans or health
8 insurance issuers offering group or individual
9 health insurance coverage with respect to air
10 ambulance services furnished to enrollees of
11 such plans or coverage, respectively.

12 (K) Any other cost, quality, or other data
13 relating to air ambulance services or the air
14 ambulance industry, as determined necessary
15 and appropriate by the Secretaries.

16 (2) OTHER SOURCES OF INFORMATION.—The
17 Secretaries may incorporate information from inde-
18 pendent experts or third-party sources in developing
19 the comprehensive report required under paragraph
20 (1).

21 (3) PROTECTION OF PROPRIETARY INFORMA-
22 TION.—The Secretaries may not make publicly avail-
23 able under this subsection any proprietary informa-
24 tion.

1 (d) RULEMAKING.—Not later than the date that is
2 one year after the date of the enactment of this Act, the
3 Secretary of Health and Human Services, in consultation
4 with the Secretary of Transportation, shall, through notice
5 and comment rulemaking, specify the form and manner
6 in which reports described in subsection (a) and in the
7 amendments made by subsection (b) shall be submitted
8 to such Secretaries, taking into consideration (as applica-
9 ble and to the extent feasible) any recommendations in-
10 cluded in the report submitted by the Advisory Committee
11 on Air Ambulance and Patient Billing under section
12 418(e) of the FAA Reauthorization Act of 2018 (Public
13 Law 115–254; 49 U.S.C. 42301 note prec.).

14 (e) CIVIL MONEY PENALTIES.—

15 (1) IN GENERAL.—Subject to paragraph (2), a
16 provider of air ambulance services who fails to sub-
17 mit all information required under subsection (a)(2)
18 by the date described in subparagraph (A) or (B) of
19 subsection (a)(1), as applicable, shall be subject to
20 a civil money penalty of not more than \$10,000.

21 (2) EXCEPTION.—In the case of a provider of
22 air ambulance services that submits only some of the
23 information required under subsection (a)(2) by the
24 date described in subparagraph (A) or (B) of sub-
25 section (a)(1), as applicable, the Secretary of Health

1 and Human Services may waive the civil money pen-
2 alty imposed under paragraph (1) if such provider
3 demonstrates a good faith effort (as defined by the
4 Secretary pursuant to regulation) in working with
5 the Secretary to submit the remaining information
6 required under subsection (a)(2).

7 (3) PROCEDURE.—The provisions of section
8 1128A of the Social Security Act (42 U.S.C. 1320a–
9 7a), other than subsections (a) and (b) and the first
10 sentence of subsection (c)(1), shall apply to civil
11 money penalties under this subsection in the same
12 manner as such provisions apply to a penalty or pro-
13 ceeding under such section.

14 (f) UNFAIR AND DECEPTIVE PRACTICES AND UN-
15 FAIR METHODS OF COMPETITION.—The Secretary of
16 Transportation may use any information submitted under
17 subsection (a) in determining whether a provider of air
18 ambulance services has violated section 41712(a) of title
19 49, United States Code.

20 (g) ADVISORY COMMITTEE ON AIR AMBULANCE
21 QUALITY AND PATIENT SAFETY.—

22 (1) ESTABLISHMENT.—Not later than the date
23 that is 60 days after the date of the enactment of
24 this Act, the Secretary of Health and Human Serv-
25 ices, in consultation with the Secretary of Transpor-

1 tation, shall establish an Advisory Committee on Air
2 Ambulance Quality and Patient Safety (referred to
3 in this subsection as the “Committee”) for the pur-
4 pose of reviewing options to establish quality, patient
5 safety, service reliability, and clinical capability
6 standards for each clinical capability level of air am-
7 bulances.

8 (2) MEMBERSHIP.—The Committee shall be
9 composed of the following members:

10 (A) The Secretary of Health and Human
11 Services, or a designee of the Secretary, who
12 shall serve as the Chair of the Committee.

13 (B) The Secretary of Transportation, or a
14 designee of the Secretary.

15 (C) One representative, to be appointed by
16 the Secretary of Health and Human Services,
17 of each of the following:

18 (i) State health insurance regulators.

19 (ii) Health care providers.

20 (iii) Group health plans and health in-
21 surance issuers offering group or indi-
22 vidual health insurance coverage.

23 (iv) Patient advocacy groups.

24 (v) Accrediting bodies with experience
25 in quality measures.

1 (D) Three representatives of the air ambu-
2 lance industry, to be appointed by the Secretary
3 of Transportation.

4 (E) Additional three representatives not
5 covered under subparagraphs (A) through (D),
6 as determined necessary and appropriate by the
7 Secretary of Health and Human Services.

8 (3) FIRST MEETING.—Not later than the date
9 that is 90 days after the date of the enactment of
10 this Act, the Committee shall hold its first meeting.

11 (4) DUTIES.—The Committee shall study and
12 make recommendations, as appropriate, to Congress
13 regarding each of the following with respect to air
14 ambulance services:

15 (A) Qualifications of different clinical ca-
16 pability levels and tiering of such levels.

17 (B) Patient safety and quality standards.

18 (C) Options for improving service reli-
19 ability during poor weather, night conditions, or
20 other adverse conditions.

21 (D) Differences between air ambulance ve-
22 hicle types, services, and technologies, and other
23 flight capability standards, and the impact of
24 such differences on patient safety.

1 LIMITATIONS.—A group health plan or a health insurance
2 issuer offering group or individual health insurance cov-
3 erage and providing or covering any benefit with respect
4 to items or services shall include, in clear writing, on any
5 physical or electronic plan or insurance identification card
6 issued to the participants, beneficiaries, or enrollees in the
7 plan or coverage the following:

8 “(1) Any deductible applicable to such plan or
9 coverage.

10 “(2) Any out-of-pocket maximum limitation ap-
11 plicable to such plan or coverage.

12 “(3) A telephone number and Internet website
13 address through which such individual may seek con-
14 sumer assistance information, such as information
15 related to hospitals and urgent care facilities that
16 have in effect a contractual relationship with such
17 plan or coverage for furnishing items and services
18 under such plan or coverage”.

19 (b) ERISA.—Section 716 of the Employee Retirement
20 Income Security Act of 1974, as added by section 102(b)
21 and amended by section 103, is further amended by add-
22 ing at the end the following new subsection:

23 “(e) TRANSPARENCY REGARDING IN-NETWORK AND
24 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
25 LIMITATIONS.—A group health plan or a health insurance

1 issuer offering group health insurance coverage and pro-
2 viding or covering any benefit with respect to items or
3 services shall include, in clear writing, on any physical or
4 electronic plan or insurance identification card issued to
5 the participants, beneficiaries, or enrollees in the plan or
6 coverage the following:

7 “(1) Any deductible applicable to such plan or
8 coverage.

9 “(2) Any out-of-pocket maximum limitation ap-
10 plicable to such plan or coverage.

11 “(3) A telephone number and Internet website
12 address through which such individual may seek con-
13 sumer assistance information, such as information
14 related to hospitals and urgent care facilities that
15 have in effect a contractual relationship with such
16 plan or coverage for furnishing items and services
17 under such plan or coverage”.

18 (c) IRC.—Section 9816 of the Internal Revenue Code
19 of 1986, as added by section 102(c) and amended by sec-
20 tion 103, is further amended by adding at the end the
21 following new subsection:

22 “(e) TRANSPARENCY REGARDING IN-NETWORK AND
23 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
24 LIMITATIONS.—A group health plan providing or covering
25 any benefit with respect to items or services shall include,

1 in clear writing, on any physical or electronic plan or in-
2 surance identification card issued to the participants,
3 beneficiaries, or enrollees in the plan the following:

4 “(1) Any deductible applicable to such plan.

5 “(2) Any out-of-pocket maximum limitation ap-
6 plicable to such plan.

7 “(3) A telephone number and Internet website
8 address through which such individual may seek con-
9 sumer assistance information, such as information
10 related to hospitals and urgent care facilities that
11 have in effect a contractual relationship with such
12 plan for furnishing items and services under such
13 plan.”.

14 (d) **EFFECTIVE DATE.**—The amendments made by
15 this subsection shall apply with respect to plan years be-
16 ginning on or after January 1, 2022.

17 **SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PRO-**
18 **VIDER DISCRIMINATION.**

19 Not later than six months after the date of the enact-
20 ment of this Act, the Secretary of Health and Human
21 Services, the Secretary of Labor, and the Secretary of the
22 Treasury shall issue a proposed rule implementing the
23 protections of section 2706(a) of the Public Health Service
24 Act (42 U.S.C. 300gg-5(a)). The Secretaries shall accept
25 and consider public comments on any proposed rule issued

1 pursuant to this subsection for a period of 60 days after
2 the date of such issuance. Not later than 6 months after
3 the date of the conclusion of the comment period, the Sec-
4 retaries shall issue a final rule implementing the protec-
5 tions of section 2706(a) of the Public Health Service Act
6 (42 U.S.C. 300gg-5(a)).

7 **SEC. 109. REPORTS.**

8 (a) REPORTS IN CONSULTATION WITH FTC AND
9 AG.—Not later than January 1, 2023, and annually
10 thereafter for each of the following 4 years, the Secretary
11 of Health and Human Services, in consultation with the
12 Federal Trade Commission and the Attorney General,
13 shall—

14 (1) conduct a study on the effects of the provi-
15 sions of, including amendments made by, this Act
16 on—

17 (A) any patterns of vertical or horizontal
18 integration of health care facilities, providers,
19 group health plans, or health insurance issuers
20 offering group or individual health insurance
21 coverage;

22 (B) overall health care costs; and

23 (C) access to health care items and serv-
24 ices, including specialty services, in rural areas
25 and health professional shortage areas, as de-

1 fined in section 332 of the Public Health Serv-
2 ice Act (42 U.S.C. 254e);

3 (2) for purposes of the reports under paragraph
4 (3), in consultation with the Secretary of Labor and
5 the Secretary of the Treasury, make recommenda-
6 tions for the effective enforcement of subsections
7 (a)(1)(C)(iv) and (b)(1)(C) of section 2799A-1 of
8 the Public Health Service Act, subsections
9 (a)(1)(C)(iv) and (b)(1)(C) of section 716 of the
10 Employee Retirement Income Security Act of 1974,
11 and subsections (a)(1)(C)(iv) and (b)(1)(C) of sec-
12 tion 9816 of the Internal Revenue Code of 1986, in-
13 cluding with respect to potential challenges to ad-
14 dressing anti-competitive consolidation of health care
15 facilities, providers, group health plans, or health in-
16 surance issuers offering group or individual health
17 insurance coverage; and

18 (3) submit a report on such study and including
19 such recommendations to the Committees on Energy
20 and Commerce; on Education and Labor; on Ways
21 and Means; and on the Judiciary of the House of
22 Representatives and the Committees on Health,
23 Education, Labor, and Pensions; on Commerce,
24 Science, and Transportation; on Finance; and on the
25 Judiciary of the Senate.

1 (b) GAO REPORT ON IMPACT OF SURPRISE BILLING
2 PROVISIONS.—Not later than January 1, 2025, the Comp-
3 troller General of the United States shall submit to Con-
4 gress a report summarizing the effects of the provisions
5 of this Act, including the amendments made by such provi-
6 sions, on changes during the period since the date on the
7 enactment of this Act in health care provider networks of
8 group health plans and group and individual health insur-
9 ance coverage offered by a health insurance issuer, in fee
10 schedules and amounts for health care services, and to
11 contracted rates under such plans or coverage. Such re-
12 port shall—

13 (1) to the extent practicable, sample a statisti-
14 cally significant group of national health care pro-
15 viders;

16 (2) examine—

17 (A) provider network participation, includ-
18 ing nonparticipating providers furnishing items
19 and services at participating facilities;

20 (B) health care provider group network
21 participation, including specialty, size, and own-
22 ership;

23 (C) the impact of State surprise billing
24 laws and network adequacy standards on par-
25 ticipation of health care providers and facilities

1 in provider networks of group health plans and
2 of group and individual health insurance cov-
3 erage offered by health insurance issuers; and

4 (D) access to providers, including in rural
5 and medically underserved communities and
6 health professional shortage areas (as defined
7 in section 332 of the Public Health Service
8 Act), and the extent of provider shortages in
9 such communities and areas;

10 (3) to the extent practicable, sample a statis-
11 tically significant group of national health insurance
12 plans and issuers and examine—

13 (A) the effects of the provisions of, includ-
14 ing amendments made by, this Act on pre-
15 miums and out-of-pocket costs with respect to
16 group health plans or group or individual health
17 insurance coverage;

18 (B) the adequacy of provider networks
19 with respect to such plans or coverage; and

20 (C) categories of providers of ancillary
21 services, as defined in section 2719(A)(i)(3), for
22 which such plans have no or a limited number
23 of in-network providers; and

24 (4) such other relevant effects of such provi-
25 sions and amendments.

1 (c) GAO REPORT ON ADEQUACY OF PROVIDER NET-
2 WORKS.—Not later than January 1, 2023, the Comp-
3 troller General of the United States shall submit to Con-
4 gress, and make publicly available, a report on the ade-
5 quacy of provider networks in group health plans and
6 group and individual health insurance coverage, including
7 legislative recommendations to improve the adequacy of
8 such networks.

9 (d) GAO REPORT ON IDR PROCESS AND POTENTIAL
10 FINANCIAL RELATIONSHIPS.—Not later than December
11 31, 2023, the Comptroller General of the United States
12 shall conduct a study and submit to Congress a report
13 on the IDR process established under this section. Such
14 study and report shall include an analysis of potential fi-
15 nancial relationships between providers and facilities that
16 utilize the IDR process established by the amendments
17 made by this Act and private equity investment firms.

18 **SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICA-**
19 **TION OF HEALTH PLAN EXTERNAL REVIEW**
20 **IN CASES OF CERTAIN SURPRISE MEDICAL**
21 **BILLS.**

22 (a) In applying the provisions of section 2719(b) of
23 the Public Health Service Act (42 U.S.C. 300gg–19(b))
24 to group health plans and health insurance issuers offer-
25 ing group or individual health insurance coverage, the Sec-

1 retary of Health and Human Services, Secretary of Labor,
2 and Secretary of the Treasury, shall require, beginning
3 not later than January 1, 2022, the external review proc-
4 ess described in paragraph (1) of such section to apply
5 with respect to any adverse determination by such a plan
6 or issuer under section 2799A-1 or 2799A-2, section 716
7 or 717 of the Employee Retirement Income Security Act
8 of 1974, or section 9816 or 9817 of the Internal Revenue
9 Code of 1986, including with respect to whether an item
10 or service that is the subject to such a determination is
11 an item or service to which such respective section applies.

12 (b) Definitions—The terms “group health plan”;
13 “health insurance issuer”; “group health insurance cov-
14 erage”, and “individual health insurance coverage” have
15 the meanings given such terms in section 2791 of the Pub-
16 lic Health Service Act (42 U.S.C. 300gg–91), section 733
17 of the Employee Retirement Income Security Act (29
18 U.S.C. 1191b), and section 9832 of the Internal Revenue
19 Code, as applicable.

20 **SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH**
21 **PLAN REQUIREMENT FOR FAIR AND HONEST**
22 **ADVANCE COST ESTIMATE.**

23 (a) PHSA AMENDMENT.—Section 2799A–1 of the
24 Public Health Service Act (42 U.S.C. 300gg–19a), as
25 added by section 102 and as further amended by the pre-

1 vious provisions of this title, is further amended by adding
2 at the end the following new subsection:

3 “(f) ADVANCED EXPLANATION OF BENEFITS.—

4 “(1) IN GENERAL.—Beginning on January 1,
5 2022, each group health plan, or a health insurance
6 issuer offering group or individual health insurance
7 coverage shall, with respect to a notification sub-
8 mitted under section 2799B–6 by a health care pro-
9 vider or health care facility to the plan or issuer for
10 a participant, beneficiary, or enrollee under plan or
11 coverage scheduled to receive an item or service from
12 the provider or facility, not later than 1 business day
13 (or, in the case such item or service was so sched-
14 uled at least 10 business days before such item or
15 service is to be furnished (or in the case of a request
16 made to such plan or coverage by such participant,
17 beneficiary, or enrollee), 3 business days) after the
18 date on which the plan or coverage receives such no-
19 tification (or such request), provide to the partici-
20 pant, beneficiary, or enrollee (through mail or elec-
21 tronic means, as requested by the participant, bene-
22 ficiary, or enrollee) a notification (in clear and un-
23 derstandable language) including the following:

24 “(A) Whether or not the provider or facil-
25 ity is a participating provider or a participating

1 facility with respect to the plan or coverage
2 with respect to the furnishing of such item or
3 service and—

4 “(i) in the case the provider or facility
5 is a participating provider or facility with
6 respect to the plan or coverage with re-
7 spect to the furnishing of such item or
8 service, the contracted rate under such
9 plan or coverage for such item or service
10 (based on the billing and diagnostic codes
11 provided by such provider or facility); and

12 “(ii) in the case the provider or facil-
13 ity is a nonparticipating provider or facility
14 with respect to such plan or coverage, a
15 description of how such individual may ob-
16 tain information on providers and facilities
17 that, with respect to such plan or coverage,
18 are participating providers and facilities.

19 “(B) The good faith estimate included in
20 the notification received from the provider or
21 facility (if applicable) based on such codes.

22 “(C) A good faith estimate of the amount
23 the plan or coverage is responsible for paying
24 for items and services included in the estimate
25 described in subparagraph (B).

1 “(D) A good faith estimate of the amount
2 of any cost-sharing for which the participant,
3 beneficiary, or enrollee would be responsible for
4 such item or service (as of the date of such no-
5 tification).

6 “(E) A good faith estimate of the amount
7 that the participant, beneficiary, or enrollee has
8 incurred toward meeting the limit of the finan-
9 cial responsibility (including with respect to
10 deductibles and out-of-pocket maximums) under
11 the plan or coverage (as of the date of such no-
12 tification).

13 “(F) In the case such item or service is
14 subject to a medical management technique (in-
15 cluding concurrent review, prior authorization,
16 and step-therapy or fail-first protocols) for cov-
17 erage under the plan or coverage, a disclaimer
18 that coverage for such item or service is subject
19 to such medical management technique.

20 “(G) A disclaimer that the information
21 provided in the notification is only an estimate
22 based on the items and services reasonably ex-
23 pected, at the time of scheduling (or requesting)
24 the item or service, to be furnished and is sub-
25 ject to change.

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

8 “(I) Any other information or disclaimer
9 the plan or coverage determines appropriate
10 that is consistent with information and dis-
11 claimers required under this section.

12 “(2) AUTHORITY TO MODIFY TIMING REQUIRE-
13 MENTS IN THE CASE OF SPECIFIED ITEMS AND
14 SERVICES.—

15 “(A) IN GENERAL.—In the case of a par-
16 ticipant, beneficiary, or enrollee scheduled to re-
17 ceive an item or service that is a specified item
18 or service (as defined in subparagraph (B)), the
19 Secretary may modify any timing requirements
20 relating to the provision of the notification de-
21 scribed in paragraph (1) to such participant,
22 beneficiary, or enrollee with respect to such
23 item or service. Any modification made by the
24 Secretary pursuant to the previous sentence
25 may not result in the provision of such notifica-

1 tion after such participant, beneficiary, or en-
2 rollee has been furnished such item or service.

3 “(B) SPECIFIED ITEM OR SERVICE DE-
4 FINED.—For purposes of subparagraph (A), the
5 term ‘specified item or service’ means an item
6 or service that has low utilization or significant
7 variation in costs (such as when furnished as
8 part of a complex treatment), as specified by
9 the Secretary.”.

10 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
11 nal Revenue Code of 1986, as added by section 102 and
12 further amended by the previous provisions of this title,
13 is further amended by inserting after subsection (e) the
14 following new subsection:

15 “(f) ADVANCED EXPLANATION OF BENEFITS.—

16 “(1) IN GENERAL.—Beginning on January 1,
17 2022, each group health plan shall, with respect to
18 a notification submitted under section 2799B–6 by
19 a health care provider or health care facility to the
20 plan for a participant, beneficiary, or enrollee under
21 plan scheduled to receive an item or service from the
22 provider or facility, not later than 1 business day
23 (or, in the case such item or service was so sched-
24 uled at least 10 business days before such item or
25 service is to be furnished (or in the case of a request

1 made to such plan or coverage by such participant,
2 beneficiary, or enrollee), 3 business days) after the
3 date on which the plan receives such notification (or
4 such request), provide to the participant, beneficiary,
5 or enrollee (through mail or electronic means, as re-
6 quested by the participant, beneficiary, or enrollee)
7 a notification (in clear and understandable language)
8 including the following:

9 “(A) Whether or not the provider or facil-
10 ity is a participating provider or a participating
11 facility with respect to the plan with respect to
12 the furnishing of such item or service and—

13 “(i) in the case the provider or facility
14 is a participating provider or facility with
15 respect to the plan or coverage with re-
16 spect to the furnishing of such item or
17 service, the contracted rate under such
18 plan for such item or service (based on the
19 billing and diagnostic codes provided by
20 such provider or facility); and

21 “(ii) in the case the provider or facil-
22 ity is a nonparticipating provider or facility
23 with respect to such plan, a description of
24 how such individual may obtain informa-
25 tion on providers and facilities that, with

1 respect to such plan, are participating pro-
2 viders and facilities.

3 “(B) The good faith estimate included in
4 the notification received from the provider or
5 facility (if applicable) based on such codes.

6 “(C) A good faith estimate of the amount
7 the plan is responsible for paying for items and
8 services included in the estimate described in
9 subparagraph (B).

10 “(D) A good faith estimate of the amount
11 of any cost-sharing for which the participant,
12 beneficiary, or enrollee would be responsible for
13 such item or service (as of the date of such no-
14 tification).

15 “(E) A good faith estimate of the amount
16 that the participant, beneficiary, or enrollee has
17 incurred toward meeting the limit of the finan-
18 cial responsibility (including with respect to
19 deductibles and out-of-pocket maximums) under
20 the plan (as of the date of such notification).

21 “(F) In the case such item or service is
22 subject to a medical management technique (in-
23 cluding concurrent review, prior authorization,
24 and step-therapy or fail-first protocols) for cov-
25 erage under the plan, a disclaimer that coverage

1 for such item or service is subject to such med-
2 ical management technique.

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

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

16 “(I) Any other information or disclaimer
17 the plan determines appropriate that is con-
18 sistent with information and disclaimers re-
19 quired under this section.

20 “(2) AUTHORITY TO MODIFY TIMING REQUIRE-
21 MENTS IN THE CASE OF SPECIFIED ITEMS AND
22 SERVICES.—

23 “(A) IN GENERAL.—In the case of a par-
24 ticipant, beneficiary, or enrollee scheduled to re-
25 ceive an item or service that is a specified item

1 or service (as defined in subparagraph (B)), the
2 Secretary may modify any timing requirements
3 relating to the provision of the notification de-
4 scribed in paragraph (1) to such participant,
5 beneficiary, or enrollee with respect to such
6 item or service. Any modification made by the
7 Secretary pursuant to the previous sentence
8 may not result in the provision of such notifica-
9 tion after such participant, beneficiary, or en-
10 rollee has been furnished such item or service.

11 “(B) SPECIFIED ITEM OR SERVICE DE-
12 FINED.—For purposes of subparagraph (A), the
13 term ‘specified item or service’ means an item
14 or service that has low utilization or significant
15 variation in costs (such as when furnished as
16 part of a complex treatment), as specified by
17 the Secretary.”.

18 (c) ERISA AMENDMENTS.—Section 716 of the Em-
19 ployee Retirement Income Security Act of 1974, as added
20 by section 102 and further amended by the previous
21 amendments of this title, is further amended by adding
22 at the end the following new subsection:

23 “(f) ADVANCED EXPLANATION OF BENEFITS.—

24 “(1) IN GENERAL.—Beginning on January 1,
25 2022, each group health plan, or a health insurance

1 issuer offering group health insurance coverage
2 shall, with respect to a notification submitted under
3 section 2799B–6 by a health care provider or health
4 care facility to the plan or issuer for a participant,
5 beneficiary, or enrollee under plan or coverage
6 scheduled to receive an item or service from the pro-
7 vider or facility, not later than 1 business day (or,
8 in the case such item or service was so scheduled at
9 least 10 business days before such item or service is
10 to be furnished (or in the case of a request made to
11 such plan or coverage by such participant, bene-
12 ficiary, or enrollee), 3 business days) after the date
13 on which the plan or coverage receives such notifica-
14 tion (or such request), provide to the participant,
15 beneficiary, or enrollee (through mail or electronic
16 means, as requested by the participant, beneficiary,
17 or enrollee) a notification (in clear and understand-
18 able language) including the following:

19 “(A) Whether or not the provider or facil-
20 ity is a participating provider or a participating
21 facility with respect to the plan or coverage
22 with respect to the furnishing of such item or
23 service and—

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

1 respect to the plan or coverage with re-
2 spect to the furnishing of such item or
3 service, the contracted rate under such
4 plan for such item or service (based on the
5 billing and diagnostic codes provided by
6 such provider or facility); and

7 “(ii) in the case the provider or facil-
8 ity is a nonparticipating provider or facility
9 with respect to such plan or coverage, a
10 description of how such individual may ob-
11 tain information on providers and facilities
12 that, with respect to such plan or coverage,
13 are participating providers and facilities.

14 “(B) The good faith estimate included in
15 the notification received from the provider or
16 facility (if applicable) based on such codes.

17 “(C) A good faith estimate of the amount
18 the health plan is responsible for paying for
19 items and services included in the estimate de-
20 scribed in subparagraph (B).

21 “(D) A good faith estimate of the amount
22 of any cost-sharing for which the participant,
23 beneficiary, or enrollee would be responsible for
24 such item or service (as of the date of such no-
25 tification).

1 “(E) A good faith estimate of the amount
2 that the participant, beneficiary, or enrollee has
3 incurred toward meeting the limit of the finan-
4 cial responsibility (including with respect to
5 deductibles and out-of-pocket maximums) under
6 the plan or coverage (as of the date of such no-
7 tification).

8 “(F) In the case such item or service is
9 subject to a medical management technique (in-
10 cluding concurrent review, prior authorization,
11 and step-therapy or fail-first protocols) for cov-
12 erage under the plan or coverage, a disclaimer
13 that coverage for such item or service is subject
14 to such medical management technique.

15 “(G) A disclaimer that the information
16 provided in the notification is only an estimate
17 based on the items and services reasonably ex-
18 pected, at the time of scheduling (or requesting)
19 the item or service, to be furnished and is sub-
20 ject to change.

21 “(H) A statement that the individual may
22 seek such an item or service from a provider
23 that is a participating provider or a facility that
24 is a participating facility and a list of partici-
25 pating facilities, or of participating providers,

1 as applicable, who are able to furnish such
2 items and services involved.

3 “(I) Any other information or disclaimer
4 the plan or coverage determines appropriate
5 that is consistent with information and dis-
6 claimers required under this section.

7 “(2) AUTHORITY TO MODIFY TIMING REQUIRE-
8 MENTS IN THE CASE OF SPECIFIED ITEMS AND
9 SERVICES.—

10 “(A) IN GENERAL.—In the case of a par-
11 ticipant, beneficiary, or enrollee scheduled to re-
12 ceive an item or service that is a specified item
13 or service (as defined in subparagraph (B)), the
14 Secretary may modify any timing requirements
15 relating to the provision of the notification de-
16 scribed in paragraph (1) to such participant,
17 beneficiary, or enrollee with respect to such
18 item or service. Any modification made by the
19 Secretary pursuant to the previous sentence
20 may not result in the provision of such notifica-
21 tion after such participant, beneficiary, or en-
22 rollee has been furnished such item or service.

23 “(B) SPECIFIED ITEM OR SERVICE DE-
24 FINED.—For purposes of subparagraph (A), the
25 term ‘specified item or service’ means an item

1 or service that has low utilization or significant
2 variation in costs (such as when furnished as
3 part of a complex treatment), as specified by
4 the Secretary.”.

5 **SEC. 112. PATIENT PROTECTIONS THROUGH TRANS-**
6 **PARENCY AND PATIENT-PROVIDER DISPUTE**
7 **RESOLUTION.**

8 Part E of title XXVII of the Public Health Service
9 Act (42 U.S.C. 300gg et seq.), as added by section 104
10 and further amended by the previous provisions of this
11 title, is further amended by adding at the end the fol-
12 lowing new sections:

13 **“SEC. 2799B-6. PROVISION OF INFORMATION UPON RE-**
14 **QUEST AND FOR SCHEDULED APPOINT-**
15 **MENTS.**

16 “Each health care provider and health care facility
17 shall, beginning January 1, 2022, in the case of an indi-
18 vidual who schedules an item or service to be furnished
19 to such individual by such provider or facility at least 3
20 business days before the date such item or service is to
21 be so furnished, not later than 1 business day after the
22 date of such scheduling (or, in the case of such an item
23 or service scheduled at least 10 business days before the
24 date such item or service is to be so furnished (or if re-

1 requested by the individual), not later than 3 business days
2 after the date of such scheduling or such request)—

3 “(1) inquire if such individual is enrolled in a
4 group health plan, group or individual health insur-
5 ance coverage offered by a health insurance issuer,
6 or a Federal health care program (and if is so en-
7 rolled in such plan or coverage, seeking to have a
8 claim for such item or service submitted to such
9 plan or coverage); and

10 “(2) provide a notification (in clear and under-
11 standable language) of the good faith estimate of the
12 expected charges for furnishing such item or service
13 (including any item or service that is reasonably ex-
14 pected to be provided in conjunction with such
15 scheduled item or service and such an item or serv-
16 ice reasonably expected to be so provided by another
17 health care provider or health care facility), with the
18 expected billing and diagnostic codes for any such
19 item or service, to—

20 “(A) in the case the individual is enrolled
21 in such a plan or such coverage (and is seeking
22 to have a claim for such item or service sub-
23 mitted to such plan or coverage), such plan or
24 issuer of such coverage; and

1 “(B) in the case the individual is not de-
2 scribed in subparagraph (A) and not enrolled in
3 a Federal health care program, the individual.

4 **“SEC. 2799B-7. PATIENT-PROVIDER DISPUTE RESOLUTION.**

5 “(a) IN GENERAL.—Not later than January 1, 2022,
6 the Secretary shall establish a process (in this subsection
7 referred to as the ‘patient-provider dispute resolution
8 process’) under which an uninsured individual, with re-
9 spect to an item or service, who received, pursuant to sec-
10 tion 2799B-6, from a health care provider or health care
11 facility a good-faith estimate of the expected charges for
12 furnishing such item or service to such individual and who
13 after being furnished such item or service by such provider
14 or facility is billed by such provider or facility for such
15 item or service for charges that are substantially in excess
16 of such estimate, may seek a determination from a se-
17 lected dispute resolution entity for the charges to be paid
18 by such individual (in lieu of such amount so billed) to
19 such provider or facility for such item or service. For pur-
20 poses of this subsection, the term ‘uninsured individual’
21 means, with respect to an item or service, an individual
22 who does not have benefits for such item or service under
23 a group health plan, group or individual health insurance
24 coverage offered by a health insurance issuer, Federal
25 health care program (as defined in section 1128B(f) of

1 the Social Security Act), or a health benefits plan under
2 chapter 89 of title 5, United States Code (or an individual
3 who has benefits for such item or service under a group
4 health plan or individual or group health insurance cov-
5 erage offered by a health insurance issuer, but who does
6 not seek to have a claim for such item or service submitted
7 to such plan or coverage).

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

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

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

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

1 “(C) does not otherwise have a conflict of
2 interest with such a party (as determined by
3 the Secretary); and

4 “(2) the provision of a notification of such se-
5 lection to the individual and the provider or facility
6 (as applicable) party to such determination.

7 An entity selected pursuant to the previous sentence to
8 make a determination described in such sentence shall be
9 referred to in this subsection as the ‘selected dispute reso-
10 lution entity’ with respect to such determination.

11 “(c) ADMINISTRATIVE FEE.—The Secretary shall es-
12 tablish a fee to participate in the patient-provider dispute
13 resolution process in such a manner as to not create a
14 barrier to an uninsured individual’s access to such process.

15 “(d) CERTIFICATION.—The Secretary shall establish
16 or recognize a process to certify entities under this sub-
17 paragraph. Such process shall ensure that an entity so cer-
18 tified satisfies at least the criteria specified in section
19 2799A–1(c).”.

20 **SEC. 113. ENSURING CONTINUITY OF CARE.**

21 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of
22 the Public Health Service Act (42 U.S.C. 300gg et seq.)
23 is amended, in the part D, as added and amended by sec-
24 tion 102(a) and further amended by the previous provi-

1 sions of this title, by inserting after section 2799A–2 the
2 following new section:

3 **“SEC. 2799A-3. CONTINUITY OF CARE.**

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

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

18 “(A) such contractual relationship is termi-
19 nated (as defined in subsection (b));

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

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

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

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

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

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

24 “(C) permit the patient to elect to continue
25 to have benefits provided under such plan or

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

12 “(i) the 90-day period beginning on
13 such date; or

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

17 “(b) DEFINITIONS.—In this section:

18 “(1) CONTINUING CARE PATIENT.—The term
19 ‘continuing care patient’ means an individual who,
20 with respect to a provider or facility—

21 “(A) is undergoing a course of treatment
22 for a serious and complex condition from the
23 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 group or individual health in-
20 surance coverage—

21 “(A) in the case of an acute illness, a con-
22 dition that is serious enough to require special-
23 ized medical treatment to avoid the reasonable
24 possibility of death or permanent harm; or

1 “(B) in the case of a chronic illness or con-
2 dition, a condition that is—

3 “(i) is life-threatening, degenerative,
4 potentially disabling, or congenital; and

5 “(ii) requires specialized medical care
6 over a prolonged period of time.

7 “(3) TERMINATED.—The term ‘terminated’ in-
8 cludes, with respect to a contract, the expiration or
9 nonrenewal of the contract, but does not include a
10 termination of the contract for failure to meet appli-
11 cable quality standards or for fraud.”.

12 (b) INTERNAL REVENUE CODE.—

13 (1) IN GENERAL.—Subchapter B of chapter
14 100 of the Internal Revenue Code of 1986, as
15 amended by sections 102(c) and 105(a)(3), is fur-
16 ther amended by inserting after section 9817 the fol-
17 lowing new section:

18 **“SEC. 9818. CONTINUITY OF CARE.**

19 “(a) ENSURING CONTINUITY OF CARE WITH RE-
20 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
21 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
22 NETWORK STATUS.—

23 “(1) IN GENERAL.—In the case of an individual
24 with benefits under a group health plan and with re-
25 spect to a health care provider or facility that has

1 a contractual relationship with such plan for fur-
2 nishing items and services under such plan, if, while
3 such individual is a continuing care patient (as de-
4 fined in subsection (b)) with respect to such provider
5 or facility—

6 “(A) such contractual relationship is termi-
7 nated (as defined in paragraph (b));

8 “(B) benefits provided under such plan
9 with respect to such provider or facility are ter-
10 minated because of a change in the terms of the
11 participation of such provider or facility in such
12 plan; or

13 “(C) a contract between such group health
14 plan and a health insurance issuer offering
15 health insurance coverage in connection with
16 such plan is terminated, resulting in a loss of
17 benefits provided under such plan with respect
18 to such provider or facility;

19 the plan shall meet the requirements of paragraph
20 (2) with respect to such individual.

21 “(2) REQUIREMENTS.—The requirements of
22 this paragraph are that the plan—

23 “(A) notify each individual enrolled under
24 such plan who is a continuing care patient with
25 respect to a provider or facility at the time of

1 a termination described in paragraph (1) affect-
2 ing such provider on a timely basis of such ter-
3 mination and such individual's right to elect
4 continued transitional care from such provider
5 or facility under this section;

6 “(B) provide such individual with an op-
7 portunity to notify the plan of the individual's
8 need for transitional care; and

9 “(C) permit the patient to elect to continue
10 to have benefits provided under such plan,
11 under the same terms and conditions as would
12 have applied and with respect to such items and
13 services as would have been covered under such
14 plan had such termination not occurred, with
15 respect to the course of treatment furnished by
16 such provider or facility relating to such indi-
17 vidual's status as a continuing care patient dur-
18 ing the period beginning on the date on which
19 the notice under subparagraph (A) is provided
20 and ending on the earlier of—

21 “(i) the 90-day period beginning on
22 such date; or

23 “(ii) the date on which such individual
24 is no longer a continuing care patient with
25 respect to such provider or facility.

1 “(b) DEFINITIONS.—In this section:

2 “(1) CONTINUING CARE PATIENT.—The term
3 ‘continuing care patient’ means an individual who,
4 with respect to a provider or facility—

5 “(A) is undergoing a course of treatment
6 for a serious and complex condition from the
7 provider or facility;

8 “(B) is undergoing a course of institu-
9 tional or inpatient care from the provider or fa-
10 cility;

11 “(C) is scheduled to undergo nonelective
12 surgery from the provider or facility, including
13 receipt of postoperative care from such provider
14 or facility with respect to such a surgery;

15 “(D) is pregnant and undergoing a course
16 of treatment for the pregnancy from the pro-
17 vider or facility; or

18 “(E) is or was determined to be terminally
19 ill (as determined under section 1861(dd)(3)(A)
20 of the Social Security Act) and is receiving
21 treatment for such illness from such provider or
22 facility.

23 “(2) SERIOUS AND COMPLEX CONDITION.—The
24 term ‘serious and complex condition’ means, with re-

1 spect to a participant, beneficiary, or enrollee under
2 a group health plan—

3 “(A) in the case of an acute illness, a con-
4 dition that is serious enough to require special-
5 ized medical treatment to avoid the reasonable
6 possibility of death or permanent harm; or

7 “(B) in the case of a chronic illness or con-
8 dition, a condition that—

9 “(i) is life-threatening, degenerative,
10 potentially disabling, or congenital; and

11 “(ii) requires specialized medical care
12 over a prolonged period of time.

13 “(3) TERMINATED.—The term ‘terminated’ in-
14 cludes, with respect to a contract, the expiration or
15 nonrenewal of the contract, but does not include a
16 termination of the contract for failure to meet appli-
17 cable quality standards or for fraud.”.

18 (2) CLERICAL AMENDMENT.—The table of sec-
19 tions for such subchapter, as amended by the pre-
20 vious sections, is further amended by inserting after
21 the item relating to section 9817 the following new
22 item:

 “Sec. 9818. Continuity of care.”.

23 (c) EMPLOYEE RETIREMENT INCOME SECURITY
24 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 102(e) and further amended by
5 the previous provisions of this title, is further
6 amended by inserting after section 717 the following
7 new section:

8 **“SEC. 718. CONTINUITY OF CARE.**

9 “(a) ENSURING CONTINUITY OF CARE WITH RE-
10 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
11 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
12 NETWORK STATUS.—

13 “(1) IN GENERAL.—In the case of an individual
14 with benefits under a group health plan or group
15 health insurance coverage offered by a health insur-
16 ance issuer and with respect to a health care pro-
17 vider or facility that has a contractual relationship
18 with such plan or such issuer (as applicable) for fur-
19 nishing items and services under such plan or such
20 coverage, if, while such individual is a continuing
21 care patient (as defined in subsection (b)) with re-
22 spect to such provider or facility—

23 “(A) such contractual relationship is termi-
24 nated (as defined in paragraph (b));

1 “(B) benefits provided under such plan or
2 such health insurance coverage with respect to
3 such provider or facility are terminated because
4 of a change in the terms of the participation of
5 the provider or facility in such plan or coverage;
6 or

7 “(C) a contract between such group health
8 plan and a health insurance issuer offering
9 health insurance coverage in connection with
10 such plan is terminated, resulting in a loss of
11 benefits provided under such plan with respect
12 to such provider or facility;

13 the plan or issuer, respectively, shall meet the re-
14 quirements of paragraph (2) with respect to such in-
15 dividual.

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

18 “(A) notify each individual enrolled under
19 such plan or coverage who is a continuing care
20 patient with respect to a provider or facility at
21 the time of a termination described in para-
22 graph (1) affecting such provider or facility on
23 a timely basis of such termination and such in-
24 dividual’s right to elect continued transitional

1 care from such provider or facility under this
2 section;

3 “(B) provide such individual with an op-
4 portunity to notify the plan or issuer of the in-
5 dividual’s need for transitional care; and

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

19 “(i) the 90-day period beginning on
20 such date; or

21 “(ii) the date on which such individual
22 is no longer a continuing care patient with
23 respect to such provider or facility.

24 “(b) DEFINITIONS.—In this section:

1 “(1) CONTINUING CARE PATIENT.—The term
2 ‘continuing care patient’ means an individual who,
3 with respect to a provider or facility—

4 “(A) is undergoing a course of treatment
5 for a serious and complex condition from the
6 provider or facility;

7 “(B) is undergoing a course of institu-
8 tional or inpatient care from the provider or fa-
9 cility;

10 “(C) is scheduled to undergo nonelective
11 surgery from the provide or facility, including
12 receipt of postoperative care from such provider
13 or facility with respect to such a surgery;

14 “(D) is pregnant and undergoing a course
15 of treatment for the pregnancy from the pro-
16 vider or facility; or

17 “(E) is or was determined to be terminally
18 ill (as determined under section 1861(dd)(3)(A)
19 of the Social Security Act) and is receiving
20 treatment for such illness from such provider or
21 facility.

22 “(2) SERIOUS AND COMPLEX CONDITION.—The
23 term ‘serious and complex condition’ means, with re-
24 spect to a participant, beneficiary, or enrollee under

1 a group health plan or group health insurance cov-
2 erage—

3 “(A) in the case of an acute illness, a con-
4 dition that is serious enough to require special-
5 ized medical treatment to avoid the reasonable
6 possibility of death or permanent harm; or

7 “(B) in the case of a chronic illness or con-
8 dition, a condition that—

9 “(i) is life-threatening, degenerative,
10 potentially disabling, or congenital; and

11 “(ii) requires specialized medical care
12 over a prolonged period of time.

13 “(3) TERMINATED.—The term ‘terminated’ in-
14 cludes, with respect to a contract, the expiration or
15 nonrenewal of the contract, but does not include a
16 termination of the contract for failure to meet appli-
17 cable quality standards or for fraud.”.

18 (2) CLERICAL AMENDMENT.—The table of con-
19 tents in section 1 of the Employee Retirement In-
20 come Security Act of 1974 is amended by inserting
21 after the item relating to section 716 the following
22 new item:

“Sec. 718. Continuity of care.”.

23 (d) PROVIDER REQUIREMENT.—Part E of title
24 XXVII of the Public Health Service Act (42 U.S.C. 300gg
25 et seq.), as added by section 104 and further amended

1 by the previous provisions of this title, is further amended
2 by adding at the end the following new section:

3 **“SEC. 2799B–8. CONTINUITY OF CARE.**

4 “A health care provider or health care facility shall,
5 in the case of an individual furnished items and services
6 by such provider or facility for which coverage is provided
7 under a group health plan or group or individual health
8 insurance coverage pursuant to section 2799A–3, section
9 9818 of the Internal Revenue Code of 1986, or section
10 718 of the Employee Retirement Income Security Act of
11 1974—

12 “(1) accept payment from such plan or such
13 issuer (as applicable) (and cost-sharing from such
14 individual, if applicable, in accordance with sub-
15 section (a)(2)(C) of such section 2799A–3, 9818, or
16 718) for such items and services as payment in full
17 for such items and services; and

18 “(2) continue to adhere to all policies, proce-
19 dures, and quality standards imposed by such plan
20 or issuer with respect to such individual and such
21 items and services in the same manner as if such
22 termination had not occurred.”.

23 (e) EFFECTIVE DATE.—The amendments made by
24 subsections (a), (b), and (c) shall apply with respect to
25 plan years beginning on or after January 1, 2022.

1 **SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL.**

2 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of
3 the Public Health Service Act (42 U.S.C. 300gg et seq.)
4 is amended, in the part D, as added and amended by sec-
5 tion 102 and further amended by the previous provisions
6 of this title, by inserting after section 2799A–3 the fol-
7 lowing new section:

8 **“SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON**
9 **TOOL.**

10 “A group health plan or a health insurance issuer of-
11 fering group or individual health insurance coverage shall
12 offer price comparison guidance by telephone and make
13 available on the Internet website of the plan or issuer a
14 price comparison tool that (to the extent practicable) al-
15 lows an individual enrolled under such plan or coverage,
16 with respect to such plan year and such geographic region,
17 to compare the amount of cost-sharing that the individual
18 would be responsible for paying under such plan or cov-
19 erage with respect to the furnishing of a specific item or
20 service by any such provider.”.

21 (b) INTERNAL REVENUE CODE.—

22 (1) IN GENERAL.—Subchapter B of chapter
23 100 of the Internal Revenue Code of 1986, as
24 amended by sections 102, 105, and 113, is further
25 amended by inserting after section 9818 the fol-
26 lowing new section:

1 **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

2 “A group health plan shall offer price comparison
3 guidance by telephone and make available on the Internet
4 website of the plan or issuer a price comparison tool that
5 (to the extent practicable) allows an individual enrolled
6 under such plan, with respect to such plan year and such
7 geographic region, to compare the amount of cost-sharing
8 that the individual would be responsible for paying under
9 such plan with respect to the furnishing of a specific item
10 or service by any such provider.”.

11 (2) CLERICAL AMENDMENT.—The table of sec-
12 tions for such subchapter, as amended by the pre-
13 vious sections, is further amended by inserting after
14 the item relating to section 9818 the following new
15 item:

“Sec. 9819. Maintenance of price comparison tool.”.

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

18 (1) IN GENERAL.—Subpart B of part 7 of sub-
19 title B of title I of the Employee Retirement Income
20 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
21 amended by sections 102, 105, and 113, is further
22 amended by inserting after section 718 the following
23 new section:

1 **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

2 “A group health plan or a health insurance issuer of-
3 fering group health insurance coverage shall offer price
4 comparison guidance by telephone and make available on
5 the Internet website of the plan or issuer a price compari-
6 son tool that (to the extent practicable) allows an indi-
7 vidual enrolled under such plan or coverage, with respect
8 to such plan year and such geographic region, to compare
9 the amount of cost-sharing that the individual would be
10 responsible for paying under such plan or coverage with
11 respect to the furnishing of a specific item or service by
12 any such provider.”.

13 (2) CLERICAL AMENDMENT.—The table of con-
14 tents in section 1 of the Employee Retirement In-
15 come Security Act of 1974, as amended by the pre-
16 vious provisions of this title, is further amended by
17 inserting after the item relating to section 716 the
18 following new item:

“Sec. 719. Maintenance of price comparison tool.”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section shall apply with respect to plan years begin-
21 ning on or after January 1, 2022.

22 **SEC. 115. STATE ALL PAYER CLAIMS DATABASES.**

23 (a) GRANTS TO STATES.—Part B of title III of the
24 Public Health Service Act (42 U.S.C. 243 et seq.) is
25 amended by adding at the end the following:

1 **“SEC. 320B. STATE ALL PAYER CLAIMS DATABASES.**

2 “(a) IN GENERAL.—The Secretary shall make one-
3 time grants to eligible States for the purposes described
4 in subsection (b).

5 “(b) USES.—A State may use a grant received under
6 subsection (a) for one of the following purposes:

7 “(1) To establish a State All Payer Claims
8 Database.

9 “(2) To improve an existing State All Payer
10 Claims Databases.

11 “(c) ELIGIBILITY.—To be eligible to receive a grant
12 under subsection (a), a State shall submit to the Secretary
13 an application at such time, in such manner, and con-
14 taining such information as the Secretary specifies, includ-
15 ing, with respect to a State All Payer Claims Database,
16 at least specifics on how the State will ensure uniform
17 data collection and the privacy and security of such data.

18 “(d) GRANT PERIOD AND AMOUNT.—Grants award-
19 ed under this section shall be for a period of 3-years, and
20 in an amount of \$2,500,000, of which \$1,000,000 shall
21 be made available to the State for each of the first 2 years
22 of the grant period, and \$500,000 shall be made available
23 to the State for the third year of the grant period.

24 “(e) AUTHORIZED USERS.—

25 “(1) APPLICATION.—An entity desiring author-
26 ization for access to a State All Payer Claims Data-

1 base that has received a grant under this section
2 shall submit to the State All Payer Claims Database
3 an application for such access, which shall include—

4 “(A) in the case of an entity requesting ac-
5 cess for research purposes—

6 “(i) a description of the uses and
7 methodologies for evaluating health system
8 performance using such data; and

9 “(ii) documentation of approval of the
10 research by an institutional review board,
11 if applicable for a particular plan of re-
12 search; or

13 “(B) in the case of an entity such as an
14 employer, health insurance issuer, third-party
15 administrator, or health care provider, request-
16 ing access for the purpose of quality improve-
17 ment or cost-containment, a description of the
18 intended uses for such data.

19 “(2) REQUIREMENTS.—

20 “(A) ACCESS FOR RESEARCH PURPOSES.—

21 Upon approval of an application for research
22 purposes under paragraph (1)(A), the author-
23 ized user shall enter into a data use and con-
24 fidentiality agreement with the State All Payer
25 Claims Database that has received a grant

1 under this subsection, which shall include a pro-
2 hibition on attempts to reidentify and disclose
3 individually identifiable health information and
4 proprietary financial information.

5 “(B) CUSTOMIZED REPORTS.—Employers
6 and employer organizations may request cus-
7 tomized reports from a State All Payer Claims
8 Database that has received a grant under this
9 section, at cost, subject to the requirements of
10 this section with respect to privacy, security,
11 and proprietary financial information.

12 “(C) NON-CUSTOMIZED REPORTS.—A
13 State All Payer Claims Database that has re-
14 ceived a grant under this section shall make
15 available to all authorized users aggregate data
16 sets available through the State All Payer
17 Claims Database, free of charge.

18 “(3) WAIVERS.—The Secretary may waive the
19 requirements of this subsection of a State All Payer
20 Claims Database to provide access of entities to such
21 database if such State All Payer Claims Database is
22 substantially in compliance with this subsection.

23 “(f) EXPANDED ACCESS.—

24 “(1) MULTI-STATE APPLICATIONS.—The Sec-
25 retary may prioritize applications submitted by a

1 State whose application demonstrates that the State
2 will work with other State All Payer Claims Data-
3 bases to establish a single application for access to
4 data by authorized users across multiple States.

5 “(2) EXPANSION OF DATA SETS.—The Sec-
6 retary may prioritize applications submitted by a
7 State whose application demonstrates that the State
8 will implement the reporting format for self-insured
9 group health plans described in section 735 of the
10 Employee Retirement Income Security Act of 1974.

11 “(g) DEFINITIONS.—In this section—

12 “(1) the term ‘individually identifiable health
13 information’ has the meaning given such term in
14 section 1171(6) of the Social Security Act;

15 “(2) the term ‘proprietary financial informa-
16 tion’ means data that would disclose the terms of a
17 specific contract between an individual health care
18 provider or facility and a specific group health plan,
19 managed care entity (as defined in section
20 1932(a)(1)(B) of the Social Security Act) or other
21 managed care organization, or health insurance
22 issuer offering group or individual health insurance
23 coverage; and

24 “(3) the term ‘State All Payer Claims Data-
25 base’ means, with respect to a State, a database that

1 may include medical claims, pharmacy claims, dental
2 claims, and eligibility and provider files, which are
3 collected from private and public payers.

4 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there are appropriated, out of
6 amounts in the Treasury not otherwise appropriated,
7 \$50,000,000 for each of fiscal years 2022 and 2023, and
8 \$25,000,000 for fiscal year 2024, to remain available until
9 expended.”.

10 (b) STANDARDIZED REPORTING FORMAT.—

11 Subpart C of part 7 of subtitle B of title I of
12 the Employee Retirement Income Security Act of
13 1974 (29 U.S.C. 1191 et seq.) is amended by adding
14 at the end the following:

15 **“SEC. 735. STANDARDIZED REPORTING FORMAT.**

16 “(a) IN GENERAL.—Not later than 1 year after the
17 date of enactment of this section, the Secretary shall es-
18 tablish a standardized reporting format for the reporting,
19 by self-insured group health plans to State All Payer
20 Claims Databases, of medical claims, pharmacy claims,
21 dental claims, and eligibility and provider files that are
22 collected from private and public payers, and shall provide
23 guidance to States on the process by which States may
24 collect such data from such plans or coverage in the stand-
25 ardized reporting format.

1 “(b) CONSULTATION.—

2 “(1) ADVISORY COMMITTEE.—Not later than
3 90 days after the date of enactment of this section,
4 the Secretary shall convene an Advisory Committee
5 (referred to in this section as the ‘Committee’), con-
6 sisting of 15 members to advise the Secretary re-
7 garding the format and guidance described in para-
8 graph (1).

9 “(2) MEMBERSHIP.—

10 “(A) APPOINTMENT.—In accordance with
11 subparagraph (B), not later than 90 days after
12 the date of enactment this section, the Sec-
13 retary, in coordination with the Secretary of
14 Health and Human Services, shall appoint
15 under subparagraph (B)(iii), and the Comp-
16 troller General of the United States shall ap-
17 point under subparagraph (B)(iv), members
18 who have distinguished themselves in the fields
19 of health services research, health economics,
20 health informatics, data privacy and security, or
21 the governance of State All Payer Claims Data-
22 bases, or who represent organizations likely to
23 submit data to or use the database, including
24 patients, employers, or employee organizations
25 that sponsor group health plans, health care

1 providers, health insurance issuers, or third-
2 party administrators of group health plans.
3 Such members shall serve 3-year terms on a
4 staggered basis. Vacancies on the Committee
5 shall be filled by appointment consistent with
6 this paragraph not later than 3 months after
7 the vacancy arises.

8 “(B) COMPOSITION.—The Committee shall
9 be comprised of—

10 “(i) the Assistant Secretary of Em-
11 ployee Benefits and Security Administra-
12 tion of the Department of Labor, or a des-
13 ignee of such Assistant Secretary;

14 “(ii) the Assistant Secretary for Plan-
15 ning and Evaluation of the Department of
16 Health and Human Services, or a designee
17 of such Assistant Secretary;

18 “(iii) members appointed by the Sec-
19 retary, in coordination with the Secretary
20 of Health and Human Services, includ-
21 ing—

22 “(I) 1 member to serve as the
23 chair of the Committee;

24 “(II) 1 representative of the Cen-
25 ters for Medicare & Medicaid Services;

1 “(III) 1 representative of the
2 Agency for Healthcare Research and
3 Quality;

4 “(IV) 1 representative of the Of-
5 fice for Civil Rights of the Depart-
6 ment of Health and Human Services
7 with expertise in data privacy and se-
8 curity;

9 “(V) 1 representative of the Na-
10 tional Center for Health Statistics;

11 “(VI) 1 representative of the Of-
12 fice of the National Coordinator for
13 Health Information Technology; and

14 “(VII) 1 representative of a
15 State All-Payer Claims Database;

16 “(iv) members appointed by the
17 Comptroller General of the United States,
18 including—

19 “(I) 1 representative of an em-
20 ployer that sponsors a group health
21 plan;

22 “(II) 1 representative of an em-
23 ployee organization that sponsors a
24 group health plan;

1 “(III) 1 academic researcher with
2 expertise in health economics or
3 health services research;

4 “(IV) 1 consumer advocate; and

5 “(V) 2 additional members.

6 “(3) REPORT.—Not later than 180 days after
7 the date of enactment of this section, the Committee
8 shall report to the Secretary, the Committee on
9 Health, Education, Labor, and Pensions of the Sen-
10 ate, and the Committee on Energy and Commerce
11 and the Committee on Education and Labor of the
12 House of Representatives. Such report shall include
13 recommendations on the establishment of the format
14 and guidance described in subsection (a).

15 “(c) STATE ALL PAYER CLAIMS DATABASE.—In this
16 section, the term ‘State All Payer Claims Database’
17 means, with respect to a State, a database that may in-
18 clude medical claims, pharmacy claims, dental claims, and
19 eligibility and provider files, which are collected from pri-
20 vate and public payers.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there are appropriated, out of
23 amounts in the Treasury not otherwise appropriated,
24 \$5,000,000 for fiscal year 2021, to remain available until
25 expended or until the date described in subsection (e).

1 “(e) SUNSET.—Beginning on the date on which the
2 report is submitted under subsection (b)(3), this section
3 shall have no force or effect.”.

4 **SEC. 116. PROTECTING PATIENTS AND IMPROVING THE AC-**
5 **CURACY OF PROVIDER DIRECTORY INFOR-**
6 **MATION.**

7 (a) PHSA.—Part D of title XXVII of the Public
8 Health Service Act (42 U.S.C. 300gg et seq.), as added
9 and amended by section 102 and further amended by the
10 previous provisions of this title, is further amended by in-
11 serting after section 2799A–4 the following:

12 **“SEC. 2799A–5. PROTECTING PATIENTS AND IMPROVING**
13 **THE ACCURACY OF PROVIDER DIRECTORY**
14 **INFORMATION.**

15 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
16 MENTS.—

17 “(1) IN GENERAL.—For plan years beginning
18 on or after January 1, 2022, each group health plan
19 and health insurance issuer offering group or indi-
20 vidual health insurance coverage shall—

21 “(A) establish the verification process de-
22 scribed in paragraph (2);

23 “(B) establish the response protocol de-
24 scribed in paragraph (3);

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

3 “(D) include in any directory (other than
4 the database described in subparagraph (C)
5 containing provider directory information with
6 respect to such plan or such coverage the infor-
7 mation described in paragraph (5).

8 “(2) VERIFICATION PROCESS.—The verification
9 process described in this paragraph is, with respect
10 to a group health plan or a health insurance issuer
11 offering group or individual health insurance cov-
12 erage, a process—

13 “(A) under which, not less frequently than
14 once every 90 days, such plan or such issuer (as
15 applicable) verifies and updates the provider di-
16 rectory information included on the database
17 described in paragraph (4) of such plan or
18 issuer of each health care provider and health
19 care facility included in such database;

20 “(B) that establishes a procedure for the
21 removal of such a provider or facility with re-
22 spect to which such plan or issuer has been un-
23 able to verify such information during a period
24 specified by the plan or issuer; and

1 “(C) that provides for the update of such
2 database within 2 business days of such plan or
3 issuer receiving from such a provider or facility
4 information pursuant to section 2799B–9.

5 “(3) RESPONSE PROTOCOL.—The response pro-
6 tocol described in this paragraph is, in the case of
7 an individual enrolled under a group health plan or
8 group or individual health insurance coverage of-
9 fered by a health insurance issuer who requests in-
10 formation through a telephone call or electronic,
11 web-based, or Internet-based means on whether a
12 health care provider or health care facility has a
13 contractual relationship to furnish items and services
14 under such plan or such coverage, a protocol under
15 which such plan or such issuer (as applicable), in the
16 case such request is made through a telephone call—

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

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

1 “(4) DATABASE.—The database described in
2 this paragraph is, with respect to a group health
3 plan or health insurance issuer offering group or in-
4 dividual health insurance coverage, a database on
5 the public website of such plan or issuer that con-
6 tains—

7 “(A) a list of each health care provider and
8 health care facility with which such plan or
9 such issuer has a direct or indirect contractual
10 relationship for furnishing items and services
11 under such plan or such coverage; 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 print
16 directory containing provider directory information
17 with respect to a group health plan or individual or
18 group health insurance coverage offered by a health
19 insurance issuer, a notification that such informa-
20 tion contained in such directory was accurate as of
21 the date of publication of such directory and that an
22 individual enrolled under such plan or such coverage
23 should consult the database described in paragraph
24 (4) with respect to such plan or such coverage or
25 contact such plan or the issuer of such coverage to

1 obtain the most current provider directory informa-
2 tion with respect to such plan or such coverage.

3 “(6) DEFINITION.—For purposes of this sub-
4 section, the term ‘provider directory information’ in-
5 cludes, with respect to a group health plan and a
6 health insurance issuer offering group or individual
7 health insurance coverage, the name, address, spe-
8 cialty, telephone number, and digital contact infor-
9 mation of each health care provider or health care
10 facility with which such plan or such issuer has a
11 contractual relationship for furnishing items and
12 services under such plan or such coverage.

13 “(7) RULE OF CONSTRUCTION.—Nothing in
14 this section shall be construed to preempt any provi-
15 sion of State law relating to health care provider di-
16 rectories.

17 “(b) COST-SHARING FOR SERVICES PROVIDED
18 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
19 WORK 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 group health plan or group or indi-
24 vidual health insurance coverage offered by a health
25 insurance issuer by a nonparticipating provider or a

1 nonparticipating facility, if such item or service
2 would otherwise be covered under such plan or cov-
3 erage if furnished by a participating provider or par-
4 ticipating facility and if either of the criteria de-
5 scribed in paragraph (2) applies with respect to such
6 participant, beneficiary, or enrollee and item or serv-
7 ice, the plan or coverage—

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

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

19 “(2) CRITERIA DESCRIBED.—For purposes of
20 paragraph (1), the criteria described in this para-
21 graph, with respect to an item or service furnished
22 to a participant, beneficiary, or enrollee of a group
23 health plan or group or individual health insurance
24 coverage offered by a health insurance issuer by a

1 nonparticipating provider or a nonparticipating facil-
2 ity, are the following:

3 “(A) The participant, beneficiary, or en-
4 rollee received through a database, provider di-
5 rectory, or response protocol described in sub-
6 section (a) information with respect to such
7 item and service to be furnished and such infor-
8 mation provided that the provider was a partici-
9 pating provider or facility was a participating
10 facility, with respect to the plan for furnishing
11 such item or service.

12 “(B) The information was not provided, in
13 accordance with subsection (a), to the partici-
14 pant, beneficiary, or enrollee and the partici-
15 pant, beneficiary, or enrollee requested through
16 the response protocol described in subsection
17 (a)(3) of the plan or coverage information on
18 whether the provider was a participating pro-
19 vider or facility was a participating facility with
20 respect to the plan for furnishing such item or
21 service and was informed through such protocol
22 that the provider was such a participating pro-
23 vider or facility was such a participating facil-
24 ity.

1 “(c) DISCLOSURE ON PATIENT PROTECTIONS
2 AGAINST BALANCE BILLING.—For plan years beginning
3 on or after January 1, 2022, each group health plan and
4 health insurance issuer offering group or individual health
5 insurance coverage shall make publicly available, post on
6 a public website of such plan or issuer, and include on
7 each explanation of benefits for an item or service with
8 respect to which the requirements under section 2799A–
9 1 applies—

10 “(1) information in plain language on—

11 “(A) the requirements and prohibitions ap-
12 plied under sections 2799B–1 and 2799B–2
13 (relating to prohibitions on balance billing in
14 certain circumstances);

15 “(B) if provided for under applicable State
16 law, any other requirements on providers and
17 facilities regarding the amounts such providers
18 and facilities may, with respect to an item or
19 service, charge a participant, beneficiary, or en-
20 rollee of such plan or coverage with respect to
21 which such a provider or facility does not have
22 a contractual relationship for furnishing such
23 item or service under the plan or coverage after
24 receiving payment from the plan or coverage for
25 such item or service and any applicable cost

1 sharing payment from such participant, bene-
2 ficiary, or enrollee; and

3 “(C) the requirements applied under sec-
4 tion 2799A-1; and

5 “(2) information on contacting appropriate
6 State and Federal agencies in the case that an indi-
7 vidual believes that such a provider or facility has
8 violated any requirement described in paragraph (1)
9 with respect to such individual.”.

10 (b) ERISA.—Subpart B of part 7 of subtitle B of
11 title I of the Employee Retirement Income Security Act
12 of 1974 (29 U.S.C. 1185 et seq.), as amended by sections
13 102, 105, 113, and 114, is further amended by inserting
14 after section 719 the following:

15 **“SEC. 720. PROTECTING PATIENTS AND IMPROVING THE**
16 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
17 **MATION.**

18 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
19 MENTS.—

20 “(1) IN GENERAL.—For plan years beginning
21 on or after January 1, 2022, each group health plan
22 and health insurance issuer offering group health in-
23 surance coverage 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 or such coverage the infor-
9 mation described in paragraph (5).

10 “(2) VERIFICATION PROCESS.—The verification
11 process described in this paragraph is, with respect
12 to a group health plan or a health insurance issuer
13 offering group health insurance coverage, a proc-
14 ess—

15 “(A) under which, not less frequently than
16 once every 90 days, such plan or such issuer (as
17 applicable) verifies and updates the provider di-
18 rectory information included on the database
19 described in paragraph (4) of such plan or
20 issuer of each health care provider and health
21 care facility included in such database;

22 “(B) that establishes a procedure for the
23 removal of such a provider or facility with re-
24 spect to which such plan or issuer has been un-

1 able to verify such information during a period
2 specified by the plan or issuer; and

3 “(C) that provides for the update of such
4 database within 2 business days of such plan or
5 issuer receiving from such a provider or facility
6 information pursuant to section 2799B–9.

7 “(3) RESPONSE PROTOCOL.—The response pro-
8 tocol described in this paragraph is, in the case of
9 an individual enrolled under a group health plan or
10 group health insurance coverage offered by a health
11 insurance issuer who requests information through a
12 telephone call or electronic, web-based, or Internet-
13 based means on whether a health care provider or
14 health care facility has a contractual relationship to
15 furnish items and services under such plan or such
16 coverage, a protocol under which such plan or such
17 issuer (as applicable), in the case such request is
18 made through a telephone call—

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 is received, through a
22 written electronic or print (as requested by such
23 individual) communication; 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 group health
6 plan or health insurance issuer offering group health
7 insurance coverage, a database on the public website
8 of such plan or issuer that contains—

9 “(A) a list of each health care provider and
10 health care facility with which such plan or
11 such issuer has a direct or indirect contractual
12 relationship for furnishing items and services
13 under such plan or such coverage; and

14 “(B) provider directory information with
15 respect to each such provider and facility.

16 “(5) INFORMATION.—The information de-
17 scribed in this paragraph is, with respect to a print
18 directory containing provider directory information
19 with respect to a group health plan or group health
20 insurance coverage offered by a health insurance
21 issuer, a notification that such information con-
22 tained in such directory was accurate as of the date
23 of publication of such directory and that an indi-
24 vidual enrolled under such plan or such coverage
25 should consult the database described in paragraph

1 (4) with respect to such plan or such coverage or
2 contact such plan or the issuer of such coverage to
3 obtain the most current provider directory informa-
4 tion with respect to such plan or such coverage.

5 “(6) DEFINITION.—For purposes of this sub-
6 section, the term ‘provider directory information’ in-
7 cludes, with respect to a group health plan and a
8 health insurance issuer offering group health insur-
9 ance coverage, the name, address, specialty, tele-
10 phone number, and digital contact information of
11 each health care provider or health care facility with
12 which such plan or such issuer has a contractual re-
13 lationship for furnishing items and services under
14 such plan or such coverage.

15 “(7) RULE OF CONSTRUCTION.—Nothing in
16 this section shall be construed to preempt any provi-
17 sion of State law relating to health care provider di-
18 rectories, to the extent such State law applies to
19 such plan, coverage, or issuer, subject to section
20 514.

21 “(b) COST-SHARING FOR SERVICES PROVIDED
22 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
23 WORK INFORMATION.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after January 1, 2022, in the case of an item

1 or service furnished to a participant, beneficiary, or
2 enrollee of a group health plan or group health in-
3 surance coverage offered by a health insurance
4 issuer by a nonparticipating provider or a non-
5 participating facility, if such item or service would
6 otherwise be covered under such plan or coverage if
7 furnished by a participating provider or partici-
8 pating facility and if either of the criteria described
9 in paragraph (2) applies with respect to such partici-
10 pant, beneficiary, or enrollee and item or service, the
11 plan or coverage—

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

19 “(B) 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, beneficiary, or enrollee of a group
2 health plan or group health insurance coverage of-
3 fered by a health insurance issuer by a nonpartici-
4 pating provider or a nonparticipating facility, are the
5 following:

6 “(A) The participant, beneficiary, or en-
7 rollee received through a database, provider di-
8 rectory, or response protocol described in sub-
9 section (a) information with respect to such
10 item and service to be furnished and such infor-
11 mation provided that the provider was a partici-
12 pating provider or facility was a participating
13 facility, with respect to the plan for furnishing
14 such item or service.

15 “(B) The information was not provided, in
16 accordance with subsection (a), to the partici-
17 pant, beneficiary, or enrollee and the partici-
18 pant, beneficiary, or enrollee requested through
19 the response protocol described in subsection
20 (a)(3) of the plan or coverage information on
21 whether the provider was a participating pro-
22 vider or facility was a participating facility with
23 respect to the plan for furnishing such item or
24 service and was informed through such protocol
25 that the provider was such a participating pro-

1 vider or facility was such a participating facil-
2 ity.

3 “(c) DISCLOSURE ON PATIENT PROTECTIONS
4 AGAINST BALANCE BILLING.—For plan years beginning
5 on or after January 1, 2022, each group health plan and
6 health insurance issuer offering group health insurance
7 coverage shall make publicly available, post on a public
8 website of such plan or issuer, and include on each expla-
9 nation of benefits for an item or service with respect to
10 which the requirements under section 2799A–1 applies—

11 “(1) information in plain language on—

12 “(A) the requirements and prohibitions ap-
13 plied under sections 2799B–1 and 2799B–2
14 (relating to prohibitions on balance billing in
15 certain circumstances);

16 “(B) if provided for under applicable State
17 law, any other requirements on providers and
18 facilities regarding the amounts such providers
19 and facilities may, with respect to an item or
20 service, charge a participant, beneficiary, or en-
21 rollee of such plan or coverage with respect to
22 which such a provider or facility does not have
23 a contractual relationship for furnishing such
24 item or service under the plan or coverage after
25 receiving payment from the plan or coverage for

1 such item or service and any applicable cost
2 sharing payment from such participant, bene-
3 ficiary, or enrollee; and

4 “(C) the requirements applied under sec-
5 tion 2799A-1; and

6 “(2) information on contacting appropriate
7 State and Federal agencies in the case that an indi-
8 vidual believes that such a provider or facility has
9 violated any requirement described in paragraph (1)
10 with respect to such individual.”.

11 (c) IRC.—Subchapter B of chapter 100 of the Inter-
12 nal Revenue Code of 1986, as amended by sections 102,
13 105, 113, and 114, is further amended by inserting after
14 section 9819 the following:

15 **“SEC. 9820. PROTECTING PATIENTS AND IMPROVING THE**
16 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
17 **MATION.**

18 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
19 MENTS.—

20 “(1) IN GENERAL.—For plan years beginning
21 on or after January 1, 2022, each group health plan
22 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 group health plan, a process—

13 “(A) under which, not less frequently than
14 once every 90 days, such plan verifies and up-
15 dates the provider directory information in-
16 cluded on the database described in paragraph
17 (4) of such plan or issuer of each health care
18 provider and health care facility included in
19 such database;

20 “(B) that establishes a procedure for the
21 removal of such a provider or facility with re-
22 spect to which such plan or issuer has been un-
23 able to verify such information during a period
24 specified by the plan or issuer; and

1 “(C) that provides for the update of such
2 database within 2 business days of such plan or
3 issuer receiving from such a provider or facility
4 information pursuant to section 2799B–9.

5 “(3) RESPONSE PROTOCOL.—The response pro-
6 tocol described in this paragraph is, in the case of
7 an individual enrolled under a group health plan who
8 requests information through a telephone call or
9 electronic, web-based, or Internet-based means on
10 whether a health care provider or health care facility
11 has a contractual relationship to furnish items and
12 services under such plan, a protocol under which
13 such plan or such issuer (as applicable), in the case
14 such request is made through a telephone call—

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

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

23 “(4) DATABASE.—The database described in
24 this paragraph is, with respect to a group health

1 plan, a database on the public website of such plan
2 or issuer that contains—

3 “(A) a list of each health care provider and
4 health care facility with which such plan or
5 such issuer has a direct or indirect contractual
6 relationship for furnishing items and services
7 under such plan; and

8 “(B) provider directory information with
9 respect to each such provider and facility.

10 “(5) INFORMATION.—The information de-
11 scribed in this paragraph is, with respect to a print
12 directory containing provider directory information
13 with respect to a group health plan, a notification
14 that such information contained in such directory
15 was accurate as of the date of publication of such
16 directory and that an individual enrolled under such
17 plan should consult the database described in para-
18 graph (4) with respect to such plan or contact such
19 plan to obtain the most current provider directory
20 information with respect to such plan.

21 “(6) DEFINITION.—For purposes of this sub-
22 section, the term ‘provider directory information’ in-
23 cludes, with respect to a group health plan, the
24 name, address, specialty, telephone number, and dig-
25 ital contact information of each health care provider

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

4 “(7) RULE OF CONSTRUCTION.—Nothing in
5 this section shall be construed to preempt any provi-
6 sion of State law relating to health care provider di-
7 rectories.

8 “(b) COST-SHARING FOR SERVICES PROVIDED
9 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
10 WORK INFORMATION.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after January 1, 2022, in the case of an item
13 or service furnished to a participant, beneficiary, or
14 enrollee of a group health plan by a nonparticipating
15 provider or a nonparticipating facility, if such item
16 or service would otherwise be covered under such
17 plan if furnished by a participating provider or par-
18 ticipating facility and if either of the criteria de-
19 scribed in paragraph (2) applies with respect to such
20 participant, beneficiary, or enrollee and item or serv-
21 ice, the plan—

22 “(A) shall not impose on such participant,
23 beneficiary, or enrollee a cost-sharing amount
24 for such item or service so furnished that is
25 greater than the cost-sharing amount that

1 would apply under such plan had such item or
2 service been furnished by a participating pro-
3 vider; and

4 “(B) 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 or a participating facility.

8 “(2) CRITERIA DESCRIBED.—For purposes of
9 paragraph (1), the criteria described in this para-
10 graph, with respect to an item or service furnished
11 to a participant, beneficiary, or enrollee of a group
12 health plan by a nonparticipating provider or a non-
13 participating facility, are the following:

14 “(A) The participant, beneficiary, or en-
15 rollee received through a database, provider di-
16 rectory, or response protocol described in sub-
17 section (a) information with respect to such
18 item and service to be furnished and such infor-
19 mation provided that the provider was a partici-
20 pating provider or facility was a participating
21 facility, with respect to the plan for furnishing
22 such item or service.

23 “(B) The information was not provided, in
24 accordance with subsection (a), to the partici-
25 pant, beneficiary, or enrollee and the partici-

1 pant, beneficiary, or enrollee requested through
2 the response protocol described in subsection
3 (a)(3) of the plan information on whether the
4 provider was a participating provider or facility
5 was a participating facility with respect to the
6 plan for furnishing such item or service and
7 was informed through such protocol that the
8 provider was such a participating provider or
9 facility was such a participating facility.

10 “(c) DISCLOSURE ON PATIENT PROTECTIONS
11 AGAINST BALANCE BILLING.—For plan years beginning
12 on or after January 1, 2022, each group health plan shall
13 make publicly available, post on a public website of such
14 plan or issuer, and include on each explanation of benefits
15 for an item or service with respect to which the require-
16 ments under section 2799A–1 applies—

17 “(1) information in plain language on—

18 “(A) the requirements and prohibitions ap-
19 plied under sections 2799B–1 and 2799B–2
20 (relating to prohibitions on balance billing in
21 certain circumstances);

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

1 service, charge a participant, beneficiary, or en-
2 rollee of such plan with respect to which such
3 a provider or facility does not have a contrac-
4 tual relationship for furnishing such item or
5 service under the plan after receiving payment
6 from the plan for such item or service and any
7 applicable cost sharing payment from such par-
8 ticipant, beneficiary, or enrollee; and

9 “(C) the requirements applied under sec-
10 tion 2799A-1; and

11 “(2) information on contacting appropriate
12 State and Federal agencies in the case that an indi-
13 vidual believes that such a provider or facility has
14 violated any requirement described in paragraph (1)
15 with respect to such individual.”.

16 (d) CLERICAL AMENDMENTS.—

17 (1) ERISA.—The table of contents in section 1
18 of the Employee Retirement Income Security Act of
19 1974 (29 U.S.C. 1001 et seq.), as amended by the
20 previous provisions of this title, is further amended
21 by inserting after the item relating to section 719
22 the following new item:

“720. Protecting patients and improving the accuracy of provider directory in-
formation.”.

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

1 1986, as amended by the previous provisions of this
2 title, is further amended by inserting after the item
3 relating to section 9819 the following new item:

“9820. Protecting patients and improving the accuracy of provider directory information.”.

4 (e) PROVIDER REQUIREMENTS.—Part E of title
5 XXVII of the Public Health Service Act (42 U.S.C. 300gg
6 et seq.), as added by section 104 and as further amended
7 by the previous provisions of this title, is further amended
8 by adding at the end the following:

9 **“SEC. 2799B-9. PROVIDER REQUIREMENTS TO PROTECT PA-**
10 **TIENTS AND IMPROVE THE ACCURACY OF**
11 **PROVIDER DIRECTORY INFORMATION.**

12 “(a) PROVIDER BUSINESS PROCESSES.—Beginning
13 not later than January 1, 2022, each health care provider
14 and each health care facility shall have in place business
15 processes to ensure the timely provision of provider direc-
16 tory information to a group health plan or a health insur-
17 ance issuer offering group or individual health insurance
18 coverage to support compliance by such plans or issuers
19 with section 2799A-5(a)(1). Such providers shall submit
20 provider directory information to a plan or issuers, at a
21 minimum—

22 “(1) when the provider or facility begins a net-
23 work agreement with a plan or with an issuer with
24 respect to certain coverage;

1 “(2) when the provider or facility terminates a
2 network agreement with a plan or with an issuer
3 with respect to certain coverage;

4 “(3) when there are material changes to the
5 content of provider directory information of the pro-
6 vider or facility described in section 2799A–5(a)(1);
7 and

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

11 “(b) REFUNDS TO ENROLLEES.—If a health care
12 provider submits a bill to an enrollee based on cost-sharing
13 for treatment or services provided by the health care pro-
14 vider that is in excess of the normal cost-sharing applied
15 for such treatment or services provided in-network, as pro-
16 hibited under section 2799A–5(b), and the enrollee pays
17 such bill, the provider shall reimburse the enrollee for the
18 full amount paid by the enrollee in excess of the in-net-
19 work cost-sharing amount for the treatment or services
20 involved, plus interest, at an interest rate determined by
21 the Secretary.

22 “(c) LIMITATION.—Nothing in this section shall pro-
23 hibit a provider from requiring in the terms of a contract,
24 or contract termination, with a group health plan or health
25 insurance issuer—

1 “(1) that the plan or issuer remove, at the time
2 of termination of such contract, the provider from a
3 directory of the plan or issuer described in section
4 2799A–5(a); or

5 “(2) that the plan or issuer bear financial re-
6 sponsibility, including under section 2799A–5(b), for
7 providing inaccurate network status information to
8 an enrollee.

9 “(d) DEFINITION.—For purposes of this section, the
10 term ‘provider directory information’ includes the names,
11 addresses, specialty, telephone numbers, and digital con-
12 tact information of individual health care providers, and
13 the names, addresses, telephone numbers, and digital con-
14 tact information of each medical group, clinic, or facility
15 contracted to participate in any of the networks of the
16 group health plan or health insurance coverage involved.

17 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to preempt any provision of State
19 law relating to health care provider directories.”.

20 **SEC. 117. TIMELY BILLS FOR PATIENTS.**

21 (a) FACILITIES AND PRACTITIONERS REQUIRE-
22 MENTS.—

23 (1) IN GENERAL.—Part E of title XXVII of the
24 Public Health Service Act (42 U.S.C. 300gg et seq.),
25 as added and amended by the previous provisions of

1 this title, is further amended by adding at the end
2 the following:

3 **“SEC. 2799B-10. PROVIDER PROVISION OF TIMELY BILLS**
4 **FOR PATIENTS.**

5 “(a) PROVISION OF LIST OF SERVICES.—Health care
6 facilities, or in the case of practitioners providing services
7 outside of such a facility, practitioners, shall provide to
8 an individual a list of services rendered to such individual
9 during the visit to such facility or practitioner, and, in
10 the case of a facility, the name of the practitioner for each
11 such service, upon discharge or end of the visit or by post-
12 al or electronic communication as soon as practicable and
13 not later than 15 calendar days after the discharge or date
14 of visit.

15 “(b) ADJUDICATION OF BILLS.—In the case of serv-
16 ices provided to an individual covered by a group health
17 plan or group or individual health insurance coverage of-
18 fered by a health insurance issuer, subject to 2799A-6(b),
19 section 721(b) of the Employee Retirement Income Secu-
20 rity Act of 1974, or section 9821(b) of the Internal Rev-
21 enue Code of 1986, as applicable—

22 “(1) the health care facility, or in the case of
23 a practitioner providing services outside of such a
24 facility, the practitioner, shall submit to the group
25 health plan or health insurance issuer the bill with

1 respect to such services not later than 30 calendar
2 days after discharge or date of visit of the indi-
3 vidual; and

4 “(2) the health care facility or practitioner, as
5 applicable under paragraph (1), shall, not later than
6 30 calendar days after transmission of the informa-
7 tion as described in section 2799A–6(a), section
8 721(a) of the Employee Retirement Income Security
9 Act of 1974, or section 9821(a) of the Internal Rev-
10 enue Code of 1986, as applicable, send to the indi-
11 vidual, using such information, the cost-sharing obli-
12 gation applied for such services (which in the case
13 of such services for which a payment is required to
14 be made by the plan or coverage pursuant to sub-
15 section (a)(1) of section 2799A–1, of 716 of the Em-
16 ployee Retirement Income Security Act of 1974, or
17 of section 9816 of the Internal Revenue Code of
18 1986, subsection (b)(1) of such sections, or sub-
19 section (a) of section 2799A–2, of 717 of the Em-
20 ployee Retirement Income Security Act of 1974, or
21 of section 9817 of the Internal Revenue Code of
22 1986, shall be in accordance with such respective
23 subsection).

24 “(c) PAYMENT AFTER BILLING.—No patient may be
25 required to pay a bill for health care services any earlier

1 than 45 days after the postmark date of a bill for such
2 services.

3 “(d) REFUND REQUIREMENT.—

4 “(1) IN GENERAL.—If a facility or practitioner
5 bills a patient after the 90-calendar-day period de-
6 scribed pursuant to subsection (b), in addition to
7 being subject to any penalty under section 2799B-
8 4, such facility or practitioner shall refund the pa-
9 tient for the full amount paid in response to such
10 bill with interest, at a rate determined by the Sec-
11 retary.

12 “(2) EXEMPTIONS.—The Secretary may exempt
13 a practitioner or facility from the penalties under
14 paragraph (1) or extend the periods specified in sub-
15 section (b) for compliance with such subsection if a
16 practitioner or facility—

17 “(A) makes a good-faith attempt to send a
18 bill within the periods specified in subsection
19 (b) but is unable to do so because of an incor-
20 rect address; or

21 “(B) experiences extenuating cir-
22 cumstances (as defined by the Secretary), such
23 as a hurricane or cyberattack, that may reason-
24 ably delay delivery of a timely bill.

1 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed to limit applicability of the appeals
3 process under section 2719 to coverage determinations or
4 claims subject to the requirements of this section. The pe-
5 riods described in subsections (b) and (c) shall be tolled
6 during any period during which a claim is subject to an
7 appeal under section 2719, provided that, in the case of
8 such an appeal by the provider, the patient is informed
9 of such appeal.”.

10 (2) RULEMAKING.—Not later than 1 year after
11 the date of enactment of this Act, the Secretary of
12 Health and Human Services shall promulgate final
13 regulations to implement section 2799B–10 of the
14 Public Health Service Act, as added by paragraph
15 (1). Such regulations shall include—

16 (A) a definition of the term “extenuating
17 circumstance” for purposes of subsection
18 (d)(3)(B) of such section 2799B–10; and

19 (B) a definition of the term “date of serv-
20 ice” for purposes of subsection (b)(1), with re-
21 spect to providers submitting global packages
22 for services provided on multiple visits.

23 (b) GROUP HEALTH PLAN AND HEALTH INSURANCE
24 ISSUER REQUIREMENTS.—

1 (1) PHSA.—Part D of title XXVII of the Pub-
2 lic Health Service Act, as added and amended by
3 section 102 and further amended by the previous
4 provisions of this title, is further amended by insert-
5 ing after section 2799A–5 the following:

6 **“SEC. 2799A–6. TIMELY BILLS FOR PATIENTS.**

7 “(a) IN GENERAL.—Subject to subsection (b), in the
8 case of a group health plan or health insurance issuer of-
9 fering group or individual health insurance coverage that
10 receives a bill as described in section 2799B–10(b)(1)
11 from a facility or practitioner, the group health plan or
12 issuer shall, not later than 30 calendar days after such
13 bill is transmitted by the facility or practitioner, send to
14 the facility or practitioner, as applicable under such sec-
15 tion, the following information:

16 “(1) In the case the bill is with respect to serv-
17 ices for which a payment is required to be made by
18 the plan or coverage pursuant to subsection (a)(1)
19 of section 2799A–1, of 716 of the Employee Retire-
20 ment Income Security Act of 1974, or of section
21 9816 of the Internal Revenue Code of 1986, sub-
22 section (b)(1) of such sections, or subsection (a) of
23 section 2799A–2, of 717 of the Employee Retire-
24 ment Income Security Act of 1974, or of section
25 9817 of the Internal Revenue Code of 1986, an ini-

1 tial response to such bill, including the cost-sharing
2 amount applicable with respect to such bill, in ac-
3 cordance with such respective subsection.

4 “(2) In the case the bill is with respect to serv-
5 ices not described in paragraph (1), the completed
6 adjudicated bill by the plan or coverage, including
7 the cost-sharing amount applicable with respect to
8 such bill.

9 “(b) CLARIFICATION.—A provider or a group health
10 plan or health insurance issuer may establish in a contract
11 the timeline for submission by either party to the other
12 party of billing information, adjudication, sending of re-
13 mittance information, or any other coordination required
14 between the provider and the plan or issuer necessary for
15 meeting the deadlines described in subsection (a) and sec-
16 tion 2799B–10(b) as long as such timeline results in the
17 90-calendar day period described in section 2799B–
18 10(d)(1)(B).

19 “(c) RULES OF CONSTRUCTION.—Nothing in this
20 section shall be construed to limit applicability of the ap-
21 peals process under section 2719 to coverage determina-
22 tions or claims subject to the requirements of this section.
23 Any timeline established under subsection (a) or (b) shall
24 be tolled during any period during which a claim is subject
25 to an appeal under section 2719, provided that, in the case

1 of such an appeal by the provider, the patient is informed
2 of such appeal. A group health plan or health insurance
3 issuer that knows or should have known that denials of
4 a claim would lead to noncompliance by providers with sec-
5 tion 2799B–10 may be found to be in violation of this
6 part.”.

7 (2) ERISA.—Subpart B of part 7 of subtitle B
8 of title I of the Employee Retirement Income Secu-
9 rity Act of 1974 (29 U.S.C. 1185 et seq.), as
10 amended by sections 102, 105, 113, 114, and 116,
11 is further amended by inserting after section 720
12 the following:

13 **“SEC. 721. TIMELY BILLS FOR PATIENTS.**

14 “(a) IN GENERAL.—Subject to subsection (b), in the
15 case of a group health plan or health insurance issuer of-
16 fering group health insurance coverage that receives a bill
17 as described in section 2799B–10(b)(1) of the Public
18 Health Service Act from a facility or practitioner, the
19 group health plan or issuer shall, not later than 30 cal-
20 endar days after such bill is transmitted by the facility
21 or practitioner, send to the facility or practitioner, as ap-
22 plicable under such section, the following information:

23 “(1) In the case the bill is with respect to serv-
24 ices for which a payment is required to be made by
25 the plan or coverage pursuant to subsection (a)(1)

1 of section 716, of section 2799A–1 of the Public
2 Health Service Act, or of section 9816 of the Inter-
3 nal Revenue Code of 1986, subsection (b)(1) of such
4 sections, or subsection (a) of section 717, of section
5 2799A–2 of the Public Health Service Act, or of sec-
6 tion 9817 of the Internal Revenue Code of 1986, an
7 initial response to such bill, including the cost-shar-
8 ing amount applicable with respect to such bill, in
9 accordance with such respective subsection.

10 “(2) In the case the bill is with respect to serv-
11 ices not described in paragraph (1), the completed
12 adjudicated bill by the plan or coverage, including
13 the cost-sharing amount applicable with respect to
14 such bill.

15 “(b) CLARIFICATION.—A provider or a group health
16 plan or health insurance issuer may establish in a contract
17 the timeline for submission by either party to the other
18 party of billing information, adjudication, sending of re-
19 mittance information, or any other coordination required
20 between the provider and the plan or issuer necessary for
21 meeting the deadlines described in subsection (a) and sec-
22 tion 2799B–10(b) of the Public Health Service Act as long
23 as such timeline results in the 90-calendar day period de-
24 scribed in section 2799B–10(d)(1)(B) of such Act.

1 “(c) RULES OF CONSTRUCTION.—Nothing in this
2 section shall be construed to limit applicability of the ap-
3 peals process under section 2719 of the Public Health
4 Service Act or section 503 to coverage determinations or
5 claims subject to the requirements of this section. Any
6 timeline established under subsection (a) or (b) shall be
7 tolled during any period during which a claim is subject
8 to an appeal under section 2719 of the Public Health
9 Service Act or section 503, provided that, in the case of
10 such an appeal by the provider, the patient is informed
11 of such appeal. A group health plan or health insurance
12 issuer that knows or should have known that denials of
13 a claim would lead to noncompliance by providers with sec-
14 tion 2799B–10 of the Public Health Service Act may be
15 found to be in violation of this subpart.”.

16 (3) IRC.—Subchapter B of chapter 100 of the
17 Internal Revenue Code of 1986, as amended by the
18 sections 102, 105, 113, 114, and 116, is further
19 amended by inserting after section 9820 the fol-
20 lowing:

21 **“SEC. 9821. TIMELY BILLS FOR PATIENTS.**

22 “(a) IN GENERAL.—Subject to subsection (b), in the
23 case of a group health plan that receives a bill as described
24 in section 2799B–10(b)(1) of the Public Health Service
25 Act from a facility or practitioner, the group health plan

1 shall, not later than 30 calendar days after such bill is
2 transmitted by the facility or practitioner, send to the fa-
3 cility or practitioner, as applicable under such section, the
4 following information:

5 “(1) In the case the bill is with respect to serv-
6 ices for which a payment is required to be made by
7 the plan pursuant to subsection (a)(1) of section
8 716, of section 2799A–1 of the Public Health Serv-
9 ice Act, or of section 9816 of the Internal Revenue
10 Code of 1986, subsection (b)(1) of such sections, or
11 subsection (a) of section 717, of section 2799A–2 of
12 the Public Health Service Act, or of section 9817 of
13 the Internal Revenue Code of 1986, an initial re-
14 sponse to such bill, including the cost-sharing
15 amount applicable with respect to such bill, in ac-
16 cordance with such respective subsection.

17 “(2) In the case the bill is with respect to serv-
18 ices not described in paragraph (1), the completed
19 adjudicated bill by the plan, including the cost-shar-
20 ing amount applicable with respect to such bill.

21 “(b) CLARIFICATION.—A provider or a group health
22 plan may establish in a contract the timeline for submis-
23 sion by either party to the other party of billing informa-
24 tion, adjudication, sending of remittance information, or
25 any other coordination required between the provider and

1 the plan necessary for meeting the deadlines described in
2 subsection (a) and section 2799B–10(b) of the Public
3 Health Service Act as long as such timeline results in the
4 90-calendar day period described in section 2799B–
5 10(d)(1)(B) of such Act.

6 “(c) RULES OF CONSTRUCTION.—Nothing in this
7 section shall be construed to limit applicability of the ap-
8 peals process under section 2719 of the Public Health
9 Service Act to coverage determinations or claims subject
10 to the requirements of this section. Any timeline estab-
11 lished under subsection (a) or (b) shall be tolled during
12 any period during which a claim is subject to an appeal
13 under section 2719 of the Public Health Service Act, pro-
14 vided that, in the case of such an appeal by the provider,
15 the patient is informed of such appeal. A group health
16 plan that knows or should have known that denials of a
17 claim would lead to noncompliance by providers with sec-
18 tion 2799B–10 of the Public Health Service Act may be
19 found to be in violation of this chapter.”.

20 (4) CLERICAL AMENDMENTS.—

21 (A) ERISA.—The table of contents in sec-
22 tion 1 of the Employee Retirement Income Se-
23 curity Act of 1974 (29 U.S.C. 1001 et seq.), as
24 amended by the previous provisions of this title,

1 is further amended by inserting after the item
2 relating to section 720 the following new item:

“721. Timely bills for patients.”.

3 (B) IRC.—The table of sections for sub-
4 chapter B of chapter 100 of the Internal Rev-
5 enue Code of 1986, as amended by the previous
6 provisions of this title, is further amended by
7 inserting after the item relating to section 9820
8 the following new item:

“9821. Timely bills for patients.”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 subsections (a) and (b) shall apply beginning 6 months
11 after the date of the enactment of this Act.

12 **SEC. 118. ADVISORY COMMITTEE ON GROUND AMBULANCE**
13 **AND PATIENT BILLING.**

14 (a) IN GENERAL.—Not later than 60 days after the
15 date of enactment of this Act, the Secretary of Labor, Sec-
16 retary of Health and Human Services, and the Secretary
17 of the Treasury (the Secretaries) shall jointly establish an
18 advisory committee for the purpose of reviewing options
19 to improve the disclosure of charges and fees for ground
20 ambulance services, better inform consumers of insurance
21 options for such services, and protect consumers from bal-
22 ance billing.

1 (b) COMPOSITION OF THE ADVISORY COMMITTEE.—

2 The advisory committee shall be composed of the following
3 members:

4 (1) The Secretary of Labor, or the Secretary's
5 designee.

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

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

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

12 (A) Each relevant Federal agency, as de-
13 termined by the Secretaries.

14 (B) State insurance regulators.

15 (C) Health insurance providers.

16 (D) Patient advocacy groups.

17 (E) Consumer advocacy groups.

18 (F) State and local governments.

19 (G) Physician specializing in emergency,
20 trauma, cardiac, or stroke.

21 (5) Three representatives, to be appointed joint-
22 ly by the Secretaries, to represent the various seg-
23 ments of the ground ambulance industry.

24 (6) Up to an additional 2 representatives other-
25 wise not described in paragraphs (1) through (5), as

1 determined necessary and appropriate by the Secre-
2 taries.

3 (c) CONSULTATION.—The advisory committee shall,
4 as appropriate, consult with relevant experts and stake-
5 holders, including those not otherwise included under sub-
6 section (b), while conducting the review described in sub-
7 section (a).

8 (d) RECOMMENDATIONS.—The advisory committee
9 shall make recommendations with respect to disclosure of
10 charges and fees for ground ambulance services and insur-
11 ance coverage, consumer protection and enforcement au-
12 thorities of the Departments of Labor, Health and Human
13 Services, and the Treasury and State authorities, and the
14 prevention of balance billing to consumers. The rec-
15 ommendations shall address, at a minimum—

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

18 (2) steps that can be taken by State legisla-
19 tures, State insurance regulators, State attorneys
20 general, and other State officials as appropriate,
21 consistent with current legal authorities regarding
22 consumer protection; and

23 (3) legislative options for Congress to prevent
24 balance billing.

1 (e) REPORT.—Not later than 180 days after the date
2 of the first meeting of the advisory committee, the advi-
3 sory committee shall submit to the Secretaries, and the
4 Committees on Education and Labor, Energy and Com-
5 merce, and Ways and Means of the House of Representa-
6 tives and the Committees on Finance and Health, Edu-
7 cation, Labor, and Pensions a report containing the rec-
8 ommendations made under subsection (d).

9 **TITLE II—EXTENDERS**

10 **PROVISIONS**

11 **SEC. 201. EXTENSION FOR COMMUNITY HEALTH CENTERS,** 12 **THE NATIONAL HEALTH SERVICE CORPS,** 13 **AND TEACHING HEALTH CENTERS THAT OP-** 14 **ERATE GME PROGRAMS.**

15 (a) COMMUNITY HEALTH CENTERS.—Section
16 10503(b)(1)(F) of the Patient Protection and Affordable
17 Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended by
18 striking “, \$4,000,000,000 for fiscal year 2019,
19 \$4,000,000,000 for fiscal year 2020, and \$865,753,425
20 for the period beginning on October 1, 2020, and ending
21 on December 18, 2020” and inserting “and
22 \$4,000,000,000 for each of fiscal years 2019 through
23 2024”.

24 (b) NATIONAL HEALTH SERVICE CORPS.—Section
25 10503(b)(2)(H) of the Patient Protection and Affordable

1 Care Act (42 U.S.C. 254b–2(b)(2)(H)) is amended by
2 striking “\$67,095,890 for the period beginning on October
3 1, 2020, and ending on December 18, 2020” and inserting
4 “\$310,000,000 for each of fiscal years 2021 through
5 2024”.

6 (c) TEACHING HEALTH CENTERS THAT OPERATE
7 GRADUATE MEDICAL EDUCATION PROGRAMS.—Section
8 340H(g)(1) of the Public Health Service Act (42 U.S.C.
9 256h(g)(1)) is amended by striking “fiscal year 2020, and
10 \$27,379,452 for the period beginning on October 1, 2020,
11 and ending on December 18, 2020” and inserting “2024”.

12 (d) APPLICATION OF PROVISIONS.—Amounts appro-
13 priated pursuant to the amendments made by this section
14 for fiscal years 2021 through 2024 shall be subject to the
15 requirements contained in Public Law 116–94 for funds
16 for programs authorized under sections 330 through 340
17 of the Public Health Service Act.

18 (e) CONFORMING AMENDMENTS.—Paragraph (4) of
19 section 3014(h) of title 18, United States Code, as amend-
20 ed by section 1201(d) of the Further Continuing Appro-
21 priations Act, 2021, and Other Extensions Act, is amend-
22 ed by striking “and section 1201(d) of the Further Con-
23 tinuing Appropriations Act, 2021, and Other Extensions
24 Act” and inserting “, section 1201(d) of the Further Con-

1 tinuing Appropriations Act, 2021, and Other Extensions
2 Act, and [section 201(d) of the _____ Act.]”.

3 **SEC. 202. DIABETES PROGRAMS.**

4 (a) TYPE I.—Section 330B(b)(2)(D) of the Public
5 Health Service Act (42 U.S.C. 254e–2(b)(2)(D)) is
6 amended by striking “2020, and \$32,465,753 for the pe-
7 riod beginning on October 1, 2020, and ending on Decem-
8 ber 18, 2020” and inserting “2024”.

9 (b) INDIANS.—Section 330C(c)(2)(D) of the Public
10 Health Service Act (42 U.S.C. 254e–3(c)(2)(D)) is
11 amended by striking “2020, and \$32,465,753 for the pe-
12 riod beginning on October 1, 2020, and ending on Decem-
13 ber 18, 2020” and inserting “2024”.