

**[DISCUSSION DRAFT]**

116<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R.** \_\_\_\_\_

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title XI of the Social Security Act to prevent certain cases of out-of-network surprise medical bills, strengthen health care consumer protections, and improve health care information transparency, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

M. \_\_\_\_\_ introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

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**A BILL**

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title XI of the Social Security Act to prevent certain cases of out-of-network surprise medical bills, strengthen health care consumer protections, and improve health care information transparency, and for other purposes.

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

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

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

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

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

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

11 (a) **PHSA AMENDMENTS.**—

12 (1) **IN GENERAL.**—Section 2719A of the Public  
13 Health Service Act (42 U.S.C. 300gg–19a) is  
14 amended—

15 (A) in subsection (b)—

1 (i) in the heading, by striking “COV-  
2 ERAGE” and inserting “COST-SHARING  
3 AND PAYMENT”;

4 (ii) in paragraph (1)—

5 (I) in the matter preceding sub-  
6 paragraph (A)—

7 (aa) by striking “a group  
8 health plan, or a health insurance  
9 issuer offering group or indi-  
10 vidual health insurance issuer,”  
11 and inserting “a health plan”;

12 (bb) by inserting “or, for  
13 plan year 2022 or a subsequent  
14 plan year, with respect to emer-  
15 gency services in an independent  
16 freestanding emergency depart-  
17 ment” after “emergency depart-  
18 ment of a hospital”;

19 (cc) by striking “the plan or  
20 issuer” and inserting “the plan”;  
21 and

22 (dd) by striking “(as defined  
23 in paragraph (2)(B))”;

24 (II) in subparagraph (B), by in-  
25 serting “or a participating facility

1 that is an emergency department of a  
2 hospital or an independent free-  
3 standing emergency department (in  
4 this subsection referred to as a ‘par-  
5 ticipating emergency facility’)” after  
6 “participating provider”; and

7 (III) in subparagraph (C)—

8 (aa) in the matter preceding  
9 clause (i), by inserting “by a  
10 nonparticipating provider or a  
11 nonparticipating facility that is  
12 an emergency department of a  
13 hospital or an independent free-  
14 standing emergency department”  
15 after “enrollee”;

16 (bb) by striking clause (i);

17 (cc) by striking “(ii)(I) such  
18 services” and inserting “(i) such  
19 services”;

20 (dd) by striking “where the  
21 provider of services does not have  
22 a contractual relationship with  
23 the plan for the providing of  
24 services”;

1 (ee) by striking “emergency  
2 department services received  
3 from providers who do have such  
4 a contractual relationship with  
5 the plan; and” and inserting  
6 “emergency services received  
7 from participating providers and  
8 participating emergency facilities  
9 with respect to such plan;”;

10 (ff) by striking “(II) if such  
11 services” and all that follows  
12 through “were provided in-net-  
13 work” and inserting the fol-  
14 lowing:

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

22 (gg) by adding at the end  
23 the following new clauses:

24 “(iii) such cost-sharing requirement is  
25 calculated as if the contracted rate for

1 such services if furnished by a partici-  
2 pating provider or a participating emer-  
3 gency facility were equal to the recognized  
4 amount for such services;

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

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

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

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

21 “(A) AUDIT PROCESS.—

22 “(i) IN GENERAL.—Not later than  
23 July 1, 2021, the Secretary, in coordina-  
24 tion with the Secretary of the Treasury  
25 and the Secretary of Labor and in con-

1 sultation with the National Association of  
2 Insurance Commissioners, shall establish  
3 through rulemaking a process, in accord-  
4 ance with clause (ii), under which health  
5 plans are audited by the Secretary to en-  
6 sure that—

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

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

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

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

21 “(II) may audit any health plan  
22 if the Secretary has received any com-  
23 plaint about such plan that involves  
24 the compliance of the plan with the  
25 requirement described in such clause.

1           “(B) RULEMAKING.—Not later than July  
2           1, 2021, the Secretary, in coordination with the  
3           Secretary of Labor and the Secretary of the  
4           Treasury, shall establish through rulemaking—

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

13                   “(ii) the information such sponsor or  
14                   issuer shall share with the nonparticipating  
15                   provider involved when making such a de-  
16                   termination.”; and

17                  (B) by adding at the end the following new  
18                  subsection:

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

20                   “(1) CONTRACTED RATE.—The term ‘con-  
21                   tracted rate’ means, with respect to a health plan  
22                   and a health care provider or health care facility fur-  
23                   nishing an item or service to a beneficiary, partici-  
24                   pant, or enrollee of such plan, the agreed upon total



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

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

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

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

1 (iii) of section 1867(e)(1)(A) of the Social Security  
2 Act.

3 “(5) EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8                   “(B) provides emergency services.

9           “(8) MEDIAN CONTRACTED RATE.—

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

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

1           dated, as appropriate) by the Secretary, in  
2           consultation with the National Association  
3           of Insurance Commissioners) in which the  
4           item or service is furnished, consistent with  
5           the methodology established by the Sec-  
6           retary under subsection (b)(2)(B), in-  
7           creased by the percentage increase in the  
8           consumer price index for all urban con-  
9           sumers (United States city average) over  
10          2019, 2020, and 2021;

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

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



1 (C)) as the plan involved) as the total max-  
2 imum payment under such plans in such  
3 year for the same or a similar item or serv-  
4 ice that is provided by a provider or facility  
5 in the same or similar specialty and pro-  
6 vided in the geographic region (as estab-  
7 lished pursuant to clause (i)) in which the  
8 item or service is furnished, consistent with  
9 the methodology established by the Sec-  
10 retary under subsection (b)(2)(B); and

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

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

21 “(i) IN GENERAL.—In the case the  
22 sponsor or issuer of a health plan has in-  
23 sufficient information (as specified by the  
24 Secretary) to calculate the median of the  
25 contracted rates in accordance with sub-

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

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

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

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

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

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

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

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

10 “(i) The individual market.

11 “(ii) The small group market.

12 “(iii) The large group market.

13 “(iv) In the case of a self-insured  
14 group health plan, other self-insured group  
15 health plans.

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

19 “(9) NONPARTICIPATING FACILITY; PARTICI-  
20 PATING FACILITY.—

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

1           tionship with the plan for furnishing such item  
2           or service.

3           “(B) PARTICIPATING FACILITY.—

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

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

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

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

20               “(III) An ambulatory surgical  
21               center (as defined in section  
22               1833(i)(1)(A) of such Act).

23               “(IV) A laboratory.

24               “(V) A radiology facility or imag-  
25               ing center.

1                   “(VI) An independent free-  
2                   standing emergency department.

3                   “(VII) Any other facility speci-  
4                   fied by the Secretary.

5                   “(10) NONPARTICIPATING PROVIDERS; PARTICI-  
6                   PATING PROVIDERS.—

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

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

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

1           “(A) subject to subparagraphs (C) and  
2           (D), in the case such State has in effect a State  
3           law that provides for a method for determining  
4           the amount payable (by the plan and the partic-  
5           ipant, beneficiary, or enrollee) under such  
6           health plan regulated by such State with re-  
7           spect to such item or service furnished by such  
8           provider or facility, such amount (including  
9           cost-sharing) determined in accordance with  
10          such law;

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

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

22                 “(ii) if such provider or facility (as  
23                 applicable) and such plan enter the medi-  
24                 ated dispute process under subsection (j)  
25                 and do not so agree before the date on

1           which a selected independent entity (as de-  
2           fined in paragraph (3) of such subsection)  
3           makes a determination with respect to  
4           such item or service under such subsection,  
5           the amount of such determination;

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

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

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



1 service furnished in a State during a year to a par-  
2 ticipant, beneficiary, or enrollee of a health plan by  
3 a nonparticipating provider or nonparticipating facil-  
4 ity—

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

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

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

22 “(D) in the case such health plan is a self-  
23 insured group health plan and in the case of a  
24 State with an agreement with such plan in ef-  
25 fect as of the date of the enactment of the Con-

1           sumer Protections Against Surprise Medical  
2           Bills Act of 2020, that provides for a method  
3           for determining the amount payable (by the  
4           plan and the participant, beneficiary, or en-  
5           rollee) under such health plan with respect to  
6           such item or service furnished by such provider  
7           or facility, such amount determined in accord-  
8           ance with such method.

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

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

16          (b) IRC AMENDMENTS.—

17          (1) IN GENERAL.—Subchapter B of chapter  
18          100 of the Internal Revenue Code of 1986 is amend-  
19          ed by adding at the end the following new section:

20          **“SEC. 9816. PATIENT PROTECTIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

13                  “(D) without regard to any other term or  
14                  condition of such coverage (other than exclusion  
15                  or coordination of benefits, or an affiliation or  
16                  waiting period, permitted under section 2704 of  
17                  the Public Health Service Act, including as in-  
18                  corporated pursuant to section 715 of the Em-  
19                  ployee Retirement Income Security Act of 1974  
20                  and section 9815, and other than applicable  
21                  cost-sharing).

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

24                  “(A) AUDIT PROCESS.—

1                   “(i) IN GENERAL.—Not later than  
2                   July 1, 2021, the Secretary, in coordina-  
3                   tion with the Secretary of Health and  
4                   Human Services and the Secretary of  
5                   Labor and in consultation with the Na-  
6                   tional Association of Insurance Commis-  
7                   sioners, shall establish through rulemaking  
8                   a process, in accordance with clause (ii),  
9                   under which health plans are audited by  
10                  the Secretary to ensure that—

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

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

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

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

1                   “(II) may audit any health plan  
2                   if the Secretary has received any com-  
3                   plaint about such plan that involves  
4                   the compliance of the plan with the  
5                   requirement described in such clause.

6                   “(B) RULEMAKING.—Not later than July  
7                   1, 2021, the Secretary, in coordination with the  
8                   Secretary of Labor and the Secretary of Health  
9                   and Human Services, shall establish through  
10                  rulemaking—

11                  “(i) the methodology the sponsor of a  
12                  health plan shall use to determine the me-  
13                  dian contracted rate, which shall account  
14                  for relevant payment adjustments that  
15                  take into account facility type that are oth-  
16                  erwise taken into account for purposes of  
17                  determining payment amounts with respect  
18                  to participating facilities; and

19                  “(ii) the information such sponsor  
20                  shall share with the nonparticipating pro-  
21                  vider involved when making such a deter-  
22                  mination.

23                  “(c) ACCESS TO PEDIATRIC CARE.—

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

1 under a health plan, if the plan requires or provides  
2 for the designation of a participating primary care  
3 provider for the child, the plan shall permit such  
4 person to designate a physician (allopathic or osteo-  
5 pathic) who specializes in pediatrics as the child's  
6 primary care provider if such provider participates  
7 in the network of the plan.

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

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

14 “(1) GENERAL RIGHTS.—

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



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

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

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

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

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

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

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

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

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

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

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

1 provider furnishing such items or services is at the  
2 facility.

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

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

17 “(5) EMERGENCY SERVICES.—

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

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

1 department) that is within the capability of  
2 the emergency department of a hospital or  
3 of an independent freestanding emergency  
4 department, as applicable, including ancil-  
5 lary services routinely available to the  
6 emergency department to evaluate such  
7 emergency medical condition; and

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

21 “(B) INCLUSION OF ADDITIONAL RELATED  
22 SERVICES.—In the case of an individual en-  
23 rolled in a health plan who is furnished services  
24 described in subparagraph (A) by a provider or  
25 hospital or independent freestanding emergency

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

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

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

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

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

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

1 department is a nonparticipating facil-  
2 ity (or, in the case the hospital or  
3 independent freestanding emergency  
4 department is a participating facility,  
5 that potentially a provider that may  
6 furnish such an item or service during  
7 such visit, may be a nonparticipating  
8 provider with respect to such health  
9 plan).

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

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

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

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

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

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

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

22           “(B) provides emergency services.

23           “(8) MEDIAN CONTRACTED RATE.—



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

4           “(i) for an item or service furnished  
5 during 2022, the median of the contracted  
6 rates recognized by the sponsor of such  
7 plan (determined with respect to all such  
8 plans of such sponsor that are within the  
9 same line of business (as specified in sub-  
10 paragraph (C)) as the plan involved) as the  
11 total maximum payment under such plans  
12 in 2019 for the same or a similar item or  
13 service that is provided by a provider or fa-  
14 cility in the same or similar specialty and  
15 provided in the geographic region (estab-  
16 lished (and updated, as appropriate) by the  
17 Secretary, in consultation with the Na-  
18 tional Association of Insurance Commis-  
19 sioners) in which the item or service is fur-  
20 nished, consistent with the methodology es-  
21 tablished by the Secretary under sub-  
22 section (b)(2)(B), increased by the percent-  
23 age increase in the consumer price index  
24 for all urban consumers (United States  
25 city average) over 2019, 2020, and 2021;

1           “(ii) for an item or service furnished  
2           during 2023 or a subsequent year through  
3           2026, the median contracted rate for the  
4           previous year, increased by the percentage  
5           increase in the consumer price index for all  
6           urban consumers (United States city aver-  
7           age) over such previous year;

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

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

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

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

1           such year under such subparagraph (A) for  
2           such plan.

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

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

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

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

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

25                         “(i) The small group market.

1 “(ii) The large group market.

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

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

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

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

17 “(B) PARTICIPATING FACILITY.—

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

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

4                   “(I) A hospital (as defined in  
5                   1861(e) of the Social Security Act),  
6                   including an emergency department of  
7                   a hospital.

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

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

14                  “(IV) A laboratory.

15                  “(V) A radiology facility or imag-  
16                  ing center.

17                  “(VI) An independent free-  
18                  standing emergency department.

19                  “(VII) Any other facility speci-  
20                  fied by the Secretary.

21                  “(10) NONPARTICIPATING PROVIDERS; PARTICI-  
22                  PATING PROVIDERS.—

23                  “(A) NONPARTICIPATING PROVIDER.—The  
24                  term ‘nonparticipating provider’ means, with re-  
25                  spect to an item or service and a health plan,

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

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

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

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



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

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

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

21          “(C) subject to subparagraph (D), in the  
22          case such State has an All-Payer Model Agree-  
23          ment under section 1115A of the Social Secu-  
24          rity Act, the amount (including cost-sharing)

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

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

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

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

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

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

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

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

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

3 (2) CONFORMING AMENDMENTS.—

4 (A) APPLICATION PROVISIONS.—Section  
5 9815(a) of the Internal Revenue Code of 1986  
6 is amended—

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

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

18 (B) APPLICATION TO RETIREE-ONLY  
19 PLANS.—Section 9831(a) of the Internal Rev-  
20 enue Code of 1986 is amended by inserting  
21 “(other than, with respect to a group health  
22 plan described in paragraph (2), the require-  
23 ments of section 9816)” before “shall not  
24 apply”.

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

“Sec. 9815. Additional market reforms.

“Sec. 9816. Patient protections.”.

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

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

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

14        **“SEC. 716. PATIENT PROTECTIONS.**

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

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

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

1 emergency department of a hospital or, for plan year  
2 2022 or a subsequent plan year, with respect to  
3 emergency services in an independent freestanding  
4 emergency department, the plan shall cover emer-  
5 gency services—

6 “(A) without the need for any prior au-  
7 thorization determination;

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

15 “(C) in a manner so that, if such services  
16 are provided to a participant or beneficiary by  
17 a nonparticipating provider or a nonpartici-  
18 pating facility that is an emergency department  
19 of a hospital or an independent freestanding  
20 emergency department—

21 “(i) such services will be provided  
22 without imposing any requirement under  
23 the plan for prior authorization of services  
24 or any limitation on coverage that is more  
25 restrictive than the requirements or limita-

1 tions that apply to emergency services re-  
2 ceived from participating providers and  
3 participating emergency facilities with re-  
4 spect to such plan;

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

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

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

24 “(v) any deductible or out-of-pocket  
25 maximum that would apply if such services

1           were furnished by a participating provider  
2           or a participating emergency facility shall  
3           be the deductible or out-of-pocket max-  
4           imum that applies; and

5           “(D) without regard to any other term or  
6           condition of such coverage (other than exclusion  
7           or coordination of benefits, or an affiliation or  
8           waiting period, permitted under section 2704 of  
9           the Public Health Service Act, including as in-  
10          corporated pursuant to section 715 and section  
11          9815 of the Internal Revenue Code of 1986,  
12          and other than applicable cost-sharing).

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

15                 “(A) AUDIT PROCESS.—

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



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

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

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

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

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

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

1           “(i) the methodology the sponsor or  
2           issuer of a health plan shall use to deter-  
3           mine the median contracted rate, which  
4           shall account for relevant payment adjust-  
5           ments that take into account facility type  
6           that are otherwise taken into account for  
7           purposes of determining payment amounts  
8           with respect to participating facilities; and

9           “(ii) the information such sponsor or  
10          issuer shall share with the nonparticipating  
11          provider involved when making such a de-  
12          termination.

13          “(c) ACCESS TO PEDIATRIC CARE.—

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

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

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

3 “(d) PATIENT ACCESS TO OBSTETRICAL AND GYNE-  
4 COLOGICAL CARE.—

5 “(1) GENERAL RIGHTS.—

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

21 “(B) OBSTETRICAL AND GYNECOLOGICAL  
22 CARE.—A health plan described in paragraph  
23 (2) shall treat the provision of obstetrical and  
24 gynecological care, and the ordering of related  
25 obstetrical and gynecological items and services,

1           pursuant to the direct access described under  
2           subparagraph (A), by a participating health  
3           care professional who specializes in obstetrics or  
4           gynecology as the authorization of the primary  
5           care provider.

6           “(2) APPLICATION OF PARAGRAPH.—A health  
7           plan described in this paragraph is a health plan  
8           that—

9                   “(A) provides coverage for obstetric or  
10                   gynecologic care; and

11                   “(B) requires the designation by a partici-  
12                   pant or beneficiary of a participating primary  
13                   care provider.

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

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

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

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

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

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

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

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

1 a prudent layperson, who possesses an average  
2 knowledge of health and medicine, could reasonably  
3 expect the absence of immediate medical attention to  
4 result in a condition described in clause (i), (ii), or  
5 (iii) of section 1867(e)(1)(A) of the Social Security  
6 Act.

7 “(5) EMERGENCY SERVICES.—

8 “(A) IN GENERAL.—The term ‘emergency  
9 services’, with respect to an emergency medical  
10 condition, means—

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

23 “(ii) within the capabilities of the  
24 staff and facilities available at the hospital  
25 or the independent freestanding emergency

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

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

1           pating facility that is an emergency department  
2           of a hospital or an independent freestanding  
3           emergency department, unless each of the fol-  
4           lowing conditions are met:

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

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

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



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

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

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

1                   “(II) To the extent practicable,  
2                   the estimated amount that such non-  
3                   participating facility or such a non-  
4                   participating provider may charge the  
5                   individual for such an item or service.

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

13                  “(ii) Before the end of such 24 hours,  
14                  the individual signs and dates such notice  
15                  confirming receipt of the notice.

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

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

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

12                   “(A) is geographically separate and dis-  
13 tinct and licensed separately from a hospital  
14 under applicable State law; and

15                   “(B) provides emergency services.

16           “(8) MEDIAN CONTRACTED RATE.—

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

20                           “(i) for an item or service furnished  
21 during 2022, the median of the contracted  
22 rates recognized by the sponsor or issuer  
23 of such plan (determined with respect to  
24 all such plans of such sponsor or such  
25 issuer that are within the same line of

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

18 “(ii) for an item or service furnished  
19 during 2023 or a subsequent year through  
20 2026, the median contracted rate for the  
21 previous year, increased by the percentage  
22 increase in the consumer price index for all  
23 urban consumers (United States city aver-  
24 age) over such previous year;

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

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

1 States city average) over such previous  
2 year.

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

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

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

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

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

18 “(II) if such sufficient informa-  
19 tion does not exist, the median of the  
20 contracted rates recognized by all  
21 health plans offered in the same line  
22 of business (as specified in subpara-  
23 graph (C)) by any group health plan  
24 for such an item or service furnished  
25 in a similarly situated geographic re-

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

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

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

17                         “(i) The small group market.

18                         “(ii) The large group market.

19                         “(iii) In the case of a self-insured  
20                         group health plan, other self-insured group  
21                         health plans.

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



1           “(9) NONPARTICIPATING FACILITY; PARTICI-  
2           PATING FACILITY.—

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

10          “(B) PARTICIPATING FACILITY.—

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

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

20                 “(I) A hospital (as defined in  
21                 1861(e) of the Social Security Act),  
22                 including an emergency department of  
23                 a hospital.

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

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

7                   “(IV) A laboratory.

8                   “(V) A radiology facility or imag-  
9                   ing center.

10                  “(VI) An independent free-  
11                  standing emergency department.

12                  “(VII) Any other facility speci-  
13                  fied by the Secretary.

14                  “(10) NONPARTICIPATING PROVIDERS; PARTICI-  
15                  PATING PROVIDERS.—

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

23                         “(B) PARTICIPATING PROVIDER.—The  
24                         term ‘participating provider’ means, with re-  
25                         spect to an item or service and a health plan,

1           a physician or other health care provider who  
2           has a contractual relationship with the plan for  
3           furnishing such item or service under the plan.

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

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

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

23                   “(i) subject to clause (ii), if the pro-  
24                   vider or facility (as applicable) and such  
25                   plan agree on an amount of payment (in-

1 including if agreed on through open negotia-  
2 tions under subsection (j)(1)) with respect  
3 to such item or service, such agreed on  
4 amount; or

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

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

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

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

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

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

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

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

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

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

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

20 (2) CONFORMING AMENDMENT.—

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

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

7 (ii) in paragraph (2), by inserting  
8 “(other than, with respect to a plan year  
9 beginning on or after January 1, 2022, the  
10 provisions of section 2719A of such Act)”  
11 after “such part A”.

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

18 (3) CLERICAL AMENDMENT.—The table of con-  
19 tents in section 1 of the Employee Retirement In-  
20 come Security Act of 1974 is amended by inserting  
21 after the item relating to section 714 the following  
22 new items:

“Sec. 715. Additional market reforms.

“Sec. 716. Patient protections.”

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

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

10       (a) PHSA AMENDMENTS.—

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

16       “(e) COST-SHARING AND PAYMENT OF NON-EMER-  
17       GENY SERVICES PERFORMED BY NONPARTICIPATING  
18       PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

19           “(1) IN GENERAL.—Subject to paragraph (2),  
20       in the case of items or services (other than emer-  
21       gency services to which subsection (b) applies or  
22       items and services to which subsection (i) applies)  
23       furnished to a participant, beneficiary, or enrollee of  
24       a health plan by a nonparticipating provider during  
25       a visit (as defined by the Secretary in accordance



1 with subsection (k)(2)) at a participating facility, if  
2 such items and services would otherwise be covered  
3 under such plan if furnished by a participating pro-  
4 vider, the plan—

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

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

18 “(C) shall pay to such provider furnishing  
19 such items and services to such participant,  
20 beneficiary, or enrollee the amount by which the  
21 out-of-network rate for such items and services  
22 exceeds the cost-sharing amount imposed under  
23 the plan for such items and services (as deter-  
24 mined in accordance with subparagraphs (A)  
25 and (B)); and

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

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

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

19          (b) IRC AMENDMENTS.—

20                 (1) IN GENERAL.—Section 9816 of the Internal  
21                 Revenue Code of 1986, as added by section 2(b), is  
22                 amended by inserting before subsection (k) the fol-  
23                 lowing new subsection:

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

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

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

23           “(B) shall calculate such cost-sharing  
24 amount as if the contracted rate for such serv-  
25 ices if furnished by a participating provider

1           were equal to the recognized amount for such  
2           items and services;

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

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

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

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

4           (c) ERISA AMENDMENTS.—

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

9           “(e) COST-SHARING AND PAYMENT OF NON-EMER-  
10          GENY SERVICES PERFORMED BY NONPARTICIPATING  
11          PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

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

23           “(A) shall not impose on such participant  
24          or beneficiary a cost-sharing amount (expressed  
25          as a copayment amount or coinsurance rate) for

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

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

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

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

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

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

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

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

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

18 (1) by striking “at a minimum, includes” and  
19 inserting “at a minimum—  
20 “(A) includes”;

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

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

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

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

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

18          “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

21                         “(A) establish the verification process de-  
22                         scribed in paragraph (2);

23                         “(B) establish the response protocol de-  
24                         scribed in paragraph (3);



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

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

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

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

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

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

24           “(B) that establishes a procedure for the  
25 removal from such database of such a provider

1 or facility with respect to which such plan has  
2 been unable to verify such information during a  
3 period specified by the plan; and

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

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

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

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

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

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

9           “(B) provider directory information with  
10 respect to each such provider and facility.

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

22           “(6) DEFINITION.—For purposes of this sec-  
23 tion, the term ‘provider directory information’ in-  
24 cludes, with respect to a health plan, the name, ad-  
25 dress, specialty, and telephone number of each

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

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

12 “(1) information in plain language on—

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

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

1 after receiving payment from the plan for such  
2 item or service and any applicable cost-sharing  
3 payment from such participant, beneficiary, or  
4 enrollee; and

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

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

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

17 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

20 “(A) establish the verification process de-  
21 scribed in paragraph (2);

22 “(B) establish the response protocol de-  
23 scribed in paragraph (3);

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

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

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

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

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

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

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

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

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

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

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

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

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

1 database on the public website of such plan or issuer  
2 that contains—

3 “(A) a list of each health care provider and  
4 health care facility with which such plan has a  
5 contractual relationship for furnishing items  
6 and services under such plan; and

7 “(B) provider directory information with  
8 respect to each such provider and facility.

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

20 “(6) DEFINITION.—For purposes of this sec-  
21 tion, the term ‘provider directory information’ in-  
22 cludes, with respect to a health plan, the name, ad-  
23 dress, specialty, and telephone number of each  
24 health care provider or health care facility with



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

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

11           “(1) information in plain language on—

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

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

1 or service and any applicable cost-sharing pay-  
2 ment from such participant or beneficiary; and

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

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

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

16 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

19 “(A) establish the verification process de-  
20 scribed in paragraph (2);

21 “(B) establish the response protocol de-  
22 scribed in paragraph (3);

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

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

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

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

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

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

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

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

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

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

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

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

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

1 database on the public website of such plan or issuer  
2 that contains—

3 “(A) a list of each health care provider and  
4 health care facility with which such plan has a  
5 contractual relationship for furnishing items  
6 and services under such plan; and

7 “(B) provider directory information with  
8 respect to each such provider and facility.

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

20 “(6) DEFINITION.—For purposes of this sec-  
21 tion, the term ‘provider directory information’ in-  
22 cludes, with respect to a health plan, the name, ad-  
23 dress, specialty, and telephone number of each  
24 health care provider or health care facility with

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

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

11               “(1) information in plain language on—

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

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

1 or service and any applicable cost-sharing pay-  
2 ment from such participant or beneficiary; and

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

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

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

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

19 “(h) **ADVANCED EXPLANATION OF BENEFITS.**—Be-  
20 ginning on January 1, 2022, each health plan shall, with  
21 respect to a notification submitted under section  
22 1150D(b)(2)(A) of the Social Security Act by a health  
23 care provider or health care facility, respectively, to the  
24 health plan for a participant, beneficiary, or enrollee under  
25 such health plan scheduled to receive an item or service

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

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

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

20                   “(B) in the case the provider or facility is  
21                   a nonparticipating provider or facility with re-  
22                   spect to such plan, a description of how such  
23                   individual may obtain information on providers  
24                   and facilities that, with respect to such health  
25                   plan, are participating providers and facilities.



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

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

7           “(4) A good faith estimate of the amount of  
8 any cost-sharing (including with respect to the de-  
9 ductible and any copayment or coinsurance obliga-  
10 tion) for which the participant, beneficiary, or en-  
11 rollee would be responsible for such item or service  
12 (as of the date of such notification).

13           “(5) A good faith estimate of the amount that  
14 the participant, beneficiary, or enrollee has incurred  
15 toward meeting the limit of the financial responsi-  
16 bility (including with respect to deductibles and out-  
17 of-pocket maximums) under the health plan (as of  
18 the date of such notification).

19           “(6) In the case such item or service is subject  
20 to a medical management technique (including con-  
21 current review, prior authorization, and step-therapy  
22 or fail-first protocols) for coverage under the health  
23 plan, a disclaimer that coverage for such item or  
24 service is subject to such medical management tech-  
25 nique.

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

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

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

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

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

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

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

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

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

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

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

1 cent (as of the date such item or services  
2 was furnished) such rate; or

3 “(ii) if no contracted rate described in  
4 such subparagraph exists, the out-of-net-  
5 work rate;

6 for such items and services exceeds the cost-  
7 sharing amount imposed under the plan for  
8 such items and services (as determined in ac-  
9 cordance with subparagraphs (A) and (B)); and

10 “(D) shall apply the deductible or out-of-  
11 pocket maximum, if any, that would apply if  
12 such services were furnished by a participating  
13 provider or a participating facility.

14 “(2) CRITERIA DESCRIBED.—For purposes of  
15 paragraph (1), the criteria described in this para-  
16 graph, with respect to an item or service furnished  
17 to a participant, beneficiary, or enrollee of a health  
18 plan by a nonparticipating provider or a nonpartici-  
19 pating facility, are the following:

20 “(A) The participant, beneficiary, or en-  
21 rollee received a notification under subsection  
22 (h) with respect to such item and service to be  
23 furnished and such notification provided infor-  
24 mation that the provider was a participating  
25 provider or facility was a participating facility,

1 with respect to the plan for furnishing such  
2 item or service.

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

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

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

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

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

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

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

1           and facilities that, with respect to such health  
2           plan, are participating providers and facilities.

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

5           “(3) A good faith estimate of the amount the  
6           health plan is responsible for paying for items and  
7           services included in the estimate described in para-  
8           graph (2).

9           “(4) A good faith estimate of the amount of  
10          any cost-sharing (including with respect to the de-  
11          ductible and any copayment or coinsurance obliga-  
12          tion) for which the participant or beneficiary would  
13          be responsible for such item or service (as of the  
14          date of such notification).

15          “(5) A good faith estimate of the amount that  
16          the participant or beneficiary has incurred toward  
17          meeting the limit of the financial responsibility (in-  
18          cluding with respect to deductibles and out-of-pocket  
19          maximums) under the health plan (as of the date of  
20          such notification).

21          “(6) In the case such item or service is subject  
22          to a medical management technique (including con-  
23          current review, prior authorization, and step-therapy  
24          or fail-first protocols) for coverage under the health  
25          plan, a disclaimer that coverage for such item or

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

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

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

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

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



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

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

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

18           “(ii) if no contracted rate described in  
19 clause (i) exists, the recognized amount for  
20 such item or service;

21           “(C) shall pay to such nonparticipating  
22 provider or facility furnishing such item or serv-  
23 ice to such participant or beneficiary the  
24 amount by which—

1                   “(i) if a contracted rate described in  
2                   subparagraph (B)(i) exists, the most re-  
3                   cent (as of the date such item or services  
4                   was furnished) such rate; or

5                   “(ii) if no contracted rate described in  
6                   such subparagraph exists, the out-of-net-  
7                   work rate;

8                   for such items and services exceeds the cost-  
9                   sharing amount imposed under the plan for  
10                  such items and services (as determined in ac-  
11                  cordance with subparagraphs (A) and (B)); and

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

16                  “(2) CRITERIA DESCRIBED.—For purposes of  
17                  paragraph (1), the criteria described in this para-  
18                  graph, with respect to an item or service furnished  
19                  to a participant or beneficiary of a health plan by  
20                  a nonparticipating provider or a nonparticipating fa-  
21                  cility, are the following:

22                  “(A) The participant or beneficiary re-  
23                  ceived a notification under subsection (h) with  
24                  respect to such item and service to be furnished  
25                  and such notification provided information that

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

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

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

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

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

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

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

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

1           and facilities that, with respect to such health  
2           plan, are participating providers and facilities.

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

5           “(3) A good faith estimate of the amount the  
6           health plan is responsible for paying for items and  
7           services included in the estimate described in para-  
8           graph (2).

9           “(4) A good faith estimate of the amount of  
10          any cost-sharing (including with respect to the de-  
11          ductible and any copayment or coinsurance obliga-  
12          tion) for which the participant or beneficiary would  
13          be responsible for such item or service (as of the  
14          date of such notification).

15          “(5) A good faith estimate of the amount that  
16          the participant or beneficiary has incurred toward  
17          meeting the limit of the financial responsibility (in-  
18          cluding with respect to deductibles and out-of-pocket  
19          maximums) under the health plan (as of the date of  
20          such notification).

21          “(6) In the case such item or service is subject  
22          to a medical management technique (including con-  
23          current review, prior authorization, and step-therapy  
24          or fail-first protocols) for coverage under the health  
25          plan, a disclaimer that coverage for such item or

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

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

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

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

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

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

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

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

18           “(ii) if no contracted rate described in  
19 clause (i) exists, the recognized amount for  
20 such item or service;

21           “(C) shall pay to such nonparticipating  
22 provider or facility furnishing such item or serv-  
23 ice to such participant or beneficiary the  
24 amount by which—

1                   “(i) if a contracted rate described in  
2                   subparagraph (B)(i) exists, the most re-  
3                   cent (as of the date such item or services  
4                   was furnished) such rate; or

5                   “(ii) if no contracted rate described in  
6                   such subparagraph exists, the out-of-net-  
7                   work rate;

8                   for such items and services exceeds the cost-  
9                   sharing amount imposed under the plan for  
10                  such items and services (as determined in ac-  
11                  cordance with subparagraphs (A) and (B)); and

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

16                  “(2) CRITERIA DESCRIBED.—For purposes of  
17                  paragraph (1), the criteria described in this para-  
18                  graph, with respect to an item or service furnished  
19                  to a participant or beneficiary of a health plan by  
20                  a nonparticipating provider or a nonparticipating fa-  
21                  cility, are the following:

22                  “(A) The participant or beneficiary re-  
23                  ceived a notification under subsection (h) with  
24                  respect to such item and service to be furnished  
25                  and such notification provided information that



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

25          “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

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

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

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

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

10 “(C) CONSIDERATIONS.—

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

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

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

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

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

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

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

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

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

6 “(7) CERTIFICATION OF ENTITIES.—

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

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

17 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

21          “(F) PROVISION OF INFORMATION.—

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

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

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

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

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



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

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

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

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

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

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

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

19                  “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

7           (b) IRC AMENDMENTS.—Section 9816 of the Inter-  
8           nal Revenue Code of 1986, as added by section 2(b) and  
9           amended by sections 3(b), 5(b), and 6(b), is further  
10          amended by inserting before subsection (k) the following  
11          new subsection:

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

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

16                         “(A) IN GENERAL.—With respect to an  
17                         item or service furnished in a year by a non-  
18                         participating provider or a nonparticipating fa-  
19                         cility, with respect to a health plan, in a State  
20                         described in subparagraph (B) of subsection  
21                         (k)(11) with respect to such plan and provider  
22                         or facility, and for which a payment is required  
23                         to be made by the health plan pursuant to sub-  
24                         section (b)(1), (e)(1), or (i)(1), the provider or  
25                         facility (as applicable) or plan may, during the

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

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

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

1 or facility that is party to such negotia-  
2 tions of the median contracted rate for  
3 such item or service and year; and

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

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

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

22 “(III) any additional information  
23 specified by the Secretary.

24 “(C) ACCESSING MEDIATED DISPUTE  
25 PROCESS IN CASE OF FAILED NEGOTIATIONS.—

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

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

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

20          “(B) AUTHORITY TO CONTINUE NEGOTIA-  
21          TIONS.—Under the mediated dispute process, in  
22          the case that the parties to a determination for  
23          a qualified mediated dispute item or service  
24          agree on a payment amount for such item or  
25          service during such process but before the date



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

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

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

1           “(i) is not a party to such determina-  
2           tion or an employee or agent of such a  
3           party;

4           “(ii) does not have a material familial,  
5           financial, or professional relationship with  
6           such a party; and

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

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

14                 “(i) select such an entity that satisfies  
15                 clauses (i) through (iii) of subparagraph  
16                 (A); and

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

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

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

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

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

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

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

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

1 such items and services included in such bun-  
2 dled payment may be part of a single deter-  
3 mination under this subsection.

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

11 “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

1 of subsection (b)(1), (e)(1), or (i)(1), as  
2 applicable; and

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

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

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

17 “(ii) information relating to such  
18 offer; and

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

21 “(C) CONSIDERATIONS.—

22 “(i) IN GENERAL.—For purposes of  
23 subparagraph (A), the considerations spec-  
24 ified in this subparagraph, with respect to

1 a determination for a qualified mediated  
2 dispute item or service, are the following:

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

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

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

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

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

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

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

18 “(7) CERTIFICATION OF ENTITIES.—

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

24 “(i) has (directly or through contracts  
25 or other arrangements) sufficient medical,

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

4 “(ii) is not—

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

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

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

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

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

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

24 “(vi) does not under the mediated dis-  
25 pute process carry out any determination



1 with respect to which the entity would not  
2 pursuant to clause (i), (ii), or (iii) of para-  
3 graph (3)(A) be eligible for selection; and

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

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

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

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

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

7           “(F) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

6                   “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

24           “(B) PUBLICATION OF INFORMATION.—  
25 Beginning with July 1, 2023, and for each cal-

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

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

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

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

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

20           (c) ERISA AMENDMENTS.—Section 716 of the Em-  
21           ployee Retirement Income Security Act of 1974, as added  
22           by section 2(c) and amended by sections 3(c), 5(c), and  
23           6(c), is further amended by inserting before subsection (k)  
24           the following new subsection:

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

3                   “(1) DETERMINATION THROUGH OPEN NEGO-  
4 TIATION.—

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

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

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

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

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

20 “(I) the median of the total  
21 amount of reimbursement (including  
22 any cost-sharing) paid, for the most  
23 recent year for which information is  
24 available, to such provider or facility  
25 for furnishing such item or service to



1 a participant or beneficiary of a  
2 health plan that, at the time such  
3 item or service was furnished, had a  
4 contract in effect with such provider  
5 or facility with respect to the fur-  
6 nishing of such item or service;

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

11 “(III) any additional information  
12 specified by the Secretary.

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

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

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

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

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

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

1           “(3) SELECTION UNDER MEDIATED DISPUTE  
2           PROCESS.—Under the mediated dispute process, the  
3           Secretary shall, with respect to the determination of  
4           the amount of payment under this subsection of a  
5           qualified mediated dispute item or service, provide  
6           for a method—

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

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

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

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

23                   “(B) that requires, in the case such parties  
24                   do not make such selection by such last day,

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

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

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

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

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

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

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

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

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

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

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

25          “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

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

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

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

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

10 “(C) CONSIDERATIONS.—

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

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

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

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



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

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

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

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

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

6 “(7) CERTIFICATION OF ENTITIES.—

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

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

17 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

21          “(F) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

19                  “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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



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

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

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

10           (d) **RULE OF CONSTRUCTION.**—Nothing in this Act,  
11 or the amendment made by this Act, shall be construed  
12 as removing any obligation of a health plan (as defined  
13 in section 2719A of the Public Health Service Act (42  
14 U.S.C. 300gg-19A), as amended by this Act) to provide  
15 payment to a health care provider or health care facility  
16 for items and services furnished by such provider or facil-  
17 ity to an individual enrolled in such plan.

1 **SEC. 8. PROHIBITING BALANCE BILLING PRACTICES BY**  
2 **PROVIDERS FOR EMERGENCY SERVICES, FOR**  
3 **SERVICES FURNISHED BY NONPARTICI-**  
4 **PATING PROVIDER AT PARTICIPATING FACIL-**  
5 **ITY, AND IN CERTAIN CASES OF MISINFORMA-**  
6 **TION.**

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

10 **“SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING**  
11 **PRACTICES.**

12 “(a) EMERGENCY SERVICES.—In the case of an indi-  
13 vidual with benefits under a group health plan or health  
14 insurance coverage offered in the group or individual mar-  
15 ket who is furnished in a plan year that begins on or after  
16 January 1, 2022, emergency services with respect to an  
17 emergency medical condition during a visit at an emer-  
18 gency department of a hospital or an independent free-  
19 standing emergency department—

20 “(1) if the hospital or independent freestanding  
21 emergency department does not have a contractual  
22 relationship with such plan or coverage for fur-  
23 nishing such services, the hospital or independent  
24 freestanding emergency department shall not bill,  
25 and shall not hold liable, the individual for a pay-  
26 ment amount for such emergency services so fur-

1 nished that is more than the cost-sharing amount  
2 for such services (as determined in accordance with  
3 section 2719A(b) of the Public Health Service Act,  
4 section 716(b) of the Employee Retirement Income  
5 Security Act of 1974, or section 9816(b) of the In-  
6 ternal Revenue Code of 1986, as applicable); and

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

23 “(b) SERVICES FURNISHED BY NONPARTICIPATING  
24 PROVIDER AT PARTICIPATING FACILITY.—

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

19           “(2) EXCEPTION IN CASE NOTICE PROVIDED.—  
20          Paragraph (1) shall not apply with respect to items  
21          and services (other than items and services described  
22          in paragraph (3)) furnished to an individual enrolled  
23          in a group health plan or in health insurance cov-  
24          erage offered in the group or individual market by  
25          a health care provider that does not have a contrac-

1 tual relationship with such plan or coverage for fur-  
2 nishing such items and services if the following cri-  
3 teria are met:

4 “(A) A written notice (as specified by the  
5 Secretary) is provided by the provider to such  
6 individual, not later than 48 hours before such  
7 items and services are to be so furnished, that  
8 includes the following information:

9 “(i) That the provider does not have  
10 such a relationship with such plan or cov-  
11 erage.

12 “(ii) The estimated amount that such  
13 provider may charge the individual for  
14 such items and services.

15 “(iii) A statement that the individual  
16 may seek such items or services from a  
17 health care provider that does have such a  
18 contractual relationship.

19 “(B) On the date such item or service is  
20 to be furnished, before such item or service is  
21 so furnished, the individual signs and dates  
22 such notice confirming receipt of the notice and  
23 consent of the individual to be so furnished  
24 such items and services.

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

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

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

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

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

7 “(e) PENALTY.—

8 “(1) GENERAL PENALTY.—

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

15 “(B) APPLICATION OF PROVISIONS.—The  
16 provisions of section 1128A (other than sub-  
17 section (a), subsection (b), the first sentence of  
18 subsection (c)(1), and subsection (o)) shall  
19 apply with respect to a civil monetary penalty  
20 imposed under this paragraph in the same man-  
21 ner as such provisions apply with respect to a  
22 penalty or proceeding under subsection (a) of  
23 such section.

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

1           “(A) IN GENERAL.—In the case of a hos-  
2           pital or independent freestanding emergency de-  
3           partment that furnishes emergency services de-  
4           scribed in subparagraph (A) of section  
5           2719A(k)(5) to an individual enrolled in a  
6           health plan, after stabilization of such indi-  
7           vidual, if the hospital or independent free-  
8           standing emergency department does not pro-  
9           vide such individual a notice in accordance with  
10          subparagraph (C)(i) of such section and—

11                   “(i) in the case the hospital or inde-  
12                   pendent freestanding emergency depart-  
13                   ment is a nonparticipating facility with re-  
14                   spect to such plan, if the hospital or de-  
15                   partment furnishes services described in  
16                   subparagraph (B) of such section to such  
17                   individual and bills the individual in viola-  
18                   tion of subsection (a) of this section; or

19                   “(ii) in the case the hospital or inde-  
20                   pendent freestanding emergency depart-  
21                   ment is a participating facility with respect  
22                   to such plan and a nonparticipating pro-  
23                   vider furnishes services described in such  
24                   subparagraph (B) during the visit at such



1           hospital or independent freestanding emer-  
2           gency department;  
3           in addition to any penalty applicable to the hos-  
4           pital or department under paragraph (1), the  
5           hospital or department shall be subject to a civil  
6           monetary penalty of \$50,000.

7           “(B) APPLICATION OF PROVISIONS.—The  
8           provisions of section 1128A (other than sub-  
9           section (a), subsection (b), the first sentence of  
10          subsection (c)(1), subsection (d), and subsection  
11          (o)) shall apply with respect to a civil monetary  
12          penalty imposed under this paragraph in the  
13          same manner as such provisions apply with re-  
14          spect to a penalty or proceeding under sub-  
15          section (a) of such section.

16          “(f) DEFINITIONS.—For purposes of this section and  
17          sections 1150D and 1150E:

18                 “(1) The terms ‘during a visit’, ‘emergency de-  
19                 partment of a hospital’, ‘emergency medical condi-  
20                 tion’, ‘emergency services’, ‘independent freestanding  
21                 emergency department’, ‘nonparticipating provider’,  
22                 ‘nonparticipating facility’, ‘participating facility’,  
23                 ‘participating provider’ have the meanings given  
24                 such terms, respectively, in section 2719A(k) of the  
25                 Public Health Service Act.

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

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

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

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

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

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

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

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

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

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

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

1 or a Federal health care program (and if is so en-  
2 rolled in such plan or coverage, seeking to have a  
3 claim for such item or service submitted to such  
4 plan or coverage); and

5 “(2) provide a notification of the good faith es-  
6 timate of the expected charges for furnishing such  
7 item or service (including any item or service that is  
8 reasonably expected to be provided in conjunction  
9 with such scheduled item or service) to—

10 “(A) in the case the individual is enrolled  
11 in such a plan or such coverage (and is seeking  
12 to have a claim for such item or service sub-  
13 mitted to such plan or coverage), such plan or  
14 issuer of such coverage; and

15 “(B) in the case the individual is not de-  
16 scribed in subparagraph (A) and not enrolled in  
17 a Federal health care program, the individual.

18 “(c) CONTINUITY OF CARE.—A health care provider  
19 or health care facility shall, in the case of an individual  
20 furnished items and services by such provider or facility  
21 for which coverage is provided under a group health plan  
22 or group or individual health insurance coverage pursuant  
23 to section 2730 of such Act, section 9817 of the Internal  
24 Revenue Code of 1986, or section 717 of the Employee  
25 Retirement Income Security Act of 1974—

1           “(1) accept payment from such plan or such  
2 issuer (as applicable) (and cost-sharing from such  
3 individual, if applicable, in accordance with sub-  
4 section (a)(2)(C) of such section 2730, 9817, or  
5 717) for such items and services as payment in full  
6 for such items and services; and

7           “(2) continue to adhere to all policies, proce-  
8 dures, and quality standards imposed by such plan  
9 or issuer with respect to such individual and such  
10 items and services in the same manner as if such  
11 termination had not occurred.

12          “(d) LIMITATION.—Beginning on January 1, 2022,  
13 a health care provider or health care facility may not ini-  
14 tiate a process to seek reimbursement of payment for  
15 items and services furnished to an individual enrolled in  
16 a group health plan or health insurance coverage offered  
17 in the group or individual market more than 1 year after  
18 the date on which such items and services were so fur-  
19 nished.

20          “(e) PENALTY.—

21               “(1) GENERAL PENALTY.—

22                       “(A) IN GENERAL.—Except as provided in  
23 paragraph (2), any health care provider or  
24 health care facility that violates a provision of  
25 this section shall be subject to a civil monetary

1 penalty in an amount not to exceed \$10,000 for  
2 each such violation.

3 “(B) APPLICATION OF PROVISIONS.—The  
4 provisions of section 1128A (other than sub-  
5 section (a), subsection (b), the first sentence of  
6 subsection (c)(1), and subsection (o)) shall  
7 apply with respect to a civil monetary penalty  
8 imposed under this paragraph in the same man-  
9 ner as such provisions apply with respect to a  
10 penalty or proceeding under subsection (a) of  
11 such section.

12 “(2) PROVIDER DIRECTORY INFORMATION PEN-  
13 ALTY.—

14 “(A) IN GENERAL.—Each health care pro-  
15 vider or health care facility that fails to trans-  
16 mit information as required under subsection  
17 (a) shall be subject to a civil monetary penalty  
18 of \$1,000 for each day such provider or facility  
19 (as applicable) fails to so transmit such infor-  
20 mation.

21 “(B) APPLICATION OF PROVISIONS.—The  
22 provisions of section 1128A (other than sub-  
23 section (a), subsection (b), the first sentence of  
24 subsection (c)(1), subsection (d), and subsection  
25 (o)) shall apply with respect to a civil monetary

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

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

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



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

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

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

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

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

1           “(C) does not otherwise have a conflict of  
2           interest with such a party (as determined by  
3           the Secretary); and

4           “(2) the provision of a notification of such se-  
5           lection to the individual and the provider or facility  
6           (as applicable) party to such determination.

7   An entity selected pursuant to the previous sentence to  
8   make a determination described in such sentence shall be  
9   referred to in this subsection as the ‘selected dispute reso-  
10   lution entity’ with respect to such determination.

11       “(c) ADMINISTRATIVE FEE.—The Secretary shall es-  
12   tablish a fee to participate in the patient-provider dispute  
13   resolution process in such a manner as to not create a  
14   barrier to an uninsured individual’s access to such process.

15       “(d) CERTIFICATION.—The Secretary shall establish  
16   or recognize a process to certify entities under this sub-  
17   paragraph. Such process shall ensure that an entity so cer-  
18   tified satisfies at least the criteria specified in section  
19   2719A(j)(7) of the Public Health Service Act.”.

20   **SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.**

21       (a) PUBLIC HEALTH SERVICE ACT.—Subpart II of  
22   part A of title XXVII of the Public Health Service Act  
23   (42 U.S.C. 300gg–11 et seq.) is amended by adding at  
24   the end the following new sections:

1 **“SEC. 2730. CONTINUITY OF CARE.**

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

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

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

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

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

1           such plan is terminated, resulting in a loss of  
2           benefits provided under such plan with respect  
3           to such provider or facility;  
4           the plan or issuer, respectively, shall meet the re-  
5           quirements of paragraph (2) with respect to such in-  
6           dividual.

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

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

18                   “(B) provide such individual with an op-  
19                   portunity to notify the plan or issuer of the in-  
20                   dividual’s need for transitional care; and

21                   “(C) permit the patient to elect to continue  
22                   to have benefits provided under such plan or  
23                   such coverage, under the same terms and condi-  
24                   tions as would have applied and with respect to  
25                   such items and services as would have been cov-

1           ered under such plan or coverage had such ter-  
2           mination not occurred, with respect to the  
3           course of treatment furnished by such provider  
4           or facility relating to such individual's status as  
5           a continuing care patient during the period be-  
6           ginning on the date on which the notice under  
7           subparagraph (A) is provided and ending on the  
8           earlier of—

9                   “(i) the 90-day period beginning on  
10                   such date; or

11                   “(ii) the date on which such individual  
12                   is no longer a continuing care patient with  
13                   respect to such provider or facility.

14           “(b) DEFINITIONS.—In this section:

15                   “(1) CONTINUING CARE PATIENT.—The term  
16                   ‘continuing care patient’ means an individual who,  
17                   with respect to a provider or facility—

18                   “(A) is undergoing a course of treatment  
19                   for a serious and complex condition from the  
20                   provider or facility;

21                   “(B) is undergoing a course of institu-  
22                   tional or inpatient care from the provider or fa-  
23                   cility;

24                   “(C) is scheduled to undergo nonelective  
25                   surgery from the provider, including receipt of

1 postoperative care from such provider or facility  
2 with respect to such a surgery;

3 “(D) is pregnant and undergoing a course  
4 of treatment for the pregnancy from the pro-  
5 vider or facility; or

6 “(E) is or was determined to be terminally  
7 ill (as determined under section 1861(dd)(3)(A)  
8 of the Social Security Act) and is receiving  
9 treatment for such illness from such provider or  
10 facility.

11 “(2) SERIOUS AND COMPLEX CONDITION.—The  
12 term ‘serious and complex condition’ means, with re-  
13 spect to a participant, beneficiary, or enrollee under  
14 a group health plan or health insurance coverage—

15 “(A) in the case of an acute illness, a con-  
16 dition that is serious enough to require special-  
17 ized medical treatment to avoid the reasonable  
18 possibility of death or permanent harm; or

19 “(B) in the case of a chronic illness or con-  
20 dition, a condition that is—

21 “(i) is life-threatening, degenerative,  
22 potentially disabling, or congenital; and

23 “(ii) requires specialized medical care  
24 over a prolonged period of time.

1           “(3) **TERMINATED.**—The term ‘terminated’ in-  
2           cludes, with respect to a contract, the expiration or  
3           nonrenewal of the contract, but does not include a  
4           termination of the contract for failure to meet appli-  
5           cable quality standards or for fraud.

6           **“SEC. 2731. INFORMATION REQUIRED TO BE INCLUDED ON**  
7                                   **HEALTH INSURANCE MEMBERSHIP CARDS.**

8           “‘In the case of a group health plan or health insur-  
9           ance issuer offering group or individual health insurance  
10          coverage that provides a physical or electronic card indi-  
11          cating membership in such plan or coverage to an indi-  
12          vidual enrolled under such plan or coverage, such group  
13          health plan or issuer shall include on such card each of  
14          the following:

15                 “(1) The nearest hospital to the primary resi-  
16                 dence of such individual that has in effect a contrac-  
17                 tual relationship with such plan or coverage for fur-  
18                 nishing items and services under such plan or cov-  
19                 erage.

20                 “(2) A telephone number or Internet website  
21                 address through which such individual may seek con-  
22                 sumer assistance information, such as information  
23                 related to hospitals and urgent care facilities that  
24                 have in effect a contractual relationship with such

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

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

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

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

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

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



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

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

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

20 (b) INTERNAL REVENUE CODE.—

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

1 **“SEC. 9817. CONTINUITY OF CARE.**

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

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

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

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

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

1 the plan shall meet the requirements of paragraph  
2 (2) with respect to such individual.

3 “(2) REQUIREMENTS.—The requirements of  
4 this paragraph are that the plan—

5 “(A) notify each individual enrolled under  
6 such plan who is a continuing care patient with  
7 respect to a provider or facility at the time of  
8 a termination described in paragraph (1) affect-  
9 ing such provider on a timely basis of such ter-  
10 mination and such individual’s right to elect  
11 continued transitional care from such provider  
12 or facility under this section;

13 “(B) provide such individual with an op-  
14 portunity to notify the plan of the individual’s  
15 need for transitional care; and

16 “(C) permit the patient to elect to continue  
17 to have benefits provided under such plan,  
18 under the same terms and conditions as would  
19 have applied and with respect to such items and  
20 services as would have been covered under such  
21 plan had such termination not occurred, with  
22 respect to the course of treatment furnished by  
23 such provider or facility relating to such indi-  
24 vidual’s status as a continuing care patient dur-  
25 ing the period beginning on the date on which

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

3 “(i) the 90-day period beginning on  
4 such date; or

5 “(ii) the date on which such individual  
6 is no longer a continuing care patient with  
7 respect to such provider or facility.

8 “(b) DEFINITIONS.—In this section:

9 “(1) CONTINUING CARE PATIENT.—The term  
10 ‘continuing care patient’ means an individual who,  
11 with respect to a provider or facility—

12 “(A) is undergoing a course of treatment  
13 for a serious and complex condition from the  
14 provider or facility;

15 “(B) is undergoing a course of institu-  
16 tional or inpatient care from the provider or fa-  
17 cility;

18 “(C) is scheduled to undergo nonelective  
19 surgery from the provider or facility, including  
20 receipt of postoperative care from such provider  
21 or facility with respect to such a surgery;

22 “(D) is pregnant and undergoing a course  
23 of treatment for the pregnancy from the pro-  
24 vider or facility; or

1           “(E) is or was determined to be terminally  
2 ill (as determined under section 1861(dd)(3)(A)  
3 of the Social Security Act) and is receiving  
4 treatment for such illness from such provider or  
5 facility.

6           “(2) SERIOUS AND COMPLEX CONDITION.—The  
7 term ‘serious and complex condition’ means, with re-  
8 spect to a participant, beneficiary, or enrollee under  
9 a group health plan—

10           “(A) in the case of an acute illness, a con-  
11 dition that is serious enough to require special-  
12 ized medical treatment to avoid the reasonable  
13 possibility of death or permanent harm; or

14           “(B) in the case of a chronic illness or con-  
15 dition, a condition that—

16           “(i) is life-threatening, degenerative,  
17 potentially disabling, or congenital; and

18           “(ii) requires specialized medical care  
19 over a prolonged period of time.

20           “(3) TERMINATED.—The term ‘terminated’ in-  
21 cludes, with respect to a contract, the expiration or  
22 nonrenewal of the contract, but does not include a  
23 termination of the contract for failure to meet appli-  
24 cable quality standards or for fraud.

1 **“SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON**  
2 **HEALTH INSURANCE MEMBERSHIP CARDS.**

3 “In the case of a group health plan that provides a  
4 physical or electronic card indicating membership in such  
5 plan to an individual enrolled under such plan, such group  
6 health plan shall include on such card each of the fol-  
7 lowing:

8 “(1) The nearest hospital to the primary resi-  
9 dence of such individual that has in effect a contrac-  
10 tual relationship with such plan for furnishing items  
11 and services under such plan.

12 “(2) A telephone number or 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 for furnishing items and services under such  
18 plan.

19 “(3) Any deductible applicable to such indi-  
20 vidual.

21 “(4) Any out-of-pocket maximum applicable to  
22 such individual.

23 “(5) Any cost-sharing obligation applicable to  
24 such individual for a visit at an emergency depart-  
25 ment, or urgent care facility, that has in effect a

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

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

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

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

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

1 fits, or right to payment of benefits, of such beneficiary,  
 2 participant, or enrollee to the provider or facility, then  
 3 payment for such item or service by such group health  
 4 plan shall be made directly to the provider or facility.”.

5 (2) CONFORMING AMENDMENT.—Section  
 6 9815(a) of the Internal Revenue Code of 1986, as  
 7 amended by section 2(b), is further amended—

8 (A) in paragraph (1), by striking “section  
 9 2719A” and inserting “section 2719A, 2730,  
 10 2731, 2732, or 2733”; and

11 (B) in paragraph (2), by striking “section  
 12 2719A” and inserting “section 2719A, 2730,  
 13 2731, 2732, or 2733”.

14 (3) CLERICAL AMENDMENT.—The table of sec-  
 15 tions for such subchapter, as amended by section  
 16 2(b), is further amended by adding at the end the  
 17 following new items:

“Sec. 9817. Continuity of care.

“Sec. 9818. Information required to be included on health insurance member-  
 ship cards.

“Sec. 9819. Maintenance of price comparison tool.

“Sec. 9820. Assignment of benefits.”.

18 (c) EMPLOYEE RETIREMENT INCOME SECURITY  
 19 ACT.—

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



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

3 **“SEC. 717. CONTINUITY OF CARE.**

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

8 “(1) IN GENERAL.—In the case of an individual  
9 with benefits under a group health plan or health in-  
10 surance coverage offered by a health insurance  
11 issuer in connection with a group health plan and  
12 with respect to a health care provider or facility that  
13 has a contractual relationship with such plan or  
14 such issuer (as applicable) for furnishing items and  
15 services under such plan or such coverage, if, while  
16 such individual is a continuing care patient (as de-  
17 fined in subsection (b)) with respect to such provider  
18 or facility—

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

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

1 the provider or facility in such plan or coverage;

2 or

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

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

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

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

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

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

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

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

19          “(b) DEFINITIONS.—In this section:

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

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

1           “(B) is undergoing a course of institu-  
2           tional or inpatient care from the provider or fa-  
3           cility;

4           “(C) is scheduled to undergo nonelective  
5           surgery from the provide or facility, including  
6           receipt of postoperative care from such provider  
7           or facility with respect to such a surgery;

8           “(D) is pregnant and undergoing a course  
9           of treatment for the pregnancy from the pro-  
10          vider or facility; or

11          “(E) is or was determined to be terminally  
12          ill (as determined under section 1861(dd)(3)(A)  
13          of the Social Security Act) and is receiving  
14          treatment for such illness from such provider or  
15          facility.

16          “(2) SERIOUS AND COMPLEX CONDITION.—The  
17          term ‘serious and complex condition’ means, with re-  
18          spect to a participant, beneficiary, or enrollee under  
19          a group health plan or health insurance coverage—

20                 “(A) in the case of an acute illness, a con-  
21                 dition that is serious enough to require special-  
22                 ized medical treatment to avoid the reasonable  
23                 possibility of death or permanent harm; or

24                 “(B) in the case of a chronic illness or con-  
25                 dition, a condition that—

1 “(i) is life-threatening, degenerative,  
2 potentially disabling, or congenital; and

3 “(ii) requires specialized medical care  
4 over a prolonged period of time.

5 “(3) **TERMINATED.**—The term ‘terminated’ in-  
6 cludes, with respect to a contract, the expiration or  
7 nonrenewal of the contract, but does not include a  
8 termination of the contract for failure to meet appli-  
9 cable quality standards or for fraud.

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

12 “In the case of a group health plan or health insur-  
13 ance issuer offering group health insurance coverage that  
14 provides a physical or electronic card indicating member-  
15 ship in such plan or coverage to an individual enrolled  
16 under such plan or coverage, such group health plan or  
17 issuer shall include on such card each of the following:

18 “(1) The nearest hospital to the primary resi-  
19 dence of such individual that has in effect a contrac-  
20 tual relationship with such plan or coverage for fur-  
21 nishing items and services under such plan or cov-  
22 erage.

23 “(2) A telephone number or Internet website  
24 address through which such individual may seek con-  
25 sumer assistance information, such as information

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

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

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

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

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

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

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

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

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

21 (2) CONFORMING AMENDMENT.—Section  
22 715(a) of the Employee Retirement Income Security  
23 Act of 1974 (29 U.S.C. 1185d(a)), as amended by  
24 section 2(c), is further amended—

1 (A) in paragraph (1), by striking “section  
2 2719A” and inserting “section 2719A, 2730,  
3 2731, 2732, or 2733”; and

4 (B) in paragraph (2), by striking “section  
5 2719A” and inserting “section 2719A, 2730,  
6 2731, 2732, or 2733”.

7 (3) CLERICAL AMENDMENT.—The table of con-  
8 tents in section 1 of the Employee Retirement In-  
9 come Security Act of 1974 is amended by inserting  
10 after the item relating to section 716 the following  
11 new items:

“Sec. 717. Continuity of care.

“Sec. 718. Information required to be included on health insurance membership  
cards.

“Sec. 719. Maintenance of price comparison tool.

“Sec. 720. Assignment of benefits.”.

12 (d) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply with respect to plan years begin-  
14 ning on or after January 1, 2022.

15 **SEC. 10. AIR AMBULANCE COST DATA REPORTING PRO-**  
16 **GRAM.**

17 (a) COST DATA REPORTING PROGRAM.—

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



1       riod (in the case of the initial period) and the pre-  
2       ceding 1-year period (in each subsequent period).

3           (2) PUBLICATION.—Not later than 180 days  
4       after the date the Secretary of Health and Human  
5       Services receives from a provider described in para-  
6       graph (1) the information specified in subsection (b),  
7       the Secretary shall make publicly available such in-  
8       formation.

9           (b) SPECIFIED INFORMATION.—For purposes of sub-  
10      section (a), information specified in this subsection is—

11           (1) information, with respect to a claim for an  
12      item or service—

13           (A) identified as paid by health insurance  
14      coverage offered in the group or individual mar-  
15      ket or a group health plan (including a self-in-  
16      sured plan);

17           (B) identified as paid for non-emergent  
18      transport requiring prior authorization and  
19      emergent transport;

20           (C) identified as paid for hospital-affiliated  
21      providers and independent providers;

22           (D) identified as paid for rural transport  
23      and urban transport;

24           (E) identified as provided using rotor  
25      transport and fixed wing transport; and

1 (F) identified as furnished by a provider of  
2 emergency air medical services that has a con-  
3 tractual relationship with the plan or coverage  
4 of an individual for which such item or service  
5 is provided and such a provider that does not  
6 have a contractual relationship with the plan or  
7 coverage or such an individual; and

8 (2) cost data for an air ambulance service fur-  
9 nished by such a provider of emergency air medical  
10 services that the Secretary of Health and Human  
11 Services, in consultation with suppliers and pro-  
12 viders of such services, determines appropriate, sepa-  
13 rated by the cost of air travel and the cost of emer-  
14 gency medical services and supplies.

15 (c) RULEMAKING.—Not later than 1 year after the  
16 date of the enactment of this Act, the Secretary of Health  
17 and Human Services shall determine the form and manner  
18 for submitting the information described in subsection (b)  
19 through notice and comment rulemaking.

20 (d) CIVIL MONETARY PENALTIES.—

21 (1) IN GENERAL.—A provider of emergency air  
22 medical services who violates the requirements of  
23 subsection (a)(1) shall be subject to a civil monetary  
24 penalty of not more than \$10,000 for each act con-  
25 stituting such violation.

1           (2) PROCEDURE.—The provisions of section  
2           1128A of the Social Security Act (42 U.S.C. 1320a–  
3           7a) (other than subsection (a), subsection (b), the  
4           first sentence of subsection (c)(1) of such subsection,  
5           and subsection (o)) shall apply to civil monetary  
6           penalties under this subsection in the same manner  
7           as such provisions apply to a penalty or proceeding  
8           under such section.

9           (e) REPORTING.—

10           (1) SECRETARY OF HEALTH AND HUMAN SERV-  
11           ICES.—Not later than July 1, 2023, the Secretary of  
12           Health and Human Services shall submit to Con-  
13           gress a report summarizing the information specified  
14           in subsection (b).

15           (2) COMPTROLLER GENERAL.—Not later than  
16           July 1, 2023, the Comptroller General of the United  
17           States shall submit to Congress a report that in-  
18           cludes—

19                   (A) an analysis of the cost variation of  
20                   suppliers and providers emergency air ambu-  
21                   lance services by geography and status; and

22                   (B) any other recommendations the Comp-  
23                   troller General determines appropriate, which  
24                   may include a recommendation of an adequate  
25                   amount of reimbursement for such services that

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

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

7 **SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.**

8 Not later than 2 years after the date of the enact-  
9 ment of this Act, the Comptroller General of the United  
10 States shall submit to Congress a report summarizing the  
11 effects of the provisions of this Act, including the amend-  
12 ments made by such provisions, on changes during such  
13 period in health care provider networks of group health  
14 plans and health insurance coverage offered by a health  
15 insurance issuer in the group or individual market, in fee  
16 schedules and amounts for health care services, and to  
17 contracted rates under such plans or coverage. Such re-  
18 port shall—

19 (1) to the extent practicable, sample a statis-  
20 tically significant group of national health care pro-  
21 viders; and

22 (2) examine—

23 (A) provider network participation, includ-  
24 ing nonparticipating providers furnishing items  
25 and services at participating facilities;

1 (B) health care provider group network  
2 participation, including specialty, size, and own-  
3 ership; and

4 (C) the impact of State surprise billing  
5 laws and network adequacy standards on par-  
6 ticipation of health care providers and facilities  
7 in provider networks of group health plans and  
8 of health insurance coverage offered by health  
9 insurance issuers in the group or individual  
10 market.