

**AMENDMENT IN THE NATURE OF A SUBSTITUTE  
TO H.R. 5826  
OFFERED BY MR. NEAL OF MASSACHUSETTS**

Strike all after the enacting clause and insert the following:

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

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

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Consumer protections through requirements on health plans to prevent surprise medical bills for emergency services.
- Sec. 3. Consumer protections through requirements on health plans to prevent surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities.
- Sec. 4. Consumer protections through application of health plan external review in cases of certain surprise medical bills.
- Sec. 5. Consumer protections through health plan transparency requirements.
- Sec. 6. Consumer protections through health plan requirement for fair and honest advance cost estimate.
- Sec. 7. Determination through open negotiation and mediation of out-of-network rates to be paid by health plans.
- Sec. 8. Prohibiting balance billing practices by providers for emergency services, for services furnished by nonparticipating provider at participating facility, and in certain cases of misinformation.
- Sec. 9. Additional consumer protections.
- Sec. 10. Reporting requirements regarding air ambulance services.
- Sec. 11. GAO report on effects of legislation.
- Sec. 12. Transitional rule allowing deduction for surprise billing expenses below AGI floor.

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

5 (a) PHSA AMENDMENTS.—

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

9 (A) in subsection (b)—

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

13 (ii) in paragraph (1)—

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

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

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

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

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

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

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

16                  (III) in subparagraph (C)—

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

25                  (bb) by striking clause (i);

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

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

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

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

23 “(ii) the cost-sharing requirement is  
24 not greater than the requirement that  
25 would apply if such services were furnished

1 by a participating provider or a partici-  
2 pating emergency facility, as applicable;”;  
3 and

4 (gg) by adding at the end  
5 the following new clauses:

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

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

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

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

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

3           “(A) AUDIT PROCESS.—

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

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

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

22                  “(ii) AUDIT SAMPLES.—Under the  
23                  process established pursuant to clause (i),  
24                  the Secretary—

1                   “(I) shall conduct audits de-  
2                   scribed in such clause of a sample of  
3                   health plans; and

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

9                   “(B) RULEMAKING.—Not later than July  
10                  1, 2021, the Secretary, in coordination with the  
11                  Secretary of Labor and the Secretary of the  
12                  Treasury, shall establish through rulemaking—

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

21                  “(ii) the information such sponsor or  
22                  issuer shall share with the nonparticipating  
23                  provider involved when making such a de-  
24                  termination.”; and

1 (B) by adding at the end the following new  
2 subsection:

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

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

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

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



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

11           “(5) EMERGENCY SERVICES.—

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

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

1 emergency department to evaluate such  
2 emergency medical condition; and

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

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

1 patient observation or an inpatient or out-  
2 patient stay during a visit in which such indi-  
3 vidual is so stabilized with respect to such  
4 emergency condition if—

5 “(i) such items and services would  
6 otherwise be covered under such plan if  
7 furnished by a participating provider or  
8 participating facility; and

9 “(ii) such items and services are fur-  
10 nished—

11 “(I) to maintain, improve, or re-  
12 solve the individual’s stabilization with  
13 respect to such condition, unless any  
14 circumstance described in subpara-  
15 graph (C) has occurred with respect  
16 to such individual before such items  
17 and services are furnished; or

18 “(II) for any purpose not de-  
19 scribed in subclause (I), unless each  
20 of the criteria described in subpara-  
21 graph (D) have been met with respect  
22 to such individual and such item or  
23 service.

24 “(C) CIRCUMSTANCES.—For purposes of  
25 subparagraph (B)(ii)(I), a circumstance de-

1           scribed in this subparagraph is any of the fol-  
2           lowing, with respect to an individual who is a  
3           beneficiary, participant, or enrollee of a health  
4           plan who is furnished services described in sub-  
5           paragraph (A) by a hospital or independent  
6           freestanding emergency department with re-  
7           spect to an emergency medical condition:

8                   “(i) A participating provider, with re-  
9                   spect to such plan, with privileges at the  
10                  hospital or independent freestanding emer-  
11                  gency department assumes responsibility  
12                  for the care of the individual.

13                  “(ii) A participating provider, with re-  
14                  spect to such plan, assumes responsibility  
15                  for the care of the individual through  
16                  transfer of the individual.

17                  “(iii) The health plan and the pro-  
18                  vider treating such individual at the hos-  
19                  pital or independent freestanding emer-  
20                  gency department for such condition reach  
21                  an agreement concerning the care for the  
22                  individual.

23                  “(iv) The individual is discharged.

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

1 described in this subparagraph, with respect to  
2 an individual and an item or service furnished  
3 by a nonparticipating provider or nonpartici-  
4 pating facility that is a hospital or an inde-  
5 pendent freestanding emergency department,  
6 are the following:

7 “(i) A written notice (as specified by  
8 the Secretary and in a clear and under-  
9 standable manner) is provided by such pro-  
10 vider or facility to such individual, before  
11 such item or service is furnished, that in-  
12 cludes the following information:

13 “(I) That such provider or facil-  
14 ity is a nonparticipating provider or  
15 nonparticipating facility (as applica-  
16 ble).

17 “(II) To the extent practicable,  
18 the estimated amount that such non-  
19 participating facility or nonpartici-  
20 pating provider may charge the indi-  
21 vidual for such item or service.

22 “(III) A statement that the indi-  
23 vidual may seek such item or service  
24 from a provider that is a participating  
25 provider or a hospital or independent

1 freestanding emergency department  
2 that is a participating facility and a  
3 list, if feasible, of participating facili-  
4 ties or participating providers, as ap-  
5 plicable, who are able to furnish such  
6 item or service.

7 “(ii) Such individual is in a condition  
8 to receive (as determined in accordance  
9 with guidance issued by the Secretary) the  
10 information described in clause (i) and to  
11 confirm notice of receipt of such notice, in  
12 accordance with applicable State law.

13 “(iii) The individual signs and dates  
14 such notice confirming receipt of the notice  
15 before such item or service is furnished.

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

22 “(7) INDEPENDENT FREESTANDING EMER-  
23 GENCY DEPARTMENT.—The term ‘independent free-  
24 standing emergency department’ means a health  
25 care facility that—

1           “(A) is geographically separate and dis-  
2           tinct and licensed separately from a hospital  
3           under applicable State law; and

4           “(B) provides emergency services.

5           “(8) MEDIAN CONTRACTED RATE.—

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

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

1 the methodology established by the Sec-  
2 retary under subsection (b)(2)(B), in-  
3 creased by the percentage increase in the  
4 consumer price index for all urban con-  
5 sumers (United States city average) over  
6 2019, 2020, and 2021;

7 “(ii) for an item or service furnished  
8 during 2023 or a subsequent year through  
9 2026, the median contracted rate for the  
10 previous year, increased by the percentage  
11 increase in the consumer price index for all  
12 urban consumers (United States city aver-  
13 age) over such previous year;

14 “(iii) for an item or service furnished  
15 during a rebasing year (as defined in sub-  
16 paragraph (D)), the median of the con-  
17 tracted rates recognized by the sponsor or  
18 issuer of such plan (determined with re-  
19 spect to all such plans of such sponsor or  
20 such issuer that are within the same line  
21 of business (as specified in subparagraph  
22 (C)) as the plan involved) as the total max-  
23 imum payment under such plans in such  
24 year for the same or a similar item or serv-  
25 ice that is provided by a provider or facility



1 in the same or similar specialty and pro-  
2 vided in the geographic region (as estab-  
3 lished pursuant to clause (i)) 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); and

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

15 “(B) USE OF SUBSTITUTE RATE IN CASE  
16 OF INSUFFICIENT DATA.—

17 “(i) IN GENERAL.—In the case the  
18 sponsor or issuer of a health plan has in-  
19 sufficient information (as specified by the  
20 Secretary) to calculate the median of the  
21 contracted rates in accordance with sub-  
22 paragraph (A) for a year for an item or  
23 service furnished in a particular geographic  
24 region (as established pursuant to subpara-  
25 graph (A)(i)) by a type of provider or facil-

1           ity, the substitute rate (as defined in  
2           clause (ii)) for such item or service shall be  
3           deemed to be the median contracted rate  
4           for such item or service furnished in such  
5           region during such year by such a provider  
6           or facility for such year under such sub-  
7           paragraph (A) for such plan.

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

17               “(I) if sufficient information (as  
18               specified by the Secretary) exists to  
19               determine the median of the con-  
20               tracted rates recognized by all health  
21               plans offered in the same line of busi-  
22               ness (as specified in subparagraph  
23               (C)) by any group health plan or  
24               health insurance issuer for such an  
25               item or service furnished in such re-

1           gion by such a provider or facility  
2           during such year using a database or  
3           other source of information deter-  
4           mined appropriate by the Secretary,  
5           such median; and

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

20          The Secretary shall develop a methodology  
21          for determining a substitute rate based on  
22          a similarly situated health plan that is not  
23          a Federal health care program (as defined  
24          in section 1128B(f) of the Social Security  
25          Act) in the case a substitute rate is not

1                   calculable under the previous sentence with  
2                   respect to an item or service.

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

6                   “(i) The individual market.

7                   “(ii) The small group market.

8                   “(iii) The large group market.

9                   “(iv) In the case of a self-insured  
10                  group health plan, other self-insured group  
11                  health plans.

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

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

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

24                  “(B) PARTICIPATING FACILITY.—

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

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

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

14           “(II) A critical access hospital  
15           (as defined in section 1861(mm)(1) of  
16           such Act).

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

20           “(IV) A laboratory.

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

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

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

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

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

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

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

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

1 law that provides for a method for determining  
2 the total amount payable under such health  
3 plan regulated by such State with respect to  
4 such item or service furnished by such provider  
5 or facility, such amount determined in accord-  
6 ance with such law;

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

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

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

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

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

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

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



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

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

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

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

1 service furnished by such provider or facility,  
2 such amount determined in accordance with  
3 such method.

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

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

10 “(1) PAYMENT TO PROVIDER OR FACILITY.—In the  
11 case of any payment required to be made by a health plan  
12 pursuant to subsection (b)(1), (e)(1), or (i)(1) to a  
13 nonparticipating provider or nonparticipating facility for  
14 an item or service, such payment shall be made to such  
15 provider or facility and not to the individual receiving such  
16 item or service.”.

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

20 (b) IRC AMENDMENTS.—

21 (1) IN GENERAL.—Subchapter B of chapter  
22 100 of the Internal Revenue Code of 1986 is amend-  
23 ed by adding at the end the following new section:

1 **“SEC. 9816. PATIENT PROTECTIONS.**

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

8       “(b) COST-SHARING AND PAYMENT OF EMERGENCY  
9 SERVICES.—

10           “(1) IN GENERAL.—If a health plan provides or  
11 covers any benefits with respect to services in an  
12 emergency department of a hospital and, for plan  
13 year 2022 or a subsequent plan year, with respect  
14 to emergency services in an independent free-  
15 standing emergency department, the plan shall cover  
16 emergency services—

17           “(A) without the need for any prior au-  
18 thorization determination;

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

1           “(C) in a manner so that, if such services  
2           are provided to a participant or beneficiary by  
3           a nonparticipating provider or a nonparticipating  
4           facility that is an emergency department  
5           of a hospital or an independent freestanding  
6           emergency department—

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

16          “(ii) the cost-sharing requirement is  
17          not greater than the requirement that  
18          would apply if such services were furnished  
19          by a participating provider or a partici-  
20          pating emergency facility, as applicable;

21          “(iii) such cost-sharing requirement is  
22          calculated as if the contracted rate for  
23          such services if furnished by a partici-  
24          pating provider or a participating emer-

1                   gency facility were equal to the recognized  
2                   amount for such services;

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

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

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

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

1 “(A) AUDIT PROCESS.—

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

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

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

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

23 “(I) shall conduct audits de-  
24 scribed in such clause of a sample of  
25 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 any  
16           cost-sharing) to such provider or facility for such item or  
17           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 SERV-  
22 ICES.—In the case of an individual enrolled in  
23 a health plan who is furnished services de-  
24 scribed 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 with respect to such  
9 emergency condition if—

10 “(i) such items and services would  
11 otherwise be covered under such plan if  
12 furnished by a participating provider or  
13 participating facility; and

14 “(ii) such items and services are fur-  
15 nished—

16 “(I) to maintain, improve, or re-  
17 solve the individual’s stabilization with  
18 respect to such condition, unless any  
19 circumstance described in subpara-  
20 graph (C) has occurred with respect  
21 to such individual before such items  
22 and services are furnished; or

23 “(II) for any purpose not de-  
24 scribed in subclause (I), unless each  
25 of the criteria described in subpara-

1 graph (D) have been met with respect  
2 to such individual and such item or  
3 service.

4 “(C) CIRCUMSTANCES.—For purposes of  
5 subparagraph (B)(ii)(I), a circumstance de-  
6 scribed in this subparagraph is any of the fol-  
7 lowing, with respect to an individual who is a  
8 beneficiary, participant, or enrollee of a health  
9 plan who is furnished services described in sub-  
10 paragraph (A) by a hospital or independent  
11 freestanding emergency department with re-  
12 spect to an emergency medical condition:

13 “(i) A participating provider, with re-  
14 spect to such plan, with privileges at the  
15 hospital or independent freestanding emer-  
16 gency department assumes responsibility  
17 for the care of the individual.

18 “(ii) A participating provider, with re-  
19 spect to such plan, assumes responsibility  
20 for the care of the individual through  
21 transfer of the individual.

22 “(iii) The health plan and the pro-  
23 vider treating such individual at the hos-  
24 pital or independent freestanding emer-  
25 gency department for such condition reach

1 an agreement concerning the care for the  
2 individual.

3 “(iv) The individual is discharged.

4 “(D) SIGNED NOTICE CRITERIA.—For pur-  
5 poses of subparagraph (B)(ii)(II), the criteria  
6 described in this subparagraph, with respect to  
7 an individual and an item or service furnished  
8 by a nonparticipating provider or nonpartici-  
9 pating facility that is a hospital or an inde-  
10 pendent freestanding emergency department,  
11 are the following:

12 “(i) A written notice (as specified by  
13 the Secretary and in a clear and under-  
14 standable manner) is provided by such pro-  
15 vider or facility to such individual, before  
16 such item or service is furnished, that in-  
17 cludes the following information:

18 “(I) That such provider or facil-  
19 ity is a nonparticipating provider or  
20 nonparticipating facility (as applica-  
21 ble).

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

1                   participating provider may charge the indi-  
2                   vidual for such item or service.

3                   “(III) A statement that the indi-  
4                   vidual may seek such item or service  
5                   from a provider that is a participating  
6                   provider or a hospital or independent  
7                   freestanding emergency department  
8                   that is a participating facility and a  
9                   list, if feasible, of participating facili-  
10                  ties or participating providers, as ap-  
11                  plicable, who are able to furnish such  
12                  item or service.

13                  “(ii) Such individual is in a condition  
14                  to receive (as determined in accordance  
15                  with guidance issued by the Secretary) the  
16                  information described in clause (i) and to  
17                  confirm notice of receipt of such notice, in  
18                  accordance with applicable State law.

19                  “(iii) The individual signs and dates  
20                  such notice confirming receipt of the notice  
21                  before such item or service is furnished.

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



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

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

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

10 “(B) provides emergency services.

11 “(8) MEDIAN CONTRACTED RATE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(i) The small group market.

10 “(ii) The large group market.

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

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

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

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

1 “(B) PARTICIPATING FACILITY.—

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

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

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

15 “(II) A critical access hospital  
16 (as defined in section 1861(mm)(1) of  
17 such Act).

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

21 “(IV) A laboratory.

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

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

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

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

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

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

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

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



1 law that provides for a method for determining  
2 the total amount payable under such health  
3 plan regulated by such State with respect to  
4 such item or service furnished by such provider  
5 or facility, such amount determined in accord-  
6 ance with such law;

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

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

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

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

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

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

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

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

1 described in paragraph (11)(A) with respect to  
2 such item or service, provider or facility, and  
3 plan, the amount determined in accordance with  
4 such law;

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

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

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

1           “(13) STABILIZE.—The term ‘to stabilize’, with  
2           respect to an emergency medical condition, has the  
3           meaning give in section 1867(e)(3)(A) of the Social  
4           Security Act).

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

7           “(1) PAYMENT TO PROVIDER OR FACILITY.—In the  
8           case of any payment required to be made by a health plan  
9           pursuant to subsection (b)(1), (e)(1), or (i)(1) to a  
10          nonparticiapting provider or nonparticipating facility for  
11          an item or service, such payment shall be made to such  
12          provider or facility and not to the individual receiving such  
13          item or service.”.

14          (2) CONFORMING AMENDMENTS.—

15                 (A) APPLICATION PROVISIONS.—Section  
16                 9815(a) of the Internal Revenue Code of 1986  
17                 is amended—

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

24                         (ii) in paragraph (2), by inserting  
25                         “(other than, with respect to a plan year

1 beginning on or after January 1, 2022, the  
2 provisions of section 2719A of such Act)”  
3 after the first occurrence of “such part A”.

4 (B) APPLICATION TO RETIREE-ONLY  
5 PLANS.—Section 9831(a) of the Internal Rev-  
6 enue Code of 1986 is amended by inserting  
7 “(other than, with respect to a group health  
8 plan described in paragraph (2), the require-  
9 ments of section 9816)” before “shall not  
10 apply”.

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

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

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

17 (c) EMPLOYEE RETIREMENT INCOME SECURITY ACT  
18 OF 1974 AMENDMENTS.—

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

1 **“SEC. 716. PATIENT PROTECTIONS.**

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

8       “(b) COST-SHARING AND PAYMENT OF EMERGENCY  
9 SERVICES.—

10           “(1) IN GENERAL.—If a health plan provides or  
11 covers any benefits with respect to services in an  
12 emergency department of a hospital and, for plan  
13 year 2022 or a subsequent plan year, with respect  
14 to emergency services in an independent free-  
15 standing emergency department, the plan shall cover  
16 emergency services—

17           “(A) without the need for any prior au-  
18 thorization determination;

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

1           “(C) in a manner so that, if such services  
2           are provided to a participant or beneficiary by  
3           a nonparticipating provider or a nonparticipating  
4           facility that is an emergency department  
5           of a hospital or an independent freestanding  
6           emergency department—

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

16                   “(ii) the cost-sharing requirement is  
17                   not greater than the requirement that  
18                   would apply if such services were furnished  
19                   by a participating provider or a partici-  
20                   pating emergency facility, as applicable;

21                   “(iii) such cost-sharing requirement is  
22                   calculated as if the contracted rate for  
23                   such services if furnished by a partici-  
24                   pating provider or a participating emer-

1                   gency facility were equal to the recognized  
2                   amount for such services;

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

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

15                  “(D) without regard to any other term or  
16                  condition of such coverage (other than exclusion  
17                  or coordination of benefits, or an affiliation or  
18                  waiting period, permitted under section 2704 of  
19                  the Public Health Service Act, including as in-  
20                  corporated pursuant to section 715 and section  
21                  9815 of the Internal Revenue Code of 1986,  
22                  and other than applicable cost-sharing).

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

25                  “(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 the  
5           Treasury 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 the Treasury and the Secretary of  
9                   Health and Human Services, shall establish  
10                  through rulemaking—

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

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

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 item  
17           or service.

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

10 “(i) such items and services would  
11 otherwise be covered under such plan if  
12 furnished by a participating provider or  
13 participating facility; and

14 “(ii) such items and services are fur-  
15 nished—

16 “(I) to maintain, improve, or re-  
17 solve the individual’s stabilization with  
18 respect to such condition, unless any  
19 circumstance described in subpara-  
20 graph (C) has occurred with respect  
21 to such individual before such items  
22 and services are furnished; or

23 “(II) for any purpose not de-  
24 scribed in subclause (I), unless each  
25 of the criteria described in subpara-



1 graph (D) have been met with respect  
2 to such individual and such item or  
3 service.

4 “(C) CIRCUMSTANCES.—For purposes of  
5 subparagraph (B)(ii)(I), a circumstance de-  
6 scribed in this subparagraph is any of the fol-  
7 lowing, with respect to an individual who is a  
8 beneficiary, participant, or enrollee of a health  
9 plan who is furnished services described in sub-  
10 paragraph (A) by a hospital or independent  
11 freestanding emergency department with re-  
12 spect to an emergency medical condition:

13 “(i) A participating provider, with re-  
14 spect to such plan, with privileges at the  
15 hospital or independent freestanding emer-  
16 gency department assumes responsibility  
17 for the care of the individual.

18 “(ii) A participating provider, with re-  
19 spect to such plan, assumes responsibility  
20 for the care of the individual through  
21 transfer of the individual.

22 “(iii) The health plan and the pro-  
23 vider treating such individual at the hos-  
24 pital or independent freestanding emer-  
25 gency department for such condition reach

1 an agreement concerning the care for the  
2 individual.

3 “(iv) The individual is discharged.

4 “(D) SIGNED NOTICE CRITERIA.—For pur-  
5 poses of subparagraph (B)(ii)(II), the criteria  
6 described in this subparagraph, with respect to  
7 an individual and an item or service furnished  
8 by a nonparticipating provider or nonpartici-  
9 pating facility that is a hospital or an inde-  
10 pendent freestanding emergency department,  
11 are the following:

12 “(i) A written notice (as specified by  
13 the Secretary and in a clear and under-  
14 standable manner) is provided by such pro-  
15 vider or facility to such individual, before  
16 such item or service is furnished, that in-  
17 cludes the following information:

18 “(I) That such provider or facil-  
19 ity is a nonparticipating provider or  
20 nonparticipating facility (as applica-  
21 ble).

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

1                   participating provider may charge the indi-  
2                   vidual for such item or service.

3                   “(III) A statement that the indi-  
4                   vidual may seek such item or service  
5                   from a provider that is a participating  
6                   provider or a hospital or independent  
7                   freestanding emergency department  
8                   that is a participating facility and a  
9                   list, if feasible, of participating facili-  
10                  ties or participating providers, as ap-  
11                  plicable, who are able to furnish such  
12                  item or service.

13                  “(ii) Such individual is in a condition  
14                  to receive (as determined in accordance  
15                  with guidance issued by the Secretary) the  
16                  information described in clause (i) and to  
17                  confirm notice of receipt of such notice, in  
18                  accordance with applicable State law.

19                  “(iii) The individual signs and dates  
20                  such notice confirming receipt of the notice  
21                  before such item or service is furnished.

22                  “(6) HEALTH PLAN.—The term ‘health plan’  
23                  means a group health plan and health insurance cov-  
24                  erage offered by a health insurance issuer in the  
25                  group market and includes a grandfathered health

1 plan (as defined in section 1251(e) of the Patient  
2 Protection and Affordable Care Act) that is such a  
3 plan or coverage.

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

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

11 “(B) provides emergency services.

12 “(8) MEDIAN CONTRACTED RATE.—

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

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

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

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

21 “(iii) for an item or service furnished  
22 during a rebasing year (as defined in sub-  
23 paragraph (D)), the median of the con-  
24 tracted rates recognized by the sponsor or  
25 issuer of such plan (determined with re-

1           spect to all such plans of such sponsor or  
2           issuer that are within the same line of  
3           business (as specified in subparagraph (C))  
4           as the plan involved) as the total maximum  
5           payment under such plans in such year for  
6           the same or a similar item or service that  
7           is provided by a provider or facility in the  
8           same or similar specialty and provided in  
9           the geographic region (as established pur-  
10          suant to clause (i)) in which the item or  
11          service is furnished, consistent with the  
12          methodology established by the Secretary  
13          under subsection (b)(2)(B); and

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

22                 “(B) USE OF SUBSTITUTE RATE IN CASE  
23                 OF INSUFFICIENT DATA.—

24                 “(i) IN GENERAL.—In the case the  
25                 sponsor or issuer of a health plan has in-

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

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

24 “(I) if sufficient information (as  
25 specified by the Secretary) exists to

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

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



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

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

12                 “(i) The small group market.

13                 “(ii) The large group market.

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

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

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

22                 “(A) NONPARTICIPATING FACILITY.—The  
23          term ‘nonparticipating facility’ means, with re-  
24          spect to an item or service and a health plan,  
25          a health care facility described in subparagraph

1 (B)(ii) that does not have a contractual rela-  
2 tionship with the plan for furnishing such item  
3 or service.

4 “(B) PARTICIPATING FACILITY.—

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

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

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

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

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

24 “(IV) A laboratory.

1                   “(V) A radiology facility or imag-  
2                   ing center.

3                   “(VI) An independent free-  
4                   standing emergency department.

5                   “(VII) Any other facility speci-  
6                   fied by the Secretary.

7                   “(10) NONPARTICIPATING PROVIDERS; PARTICI-  
8                   PATING PROVIDERS.—

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

16                  “(B) PARTICIPATING PROVIDER.—The  
17                  term ‘participating 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                  has a contractual relationship with the plan for  
21                  furnishing such item or service under the plan.

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

1 such item or service from a nonparticipating pro-  
2 vider or facility—

3 “(A) subject to subparagraphs (C) and  
4 (D), in the case such State has in effect a State  
5 law that provides for a method for determining  
6 the total amount payable under such health  
7 plan regulated by such State with respect to  
8 such item or service furnished by such provider  
9 or facility, such amount determined in accord-  
10 ance with 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) in the case such State has an All-  
7           Payer Model Agreement under section 1115A of  
8           the Social Security Act, the amount that the  
9           State approves under such system for such item  
10          or service so furnished; or

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

22          “(12) RECOGNIZED AMOUNT.—The term ‘recog-  
23          nized amount’ means, with respect to an item or  
24          service furnished in a State during a year to a par-

1        ticipant or beneficiary of a health plan by a non-  
2        participating provider or nonparticipating facility—

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

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

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

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

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

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

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

11          “(1) PAYMENT TO PROVIDER OR FACILITY.—In the  
12          case of any payment required to be made by a health plan  
13          pursuant to subsection (b)(1), (e)(1), or (i)(1) to a  
14          nonparticipating provider or nonparticipating facility for  
15          an item or service, such payment shall be made to such  
16          provider or facility and not to the individual receiving such  
17          item or service.”.

18                 (2) CONFORMING AMENDMENT.—

19                         (A) APPLICATION PROVISIONS.—Section  
20                         715(a) of the Employee Retirement Income Se-  
21                         curity Act of 1974 (29 U.S.C. 1185d(a)) is  
22                         amended—

23                                 (i) in paragraph (1), by striking “(as  
24                                 amended by the Patient Protection and Af-  
25                                 fordable Care Act)” and inserting “(other

1 than, with respect to a plan year beginning  
2 on or after January 1, 2022, the provisions  
3 of section 2719A of such Act)”; and

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

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

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

“Sec. 715. Additional market reforms.

“Sec. 716. Patient protections.”.

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



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

7 (a) PHSA AMENDMENTS.—

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

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

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

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

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

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

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

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

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

15          (b) IRC AMENDMENTS.—

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

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

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

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

9 “(A) shall not impose on such participant  
10 or beneficiary a cost-sharing amount for such  
11 items and services so furnished that is greater  
12 than the cost-sharing amount that would apply  
13 under such plan had such items or services been  
14 furnished by a participating provider;

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

20 “(C) shall pay to such provider furnishing  
21 such items and services to such participant or  
22 beneficiary the amount by which the out-of-net-  
23 work rate for such items and services exceeds  
24 the cost-sharing amount imposed under the  
25 plan for such items and services (as determined

1 in accordance with subparagraphs (A) and (B));  
2 and

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

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

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

21 (c) ERISA AMENDMENTS.—

22 (1) IN GENERAL.—Section 716 of the Employee  
23 Retirement Income Security Act of 1974, as added  
24 by section 2(c), is amended by inserting before sub-  
25 section (k) the following 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 for such  
17 items and services so furnished that is greater  
18 than the cost-sharing amount that would apply  
19 under such plan had such items or services been  
20 furnished by a participating provider;

21           “(B) shall calculate such cost-sharing  
22 amount as if the contracted rate for such serv-  
23 ices if furnished by a participating provider  
24 were equal to the recognized amount for such  
25 items and services;

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

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

13          “(2) EXCEPTION.—Paragraph (1) shall not  
14          apply to a health plan in the case of items or serv-  
15          ices furnished to a participant or beneficiary of a  
16          health plan by a nonparticipating provider during a  
17          visit (as so defined by the Secretary in accordance  
18          with subsection (k)(2)) at a participating facility if  
19          the requirement described in paragraph (1) of sec-  
20          tion 1150C(b) of the Social Security Act does not  
21          apply with respect to such provider and such items  
22          and services due to the application of paragraph (2)  
23          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 **SEC. 4. CONSUMER PROTECTIONS THROUGH APPLICATION**  
5                           **OF HEALTH PLAN EXTERNAL REVIEW IN**  
6                           **CASES OF CERTAIN SURPRISE MEDICAL**  
7                           **BILLS.**

8           Section 2719(b)(1) of the Public Health Service Act  
9 (42 U.S.C. 300gg–19(b)(1)) is amended—

10           (1) by striking “at a minimum, includes” and  
11           inserting “at a minimum—

12                           “(A) includes”;

13           (2) by striking at the end “or” and inserting  
14           “and”; and

15           (3) by adding at the end the following new sub-  
16           paragraph:

17                           “(B) beginning not later than January 1,  
18                           2022, applies such external review process with  
19                           respect to any adverse determination by such  
20                           plan or issuer under subsection (b) of section  
21                           2719A, subsection (e) of such section, or sub-  
22                           section (i) of such section, including with re-  
23                           spect to whether an item or service that is the  
24                           subject to such a determination is an item or



1 service to which such subsection (b), (e), or (i)  
2 applies; or”.

3 **SEC. 5. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**  
4 **TRANSPARENCY REQUIREMENTS.**

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

10 “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

13 “(A) establish the verification process de-  
14 scribed in paragraph (2);

15 “(B) establish the response protocol de-  
16 scribed in paragraph (3);

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

19 “(D) include in any directory (other than  
20 the database described in subparagraph (C))  
21 containing provider directory information with  
22 respect to such plan the information described  
23 in paragraph (5).

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

4                   “(A) under which such plan verifies and  
5                   updates the provider directory information in-  
6                   cluded on the database described in paragraph  
7                   (4) of such plan of—

8                           “(i) not less frequently than once  
9                           every 90 days, a random sample of at least  
10                           10 percent of health care providers and  
11                           health care facilities included in such data-  
12                           base; and

13                           “(ii) any such provider or such facility  
14                           included in such database that has not  
15                           submitted any claim to such plan during a  
16                           12-month period;

17                           “(B) that establishes a procedure for the  
18                           removal from such database of such a provider  
19                           or facility with respect to which such plan has  
20                           been unable to verify such information during a  
21                           period specified by the plan; and

22                           “(C) that provides for the update of such  
23                           database within 2 business days of such plan  
24                           receiving from such a provider or facility infor-

1           mation pursuant to section 1150D of the Social  
2           Security Act.

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

11                 “(A) responds to such individual as soon  
12                 as practicable, and in no case later than 1 busi-  
13                 ness day after such call or email is received,  
14                 through a written electronic or paper (as re-  
15                 quested by such individual) communication; and

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

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

23                 “(A) a list of each health care provider and  
24                 health care facility with which such plan has a

1 contractual relationship for furnishing items  
2 and services under such plan; and

3 “(B) provider directory information with  
4 respect to each such provider and facility.

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

16 “(6) DEFINITION.—For purposes of this sec-  
17 tion, the term ‘provider directory information’ in-  
18 cludes, with respect to a health plan, the name, ad-  
19 dress, specialty, and telephone number of each  
20 health care provider or health care facility with  
21 which such plan has a contractual relationship for  
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS  
24 AGAINST BALANCE BILLING.—Beginning not later than  
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-  
2 viduals enrolled under such plan, and include on each ex-  
3 planation of benefits for an item or service with respect  
4 to which the requirements under subsection (b), (e), or  
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-  
8 plied under section 1150C of the Social Secu-  
9 rity Act (relating to prohibitions on balance bill-  
10 ing in certain circumstances);

11 “(B) if provided for under applicable State  
12 law, any other requirements on providers and  
13 facilities regarding the amounts such providers  
14 and facilities may, with respect to an item or  
15 service, charge a participant, beneficiary, or en-  
16 rollee of such plan with respect to which such  
17 a provider is a nonparticipating provider or fa-  
18 cility is a nonparticipating facility, with respect  
19 to such plan, for furnishing such item or service  
20 after receiving payment from the plan for such  
21 item or service and any applicable cost-sharing  
22 payment from such participant, beneficiary, or  
23 enrollee; and

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

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

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 section 3(b), is further amended by inserting  
10          before subsection (k) the following new subsections:

11          “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

14                         “(A) establish the verification process de-  
15                         scribed in paragraph (2);

16                         “(B) establish the response protocol de-  
17                         scribed in paragraph (3);

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

20                         “(D) include in any directory (other than  
21                         the database described in subparagraph (C))  
22                         containing provider directory information with  
23                         respect to such plan the information described  
24                         in paragraph (5).

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

4                   “(A) under which such plan verifies and  
5           updates the provider directory information in-  
6           cluded on the database described in paragraph  
7           (4) of such plan of—

8                           “(i) not less frequently than once  
9                           every 90 days, a random sample of at least  
10                          10 percent of health care providers and  
11                          health care facilities included in such data-  
12                          base; and

13                           “(ii) any such provider or such facility  
14                          included in such database that has not  
15                          submitted any claim to such plan during a  
16                          12-month period;

17                          “(B) that establishes a procedure for the  
18                          removal from such database of such a provider  
19                          or facility with respect to which such plan has  
20                          been unable to verify such information during a  
21                          period specified by the plan; and

22                          “(C) that provides for the update of such  
23                          database within 2 business days of such plan  
24                          receiving from such a provider or facility infor-

1           mation pursuant to section 1150D of the Social  
2           Security Act.

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

11                 “(A) responds to such individual as soon  
12                 as practicable, and in no case later than 1 busi-  
13                 ness day after such call or email is received,  
14                 through a written electronic or paper (as re-  
15                 quested by such individual) communication; and

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

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

23                 “(A) a list of each health care provider and  
24                 health care facility with which such plan has a



1 contractual relationship for furnishing items  
2 and services under such plan; and

3 “(B) provider directory information with  
4 respect to each such provider and facility.

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

16 “(6) DEFINITION.—For purposes of this sec-  
17 tion, the term ‘provider directory information’ in-  
18 cludes, with respect to a health plan, the name, ad-  
19 dress, specialty, and telephone number of each  
20 health care provider or health care facility with  
21 which such plan has a contractual relationship for  
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS  
24 AGAINST BALANCE BILLING.—Beginning not later than  
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-  
2 viduals enrolled under such plan, and include on each ex-  
3 planation of benefits for an item or service with respect  
4 to which the requirements under subsection (b), (e), or  
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-  
8 plied under section 1150C of the Social Secu-  
9 rity Act (relating to prohibitions on balance bill-  
10 ing in certain circumstances);

11 “(B) if provided for under applicable State  
12 law, any other requirements on providers and  
13 facilities regarding the amounts such providers  
14 and facilities may, with respect to an item or  
15 service, charge a participant or beneficiary of  
16 such plan with respect to which such a provider  
17 is a nonparticipating provider or facility is a  
18 nonparticipating facility, with respect to such  
19 plan, for furnishing such item or service after  
20 receiving payment from the plan for such item  
21 or service and any applicable cost-sharing pay-  
22 ment from such participant or beneficiary; and

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

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

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

12          “(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

15                         “(A) establish the verification process de-  
16                         scribed in paragraph (2);

17                         “(B) establish the response protocol de-  
18                         scribed in paragraph (3);

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

21                         “(D) include in any directory (other than  
22                         the database described in subparagraph (C))  
23                         containing provider directory information with  
24                         respect to such plan the information described  
25                         in paragraph (5).

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

4                   “(A) under which such plan verifies and  
5                   updates the provider directory information in-  
6                   cluded on the database described in paragraph  
7                   (4) of such plan of—

8                           “(i) not less frequently than once  
9                           every 90 days, a random sample of at least  
10                           10 percent of health care providers and  
11                           health care facilities included in such data-  
12                           base; and

13                           “(ii) any such provider or such facility  
14                           included in such database that has not  
15                           submitted any claim to such plan during a  
16                           12-month period;

17                           “(B) that establishes a procedure for the  
18                           removal from such database of such a provider  
19                           or facility with respect to which such plan has  
20                           been unable to verify such information during a  
21                           period specified by the plan; and

22                           “(C) that provides for the update of such  
23                           database within 2 business days of such plan  
24                           receiving from such a provider or facility infor-

1           mation pursuant to section 1150D of the Social  
2           Security Act.

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

11                   “(A) responds to such individual as soon  
12                   as practicable, and in no case later than 1 busi-  
13                   ness day after such call or email is received,  
14                   through a written electronic or paper (as re-  
15                   quested by such individual) communication; and

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

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

23                   “(A) a list of each health care provider and  
24                   health care facility with which such plan has a

1 contractual relationship for furnishing items  
2 and services under such plan; and

3 “(B) provider directory information with  
4 respect to each such provider and facility.

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

16 “(6) DEFINITION.—For purposes of this sec-  
17 tion, the term ‘provider directory information’ in-  
18 cludes, with respect to a health plan, the name, ad-  
19 dress, specialty, and telephone number of each  
20 health care provider or health care facility with  
21 which such plan has a contractual relationship for  
22 furnishing items and services under such plan.

23 “(g) DISCLOSURE ON PATIENT PROTECTIONS  
24 AGAINST BALANCE BILLING.—Beginning not later than  
25 January 1, 2022, each health plan shall make publicly

1 available, post on a website of such plan available to indi-  
2 viduals enrolled under such plan, and include on each ex-  
3 planation of benefits for an item or service with respect  
4 to which the requirements under subsection (b), (e), or  
5 (i) applies—

6 “(1) information in plain language on—

7 “(A) the requirements and prohibitions ap-  
8 plied under section 1150C of the Social Secu-  
9 rity Act (relating to prohibitions on balance bill-  
10 ing in certain circumstances);

11 “(B) if provided for under applicable State  
12 law, any other requirements on providers and  
13 facilities regarding the amounts such providers  
14 and facilities may, with respect to an item or  
15 service, charge a participant or beneficiary of  
16 such plan with respect to which such a provider  
17 is a nonparticipating provider or facility is a  
18 nonparticipating facility, with respect to such  
19 plan, for furnishing such item or service after  
20 receiving payment from the plan for such item  
21 or service and any applicable cost-sharing pay-  
22 ment from such participant or beneficiary; and

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

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

7   **SEC. 6. CONSUMER PROTECTIONS THROUGH HEALTH PLAN**  
8                   **REQUIREMENT FOR FAIR AND HONEST AD-**  
9                   **VANCE COST ESTIMATE.**

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

15          “(h) **ADVANCED EXPLANATION OF BENEFITS.**—Be-  
16          ginning on January 1, 2022, each health plan shall, with  
17          respect to a notification submitted under section  
18          1150D(b)(2)(A) of the Social Security Act by a health  
19          care provider or health care facility, respectively, to the  
20          health plan for a participant, beneficiary, or enrollee under  
21          such health plan scheduled to receive an item or service  
22          from the provider or facility, not later than 1 business day  
23          (or, in the case such item or service was so scheduled at  
24          least 10 business days before such item or service is to  
25          be furnished (or in the case such notification was made



1 pursuant to a request by such participant, beneficiary, or  
2 enrollee), 3 business days) after the date on which the  
3 health plan receives such notification, provide to the par-  
4 ticipant, beneficiary, or enrollee (through mail or elec-  
5 tronic means, as requested by the participant, beneficiary,  
6 or enrollee) a notification (in clear and understandable  
7 language) including the following:

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

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

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

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

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

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

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

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

24           “(7) A disclaimer that the information provided  
25 in the notification is only an estimate based on the

1 items and services reasonably expected, at the time  
2 of scheduling (or requesting) the item or service, to  
3 be furnished and is subject to change.

4 “(8) A statement that the individual may seek  
5 such an item or service from a provider that is a  
6 participating provider or a facility that is a partici-  
7 pating facility and a list of participating facilities, or  
8 of participating providers, as applicable, who are  
9 able to furnish such items and services involved.

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

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

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

1       pant, beneficiary, or enrollee and item or service, the  
2       plan—

3               “(A) shall not impose on such enrollee a  
4               cost-sharing amount for such item or service so  
5               furnished that is greater than the cost-sharing  
6               amount that would apply under such plan had  
7               such item or service been furnished by a partici-  
8               pating provider;

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

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

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

22              “(C) shall pay to such nonparticipating  
23              provider or facility furnishing such item or serv-  
24              ice to such participant, beneficiary, or enrollee  
25              the 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, beneficiary, or enrollee of a health  
20                  plan by a nonparticipating provider or a nonparti-  
21                  cating facility, are the following:

22                  “(A) The participant, beneficiary, or en-  
23                  rollee received a notification under subsection  
24                  (h) with respect to such item and service to be  
25                  furnished and such notification provided infor-

1           mation that the provider was a participating  
2           provider or facility was a participating facility,  
3           with respect to the plan for furnishing such  
4           item or service.

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

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

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

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

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

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

23                   “(B) in the case the provider or facility is  
24                   a nonparticipating provider or facility with re-  
25                   spect to such plan, a description of how such

1 individual may obtain information on providers  
2 and facilities that, with respect to such health  
3 plan, are participating providers and facilities.

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

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

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

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

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



1 plan, a disclaimer that coverage for such item or  
2 service is subject to such medical management tech-  
3 nique.

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

9 “(8) A statement that the individual may seek  
10 such an item or service from a provider that is a  
11 participating provider or a facility that is a partici-  
12 pating facility and a list of participating facilities, or  
13 of participating providers, as applicable, who are  
14 able to furnish such items and services involved.

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

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

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

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

7 “(A) shall not impose on such enrollee a  
8 cost-sharing amount for such item or service so  
9 furnished that is greater than the cost-sharing  
10 amount that would apply under such plan had  
11 such item or service been furnished by a partici-  
12 pating provider;

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

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

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

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

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

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

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

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

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

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

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

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) and 5(c),  
23          is further amended by inserting before subsection (k) the  
24          following new subsections:

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

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

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

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

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

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

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

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

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

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

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

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

15 “(8) A statement that the individual may seek  
16 such an item or service from a provider that is a  
17 participating provider or a facility that is a partici-  
18 pating facility and a list of participating facilities, or  
19 of participating providers, as applicable, who are  
20 able to furnish such items and services involved.

21 “(9) Any other information or disclaimer the  
22 health plan determines appropriate that is consistent  
23 with information and disclaimers required under this  
24 section.

1           “(i) COST-SHARING AND PAYMENT FOR SERVICES  
2 PROVIDED BASED ON RELIANCE ON INCORRECT PRO-  
3 VIDER NETWORK INFORMATION.—

4           “(1) IN GENERAL.—For plan years beginning  
5 on or after January 1, 2022, in the case of an item  
6 or service furnished to a participant or beneficiary of  
7 a health plan by a nonparticipating provider or a  
8 nonparticipating facility, if such item or service  
9 would otherwise be covered under such plan if fur-  
10 nished by a participating provider or participating  
11 facility and if either of the criteria described in para-  
12 graph (2) applies with respect to such participant or  
13 beneficiary and item or service, the plan—

14           “(A) shall not impose on such enrollee a  
15 cost-sharing amount for such item or service so  
16 furnished that is greater than the cost-sharing  
17 amount that would apply under such plan had  
18 such item or service been furnished by a partici-  
19 pating provider;

20           “(B) shall calculate such cost-sharing  
21 amount as if the contracted rate for such item  
22 or service furnished by such a participating pro-  
23 vider or facility were equal to—

24           “(i) the most recent (as of the date  
25           such item or service was furnished) con-



1           tracted rate in effect between such pro-  
2           vider or facility and such plan for such  
3           item or service furnished under such plan,  
4           if any; or

5                   “(ii) if no contracted rate described in  
6           clause (i) exists, the recognized amount for  
7           such item or service;

8                   “(C) shall pay to such nonparticipating  
9           provider or facility furnishing such item or serv-  
10          ice to such participant or beneficiary the  
11          amount by which—

12                   “(i) if a contracted rate described in  
13          subparagraph (B)(i) exists, the most re-  
14          cent (as of the date such item or services  
15          was furnished) such rate; or

16                   “(ii) if no contracted rate described in  
17          such subparagraph exists, the out-of-net-  
18          work rate;

19          for such items and services exceeds the cost-  
20          sharing amount imposed under the plan for  
21          such items and services (as determined in ac-  
22          cordance with subparagraphs (A) and (B)); and

23                   “(D) shall apply the deductible or out-of-  
24          pocket maximum, if any, that would apply if

1           such services were furnished by a participating  
2           provider or a participating facility.

3           “(2) CRITERIA DESCRIBED.—For purposes of  
4           paragraph (1), the criteria described in this para-  
5           graph, with respect to an item or service furnished  
6           to a participant or beneficiary of a health plan by  
7           a nonparticipating provider or a nonparticipating fa-  
8           cility, are the following:

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

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

1           participating provider or facility was such a partici-  
2           pating facility.”.

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

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

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

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

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

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

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

23 “(i) the health plan that is party to  
24 such negotiations shall notify the provider  
25 or facility that is party to such negotia-

1                   tions of the median contracted rate for  
2                   such item or service and year; and

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

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

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

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

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

25                  In the case of open negotiations pursuant to

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

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

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

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

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

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

17                   “(A) that allows the parties to such deter-  
18                   mination to jointly select, not later than the last  
19                   day of the 3-day period following the date of  
20                   the initiation of the process with respect to such  
21                   item or service, for purposes of making such de-  
22                   termination, an entity certified under paragraph  
23                   (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 the Treas-  
4 ury and the Secretary of Labor, periodically  
5 study and submit to Congress a report on—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(C) ACCESSING MEDIATED DISPUTE  
12 PROCESS IN CASE OF FAILED NEGOTIATIONS.—

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25          “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

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

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

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

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

10 “(C) CONSIDERATIONS.—

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

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

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

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

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

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

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

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



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

6 “(7) CERTIFICATION OF ENTITIES.—

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

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

17 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

21          “(F) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

19                  “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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



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

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

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

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

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

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

23 “(C) CONSIDERATIONS.—

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

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

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

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

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

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

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

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

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

19          “(7) CERTIFICATION OF ENTITIES.—

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

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

6           “(ii) is not—

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

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

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

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

19           “(iv) meets appropriate indicators of  
20           fiscal integrity;

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

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

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

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

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

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

1 paragraph for failure of meeting a requirement  
2 of this subsection.

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

9 “(F) PROVISION OF INFORMATION.—

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

1                   “(ii) INFORMATION TO BE IN-  
2                   CLUDED.—The information described in  
3                   this clause with respect to an entity is the  
4                   following:

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

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

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

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

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

23                  “(IV) The amount of each such  
24                  determination.

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

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

6                   “(VII) Any other information  
7                   specified by the Secretary.

8                   “(8) ADMINISTRATIVE FEE.—

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

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



1           “(9) SECRETARIAL REPORT; PUBLICATION OF  
2 INFORMATION.—

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

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

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

1           “(B) PUBLICATION OF INFORMATION.—  
2           Beginning with July 1, 2023, and for each cal-  
3           endar quarter thereafter, the Secretary shall, in  
4           coordination with the Secretary of Health and  
5           Human Services and the Secretary of Labor,  
6           make publicly available a summary of the fol-  
7           lowing:

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

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

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

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

22           (d) RULE OF CONSTRUCTION.—Nothing in this Act,  
23           or the amendments made by this Act, shall be construed  
24           as removing any obligation of a health plan (as defined  
25           in subsection (k)(6) of section 2719A of the Public Health

1 Service Act (42 U.S.C. 300gg–19A), as amended by this  
2 Act) to provide payment to a health care provider or  
3 health care facility for items and services furnished by  
4 such provider or facility to an individual enrolled in such  
5 plan.

6 **SEC. 8. PROHIBITING BALANCE BILLING PRACTICES BY**  
7 **PROVIDERS FOR EMERGENCY SERVICES, FOR**  
8 **SERVICES FURNISHED BY NONPARTICI-**  
9 **PATING PROVIDER AT PARTICIPATING FACIL-**  
10 **ITY, AND IN CERTAIN CASES OF MISINFORMA-**  
11 **TION.**

12 (a) No BALANCE BILLING.—Part A of title XI of the  
13 Social Security Act (42 U.S.C. 1301 et seq.) is amended  
14 by adding at the end the following new section:

15 **“SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING**  
16 **PRACTICES.**

17 “(a) EMERGENCY SERVICES.—In the case of an indi-  
18 vidual with benefits under a group health plan or health  
19 insurance coverage offered in the group or individual mar-  
20 ket who is furnished in a plan year that begins on or after  
21 January 1, 2022, emergency services with respect to an  
22 emergency medical condition during a visit at an emer-  
23 gency department of a hospital or an independent free-  
24 standing emergency department—

1           “(1) if the hospital or independent freestanding  
2           emergency department does not have a contractual  
3           relationship with such plan or coverage for fur-  
4           nishing such services, the hospital or independent  
5           freestanding emergency department shall not bill,  
6           and shall not hold liable, the individual for a pay-  
7           ment amount for such emergency services so fur-  
8           nished that is more than the cost-sharing amount  
9           for such services (as determined in accordance with  
10          section 2719A(b) of the Public Health Service Act,  
11          section 716(b) of the Employee Retirement Income  
12          Security Act of 1974, or section 9816(b) of the In-  
13          ternal Revenue Code of 1986, as applicable); and

14          “(2) a health care provider without a contrac-  
15          tual relationship with such plan or coverage for fur-  
16          nishing such services shall not bill, and shall not  
17          hold liable, such individual for a payment amount  
18          for such services furnished to such individual by  
19          such provider with respect to such emergency med-  
20          ical condition and visit for which the individual re-  
21          ceives emergency services at the emergency depart-  
22          ment of the hospital or independent freestanding  
23          emergency department that is more than the cost-  
24          sharing amount for such services furnished by the  
25          provider (as determined in accordance with section

1       2719A(b) of the Public Health Service Act, section  
2       716(b) of the Employee Retirement Income Security  
3       Act of 1974, or section 9816(b) of the Internal Rev-  
4       enue Code of 1986, as applicable).

5       “(b) SERVICES FURNISHED BY NONPARTICIPATING  
6 PROVIDER AT PARTICIPATING FACILITY.—

7           “(1) IN GENERAL.—Subject to paragraph (2),  
8       in the case of an individual with benefits under a  
9       health plan who is furnished items or services (other  
10      than emergency services to which subsection (a) ap-  
11      plies or items and services to which subsection (c)  
12      applies) in a plan year that, with respect to such  
13      plan or such coverage (as applicable), begins on or  
14      after January 1, 2022, at a participating facility by  
15      a nonparticipating provider, such provider shall not  
16      bill, and shall not hold liable, such individual for a  
17      payment amount for such an item or service fur-  
18      nished by such provider during a visit at such facil-  
19      ity that is more than the cost-sharing amount for  
20      such item or service (as determined in accordance  
21      with section 2719A(e) of the Public Health Service  
22      Act, section 716(e) of the Employee Retirement In-  
23      come Security Act of 1974, or section 9816(e) of the  
24      Internal Revenue Code of 1986, as applicable).

1           “(2) EXCEPTION IN CASE NOTICE PROVIDED.—  
2           Paragraph (1) shall not apply with respect to items  
3           and services (other than items and services described  
4           in paragraph (3)) furnished to an individual enrolled  
5           in a group health plan or in health insurance cov-  
6           erage offered in the group or individual market by  
7           a health care provider that does not have a contrac-  
8           tual relationship with such plan or coverage for fur-  
9           nishing such items and services if the following cri-  
10          teria are met:

11                   “(A) A written notice (as specified by the  
12                   Secretary and in clear and understandable lan-  
13                   guage) is provided by the provider to such indi-  
14                   vidual, not later than 48 hours before such  
15                   items and services are to be so furnished, that  
16                   includes the following information:

17                           “(i) A statement verifying that the  
18                           provider does not have such a relationship  
19                           with such plan or coverage.

20                           “(ii) The estimated amount that such  
21                           provider may charge the individual for  
22                           such items and services.

23                           “(iii) A statement that the individual  
24                           may seek such items or services from a  
25                           health care provider that does have such a

1 contractual relationship and a list, if fea-  
2 sible, of providers with such a relationship  
3 who are able to furnish such items and  
4 services involved.

5 “(B) On the date such item or service is  
6 to be furnished, before such item or service is  
7 so furnished, the individual signs and dates  
8 such notice confirming receipt of the notice and  
9 consent of the individual to be so furnished  
10 such items and services.

11 “(C) A copy of such signed and dated no-  
12 tice is provided by the provider to the plan or  
13 coverage.

14 “(3) ITEMS AND SERVICES DESCRIBED.—The  
15 items and services described in this paragraph are  
16 items and services furnished by a specified provider  
17 (as defined in subsection (f)(3)).

18 “(c) RELIANCE ON INCORRECT PROVIDER INFORMA-  
19 TION.—In the case of an individual who is furnished items  
20 or services by a health care provider or health care facility  
21 for which a group health plan or health insurance issuer  
22 is required to make payment under section 2719A(i) of  
23 the Public Health Service Act, section 716(i) of the Em-  
24 ployee Retirement Income Security Act of 1974, or section  
25 9816(i) of the Internal Revenue Code of 1986, such pro-

1 vider or facility shall not bill, and shall not hold liable,  
2 such individual for a payment amount for such an item  
3 or service that is more than the cost-sharing amount for  
4 such item or service (as determined in accordance with  
5 section 2719A(i) of the Public Health Service Act, section  
6 716(i) of the Employee Retirement Income Security Act  
7 of 1974, or section 9816(i) of the Internal Revenue Code  
8 of 1986, as applicable).

9 “(d) COMPLIANCE WITH REQUIREMENTS UNDER  
10 OPEN NEGOTIATION AND MEDIATED DISPUTE RESOLU-  
11 TION PROCESSES.—A health care provider or health care  
12 facility shall comply with any requirement imposed on  
13 such provider or facility, respectively, under section  
14 2719A(j) of the Public Health Service Act, 9816(j) of the  
15 Internal Revenue Code of 1986, or 716(j) of the Employee  
16 Retirement Income Security Act of 1974.

17 “(e) PENALTY.—

18 “(1) IN GENERAL.—Any health care provider or  
19 health care facility that violates a provision of this  
20 section shall be subject to a civil monetary penalty  
21 in an amount not to exceed \$10,000 for each such  
22 violation.

23 “(2) APPLICATION OF PROVISIONS.—The provi-  
24 sions of section 1128A (other than subsection (a),  
25 subsection (b), the first sentence of subsection



1 (c)(1), and subsection (o)) shall apply with respect  
2 to a civil monetary penalty imposed under this sub-  
3 section in the same manner as such provisions apply  
4 with respect to a penalty or proceeding under sub-  
5 section (a) of such section.

6 “(f) DEFINITIONS.—For purposes of this section and  
7 sections 1150D and 1150E:

8 “(1) The terms ‘during a visit’, ‘emergency de-  
9 partment of a hospital’, ‘emergency medical condi-  
10 tion’, ‘emergency services’, ‘independent freestanding  
11 emergency department’, ‘nonparticipating provider’,  
12 ‘nonparticipating facility’, ‘participating facility’,  
13 ‘participating provider’ have the meanings given  
14 such terms, respectively, in section 2719A(k) of the  
15 Public Health Service Act.

16 “(2) The terms ‘group health plan’, ‘group mar-  
17 ket’, ‘health insurance issuer’, ‘health insurance cov-  
18 erage’, and ‘individual market’ have the meanings  
19 given such terms, respectively, in section 2791 of the  
20 Public Health Service Act.

21 “(3) The term ‘specified provider’, with respect  
22 to an individual with benefits under a group health  
23 plan or health insurance coverage and a hospital  
24 with a contractual relationship with such plan or  
25 coverage for furnishing items and services—



1 of this section, each health care provider and health care  
2 facility shall establish a process under which such provider  
3 or facility transmits, to each health insurance issuer offer-  
4 ing group or individual health insurance coverage and  
5 group health plan with which such provider or supplier  
6 has in effect a contractual relationship for furnishing  
7 items and services under such coverage or such plan, pro-  
8 vider directory information (as defined in section  
9 2719A(f)(6) of the Public Health Service Act, section  
10 716(f)(6) of the Employee Retirement Income Security  
11 Act of 1974, or section 9816(f)(6) of the Internal Revenue  
12 Code of 1986, as applicable) with respect to such provider  
13 or facility, as applicable. Such provider or facility shall so  
14 transmit such information to such issuer offering such  
15 coverage or such group health plan—

16           “(1) when there are any material changes (in-  
17           cluding a change in address, telephone number, or  
18           other contact information) to such provider directory  
19           information of the provider or facility with respect to  
20           such coverage offered by such issuer or with respect  
21           to such plan; and

22           “(2) at any other time (including upon the re-  
23           quest of such issuer or plan) determined appropriate  
24           by the provider, facility, or the Secretary.

1           “(b) PROVISION OF INFORMATION UPON REQUEST  
2 AND FOR SCHEDULED APPOINTMENTS.—Each health care  
3 provider and health care facility shall, beginning January  
4 1, 2022, in the case of an individual who schedules an  
5 item or service to be furnished to such individual by such  
6 provider or facility at least 3 business days before the date  
7 such item or service is to be so furnished, not later than  
8 1 business day after the date of such scheduling (or, in  
9 the case of such an item or service scheduled at least 10  
10 business days before the date such item or service is to  
11 be so furnished (or if requested by the individual), not  
12 later than 3 business days after the date of such sched-  
13 uling or such request)—

14           “(1) inquire if such individual is enrolled in a  
15 group health plan, group or individual health insur-  
16 ance coverage offered by a health insurance issuer,  
17 or a Federal health care program (and if is so en-  
18 rolled in such plan or coverage, seeking to have a  
19 claim for such item or service submitted to such  
20 plan or coverage); and

21           “(2) provide a notification (in clear and under-  
22 standable language) of the good faith estimate of the  
23 expected charges for furnishing such item or service  
24 (including any item or service that is reasonably ex-

1       pected to be provided in conjunction with such  
2       scheduled item or service) to—

3               “(A) in the case the individual is enrolled  
4               in such a plan or such coverage (and is seeking  
5               to have a claim for such item or service sub-  
6               mitted to such plan or coverage), such plan or  
7               issuer of such coverage; and

8               “(B) in the case the individual is not de-  
9               scribed in subparagraph (A) and not enrolled in  
10              a Federal health care program, the individual.

11       “(c) CONTINUITY OF CARE.—A health care provider  
12       or health care facility shall, in the case of an individual  
13       furnished items and services by such provider or facility  
14       for which coverage is provided under a group health plan  
15       or group or individual health insurance coverage pursuant  
16       to section 2730 of such Act, section 9817 of the Internal  
17       Revenue Code of 1986, or section 717 of the Employee  
18       Retirement Income Security Act of 1974—

19              “(1) accept payment from such plan or such  
20              issuer (as applicable) (and cost-sharing from such  
21              individual, if applicable, in accordance with sub-  
22              section (a)(2)(C) of such section 2730, 9817, or  
23              717) for such items and services as payment in full  
24              for such items and services; and

1           “(2) continue to adhere to all policies, proce-  
2           dures, and quality standards imposed by such plan  
3           or issuer with respect to such individual and such  
4           items and services in the same manner as if such  
5           termination had not occurred.

6           “(d) LIMITATION.—Beginning on January 1, 2022,  
7           a health care provider or health care facility may not ini-  
8           tiate a process to seek reimbursement of payment for  
9           items and services furnished to an individual enrolled in  
10          a group health plan or health insurance coverage offered  
11          in the group or individual market more than 1 year after  
12          the date on which such items and services were so fur-  
13          nished.

14          “(e) PENALTY.—

15                  “(1) GENERAL PENALTY.—

16                          “(A) IN GENERAL.—Except as provided in  
17                          paragraph (2), any health care provider or  
18                          health care facility that violates a provision of  
19                          this section shall be subject to a civil monetary  
20                          penalty in an amount not to exceed \$10,000 for  
21                          each such violation.

22                          “(B) APPLICATION OF PROVISIONS.—The  
23                          provisions of section 1128A (other than sub-  
24                          section (a), subsection (b), the first sentence of  
25                          subsection (c)(1), and subsection (o)) shall

1 apply with respect to a civil monetary penalty  
2 imposed under this paragraph in the same man-  
3 ner as such provisions apply with respect to a  
4 penalty or proceeding under subsection (a) of  
5 such section.

6 “(2) PROVIDER DIRECTORY INFORMATION PEN-  
7 ALTY.—

8 “(A) IN GENERAL.—Each health care pro-  
9 vider or health care facility that fails to trans-  
10 mit information as required under subsection  
11 (a) shall be subject to a civil monetary penalty  
12 of \$1,000 for each day such provider or facility  
13 (as applicable) fails to so transmit such infor-  
14 mation.

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), subsection (d), and subsection  
19 (o)) shall apply with respect to a civil monetary  
20 penalty imposed under this paragraph in the  
21 same manner as such provisions apply with re-  
22 spect to a penalty or proceeding under sub-  
23 section (a) of such section.

1 **“SEC. 1150E. PATIENT-PROVIDER DISPUTE RESOLUTION.**

2       “(a) IN GENERAL.—Not later than July 1, 2021, the  
3 Secretary shall establish a process (in this subsection re-  
4 ferred to as the ‘patient-provider dispute resolution proc-  
5 ess’) under which an uninsured individual, with respect  
6 to an item or service, who received, pursuant to section  
7 1150D(b), from a health care provider or health care facil-  
8 ity a good-faith estimate of the expected charges for fur-  
9 nishing such item or service to such individual and who  
10 after being furnished such item or service by such provider  
11 or facility is billed by such provider or facility for such  
12 item or service for charges that are substantially in excess  
13 of such estimate, may seek a determination from a se-  
14 lected dispute resolution entity for the charges to be paid  
15 by such individual (in lieu of such amount so billed) to  
16 such provider or facility for such item or service. For pur-  
17 poses of this subsection, the term ‘uninsured individual’  
18 means, with respect to an item or service, an individual  
19 who does not have benefits for such item or service under  
20 a group health plan, health insurance coverage offered in  
21 the group or individual market by a health insurance  
22 issuer, Federal health care program (as defined in section  
23 1128B(f)), or a health benefits plan under chapter 89 of  
24 title 5, United States Code (or an individual who has bene-  
25 fits for such item or service under a group health plan  
26 or health insurance coverage offered in the group or indi-



1 vidual market by a health insurance issuer, but who does  
2 not seek to have a claim for such item or service submitted  
3 to such plan or coverage).

4 “(b) SELECTION OF ENTITIES.—Under the patient-  
5 provider dispute resolution process, the Secretary shall,  
6 with respect to a determination sought by an individual  
7 under subsection (a), with respect to charges to be paid  
8 by such individual to a health care provider or health care  
9 facility described in such paragraph for an item or service  
10 furnished to such individual by such provider or facility,  
11 provide for—

12 “(1) a method to select to make such deter-  
13 mination an entity certified under subsection (d)  
14 that—

15 “(A) is not a party to such determination  
16 or an employee or agent of such party;

17 “(B) does not have a material familial, fi-  
18 nancial, or professional relationship with such a  
19 party; and

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

23 “(2) the provision of a notification of such se-  
24 lection to the individual and the provider or facility  
25 (as applicable) party to such determination.

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

5 “(c) ADMINISTRATIVE FEE.—The Secretary shall es-  
6 tablish a fee to participate in the patient-provider dispute  
7 resolution process in such a manner as to not create a  
8 barrier to an uninsured individual’s access to such process.

9 “(d) CERTIFICATION.—The Secretary shall establish  
10 or recognize a process to certify entities under this sub-  
11 paragraph. Such process shall ensure that an entity so cer-  
12 tified satisfies at least the criteria specified in section  
13 2719A(j)(7) of the Public Health Service Act.”.

14 **SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.**

15 (a) PUBLIC HEALTH SERVICE ACT.—Subpart II of  
16 part A of title XXVII of the Public Health Service Act  
17 (42 U.S.C. 300gg–11 et seq.) is amended by adding at  
18 the end the following new sections:

19 **“SEC. 2730. CONTINUITY OF CARE.**

20 “(a) ENSURING CONTINUITY OF CARE WITH RE-  
21 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL  
22 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER  
23 NETWORK STATUS.—

24 “(1) IN GENERAL.—In the case of an individual  
25 with benefits under a group health plan or group or

1 individual health insurance coverage offered by a  
2 health insurance issuer and with respect to a health  
3 care provider or facility that has a contractual rela-  
4 tionship with such plan or such issuer (as applica-  
5 ble) for furnishing items and services under such  
6 plan or such coverage, if, while such individual is a  
7 continuing care patient (as defined in subsection (b))  
8 with respect to such provider or facility—

9 “(A) such contractual relationship is termi-  
10 nated (as defined in subsection (b));

11 “(B) benefits provided under such plan or  
12 such health insurance coverage with respect to  
13 such provider or facility are terminated because  
14 of a change in the terms of the participation of  
15 such provider or facility in such plan or cov-  
16 erage; or

17 “(C) a contract between such group health  
18 plan and a health insurance issuer offering  
19 health insurance coverage in connection with  
20 such plan is terminated, resulting in a loss of  
21 benefits provided under such plan with respect  
22 to such provider or facility;

23 the plan or issuer, respectively, shall meet the re-  
24 quirements of paragraph (2) with respect to such in-  
25 dividual.

1           “(2) REQUIREMENTS.—The requirements of  
2 this paragraph are that the plan or issuer—

3           “(A) notify each individual enrolled under  
4 such plan or coverage who is a continuing care  
5 patient with respect to a provider or facility at  
6 the time of a termination described in para-  
7 graph (1) affecting such provider or facility on  
8 a timely basis of such termination and such in-  
9 dividual’s right to elect continued transitional  
10 care from such provider or facility under this  
11 section;

12           “(B) provide such individual with an op-  
13 portunity to notify the plan or issuer of the in-  
14 dividual’s need for transitional care; and

15           “(C) permit the patient to elect to continue  
16 to have benefits provided under such plan or  
17 such coverage, under the same terms and condi-  
18 tions as would have applied and with respect to  
19 such items and services as would have been cov-  
20 ered under such plan or coverage had such ter-  
21 mination not occurred, with respect to the  
22 course of treatment furnished by such provider  
23 or facility relating to such individual’s status as  
24 a continuing care patient during the period be-  
25 ginning on the date on which the notice under

1           subparagraph (A) is provided and ending on the  
2           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, including receipt of  
20                          postoperative care from such provider or facility  
21                          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 or health insurance coverage—

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 is—

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. 2731. INFORMATION REQUIRED TO BE INCLUDED ON**  
2 **HEALTH INSURANCE MEMBERSHIP CARDS.**

3 “In the case of a group health plan or health insur-  
4 ance issuer offering group or individual health insurance  
5 coverage that provides a physical or electronic card indi-  
6 cating membership in such plan or coverage to an indi-  
7 vidual enrolled under such plan or coverage, such group  
8 health plan or issuer shall include on such card each of  
9 the following:

10 “(1) The nearest hospital to the primary resi-  
11 dence of such individual that has in effect a contrac-  
12 tual relationship with such plan or coverage for fur-  
13 nishing items and services under such plan or cov-  
14 erage.

15 “(2) A telephone number or Internet website  
16 address through which such individual may seek con-  
17 sumer assistance information, such as information  
18 related to hospitals and urgent care facilities that  
19 have in effect a contractual relationship with such  
20 plan or coverage for furnishing items and services  
21 under such plan or coverage.

22 “(3) Any deductible applicable to such indi-  
23 vidual.

24 “(4) Any out-of-pocket maximum applicable to  
25 such individual.

1           “(5) Any cost-sharing obligation applicable to  
2           such individual for a visit at an emergency depart-  
3           ment, or urgent care facility, that has in effect a  
4           contractual relationship with such plan or coverage  
5           for furnishing items and services under such plan or  
6           coverage.

7   **“SEC. 2732. MAINTENANCE OF PRICE COMPARISON TOOL.**

8           “In connection with the offering of a group health  
9           plan or group or individual health insurance coverage in  
10          a geographic region for a plan year, a plan sponsor or  
11          health insurance issuer, respectively, shall employ an indi-  
12          vidual to offer price comparison guidance, or make avail-  
13          able on an Internet website a price comparison tool, that  
14          (to the extent practicable) allows an individual enrolled  
15          under such plan or coverage, with respect to such plan  
16          year and such geographic region, to compare the amount  
17          (determined by historic claims data of participating pro-  
18          viders with respect to such plan or coverage) of cost-shar-  
19          ing (including deductibles, copayments, and coinsurance)  
20          that the individual would be responsible for paying under  
21          such plan or coverage with respect to the furnishing of  
22          a specific item or service by any such provider.”.

23          (b) INTERNAL REVENUE CODE.—

24                  (1) IN GENERAL.—Subchapter B of chapter  
25          100 of the Internal Revenue Code of 1986, as



1 amended by the previous sections, is further amend-  
2 ed by adding at the end the following new sections:

3 **“SEC. 9817. CONTINUITY OF CARE.**

4 “(a) ENSURING CONTINUITY OF CARE WITH RE-  
5 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL  
6 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER  
7 NETWORK STATUS.—

8 “(1) IN GENERAL.—In the case of an individual  
9 with benefits under a group health plan and with re-  
10 spect to a health care provider or facility that has  
11 a contractual relationship with such plan for fur-  
12 nishing items and services under such plan, if, while  
13 such individual is a continuing care patient (as de-  
14 fined in subsection (b)) with respect to such provider  
15 or facility—

16 “(A) such contractual relationship is termi-  
17 nated (as defined in paragraph (b));

18 “(B) benefits provided under such plan  
19 with respect to such provider or facility are ter-  
20 minated because of a change in the terms of the  
21 participation of such provider or facility in such  
22 plan; or

23 “(C) a contract between such group health  
24 plan and a health insurance issuer offering  
25 health insurance coverage in connection with

1           such plan is terminated, resulting in a loss of  
2           benefits provided under such plan with respect  
3           to such provider or facility;  
4           the plan shall meet the requirements of paragraph  
5           (2) with respect to such individual.

6           “(2) REQUIREMENTS.—The requirements of  
7           this paragraph are that the plan—

8                   “(A) notify each individual enrolled under  
9                   such plan who is a continuing care patient with  
10                  respect to a provider or facility at the time of  
11                  a termination described in paragraph (1) affect-  
12                  ing such provider on a timely basis of such ter-  
13                  mination and such individual’s right to elect  
14                  continued transitional care from such provider  
15                  or facility under this section;

16                   “(B) provide such individual with an op-  
17                   portunity to notify the plan of the individual’s  
18                   need for transitional care; and

19                   “(C) permit the patient to elect to continue  
20                   to have benefits provided under such plan,  
21                   under the same terms and conditions as would  
22                   have applied and with respect to such items and  
23                   services as would have been covered under such  
24                   plan had such termination not occurred, with  
25                   respect to the course of treatment furnished by

1           such provider or facility relating to such indi-  
2           vidual's status as a continuing care patient dur-  
3           ing the period beginning on the date on which  
4           the notice under subparagraph (A) is provided  
5           and ending on the earlier of—

6                   “(i) the 90-day period beginning on  
7                   such date; or

8                   “(ii) the date on which such individual  
9                   is no longer a continuing care patient with  
10                  respect to such provider or facility.

11          “(b) DEFINITIONS.—In this section:

12                  “(1) CONTINUING CARE PATIENT.—The term  
13                  ‘continuing care patient’ means an individual who,  
14                  with respect to a provider or facility—

15                          “(A) is undergoing a course of treatment  
16                          for a serious and complex condition from the  
17                          provider or facility;

18                          “(B) is undergoing a course of institu-  
19                          tional or inpatient care from the provider or fa-  
20                          cility;

21                          “(C) is scheduled to undergo nonelective  
22                          surgery from the provider or facility, including  
23                          receipt of postoperative care from such provider  
24                          or facility with respect to such a surgery;

1           “(D) is pregnant and undergoing a course  
2           of treatment for the pregnancy from the pro-  
3           vider or facility; or

4           “(E) is or was determined to be terminally  
5           ill (as determined under section 1861(dd)(3)(A)  
6           of the Social Security Act) and is receiving  
7           treatment for such illness from such provider or  
8           facility.

9           “(2) SERIOUS AND COMPLEX CONDITION.—The  
10          term ‘serious and complex condition’ means, with re-  
11          spect to a participant, beneficiary, or enrollee under  
12          a group health plan—

13                 “(A) in the case of an acute illness, a con-  
14                 dition that is serious enough to require special-  
15                 ized medical treatment to avoid the reasonable  
16                 possibility of death or permanent harm; or

17                 “(B) in the case of a chronic illness or con-  
18                 dition, a condition that—

19                         “(i) is life-threatening, degenerative,  
20                         potentially disabling, or congenital; and

21                         “(ii) requires specialized medical care  
22                         over a prolonged period of time.

23           “(3) TERMINATED.—The term ‘terminated’ in-  
24          cludes, with respect to a contract, the expiration or  
25          nonrenewal of the contract, but does not include a

1 termination of the contract for failure to meet appli-  
2 cable quality standards or for fraud.

3 **“SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON**  
4 **HEALTH INSURANCE MEMBERSHIP CARDS.**

5 “In the case of a group health plan that provides a  
6 physical or electronic card indicating membership in such  
7 plan to an individual enrolled under such plan, such group  
8 health plan shall include on such card each of the fol-  
9 lowing:

10 “(1) The nearest hospital to the primary resi-  
11 dence of such individual that has in effect a contrac-  
12 tual relationship with such plan for furnishing items  
13 and services under such plan.

14 “(2) A telephone number or Internet website  
15 address through which such individual may seek con-  
16 sumer assistance information, such as information  
17 related to hospitals and urgent care facilities that  
18 have in effect a contractual relationship with such  
19 plan for furnishing items and services under such  
20 plan.

21 “(3) Any deductible applicable to such indi-  
22 vidual.

23 “(4) Any out-of-pocket maximum applicable to  
24 such individual.

1           “(5) Any cost-sharing obligation applicable to  
2           such individual for a visit at an emergency depart-  
3           ment, or urgent care facility, that has in effect a  
4           contractual relationship with such plan for fur-  
5           nishing items and services under such plan.

6   **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

7           “In connection with the offering of a group health  
8           plan in a geographic region for a plan year, a plan sponsor  
9           shall employ an individual to offer price comparison guid-  
10          ance, or make available on an Internet website a price  
11          comparison tool, that (to the extent practicable) allows an  
12          individual enrolled under such plan, with respect to such  
13          plan year and such geographic region, to compare the  
14          amount (determined by historic claims data of partici-  
15          pating providers with respect to such plan) of cost-sharing  
16          (including deductibles, copayments, and coinsurance) that  
17          the individual would be responsible for paying under such  
18          plan with respect to the furnishing of a specific item or  
19          service by any such provider.”.

20                 (2)    CONFORMING    AMENDMENT.—Section  
21                 9815(a) of the Internal Revenue Code of 1986, as  
22                 amended by section 2(b), is further amended—

23                         (A) in paragraph (1), by striking “section  
24                         2719A” and inserting “section 2719A, 2730,  
25                         2731, or 2732”; and

1 (B) in paragraph (2), by striking “section  
2 2719A” and inserting “section 2719A, 2730,  
3 2731, or 2732”.

4 (3) CLERICAL AMENDMENT.—The table of sec-  
5 tions for such subchapter, as amended by section  
6 2(b), is further amended by adding at the end the  
7 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.”.

8 (c) EMPLOYEE RETIREMENT INCOME SECURITY  
9 ACT.—

10 (1) IN GENERAL.—Subpart B of part 7 of sub-  
11 title B of title I of the Employee Retirement Income  
12 Security Act of 1974 (29 U.S.C. 1185 et seq.), as  
13 amended by section 2(c), is further amended by add-  
14 ing at the end the following new sections:

15 **“SEC. 717. CONTINUITY OF CARE.**

16 “(a) ENSURING CONTINUITY OF CARE WITH RE-  
17 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL  
18 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER  
19 NETWORK STATUS.—

20 “(1) IN GENERAL.—In the case of an individual  
21 with benefits under a group health plan or health in-  
22 surance coverage offered by a health insurance  
23 issuer in connection with a group health plan and

1 with respect to a health care provider or facility that  
2 has a contractual relationship with such plan or  
3 such issuer (as applicable) for furnishing items and  
4 services under such plan or such coverage, if, while  
5 such individual is a continuing care patient (as de-  
6 fined in subsection (b)) with respect to such provider  
7 or facility—

8 “(A) such contractual relationship is termi-  
9 nated (as defined in paragraph (b));

10 “(B) benefits provided under such plan or  
11 such health insurance coverage with respect to  
12 such provider or facility are terminated because  
13 of a change in the terms of the participation of  
14 the provider or facility in such plan or coverage;  
15 or

16 “(C) a contract between such group health  
17 plan and a health insurance issuer offering  
18 health insurance coverage in connection with  
19 such plan is terminated, resulting in a loss of  
20 benefits provided under such plan with respect  
21 to such provider or facility;

22 the plan or issuer, respectively, shall meet the re-  
23 quirements of paragraph (2) with respect to such in-  
24 dividual.



1           “(2) REQUIREMENTS.—The requirements of  
2 this paragraph are that the plan or issuer—

3           “(A) notify each individual enrolled under  
4 such plan or coverage who is a continuing care  
5 patient with respect to a provider or facility at  
6 the time of a termination described in para-  
7 graph (1) affecting such provider or facility on  
8 a timely basis of such termination and such in-  
9 dividual’s right to elect continued transitional  
10 care from such provider or facility under this  
11 section;

12           “(B) provide such individual with an op-  
13 portunity to notify the plan or issuer of the in-  
14 dividual’s need for transitional care; and

15           “(C) permit the patient to elect to continue  
16 to have benefits provided under such plan or  
17 such coverage, under the same terms and condi-  
18 tions as would have applied and with respect to  
19 such items and services as would have been cov-  
20 ered under such plan or coverage had such ter-  
21 mination not occurred, with respect to the  
22 course of treatment furnished by such provider  
23 or facility relating to such individual’s status as  
24 a continuing care patient during the period be-  
25 ginning on the date on which the notice under

1           subparagraph (A) is provided and ending on the  
2           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 provide 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 or health insurance coverage—

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. 718. INFORMATION REQUIRED TO BE INCLUDED ON**  
2 **HEALTH INSURANCE MEMBERSHIP CARDS.**

3 “In the case of a group health plan or health insur-  
4 ance issuer offering group health insurance coverage that  
5 provides a physical or electronic card indicating member-  
6 ship in such plan or coverage to an individual enrolled  
7 under such plan or coverage, such group health plan or  
8 issuer shall include on such card each of the following:

9 “(1) The nearest hospital to the primary resi-  
10 dence of such individual that has in effect a contrac-  
11 tual relationship with such plan or coverage for fur-  
12 nishing items and services under such plan or cov-  
13 erage.

14 “(2) A telephone number or Internet website  
15 address through which such individual may seek con-  
16 sumer assistance information, such as information  
17 related to hospitals and urgent care facilities that  
18 have in effect a contractual relationship with such  
19 plan or coverage for furnishing items and services  
20 under such plan or coverage.

21 “(3) Any deductible applicable to such indi-  
22 vidual.

23 “(4) Any out-of-pocket maximum applicable to  
24 such individual.

25 “(5) Any cost-sharing obligation applicable to  
26 such individual for a visit at an emergency depart-

1       ment, or urgent care facility, that has in effect a  
2       contractual relationship with such plan or coverage  
3       for furnishing items and services under such plan or  
4       coverage.

5       **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

6       “*In connection with the offering of a group health*  
7 *plan or group health insurance coverage in a geographic*  
8 *region for a plan year, a plan sponsor or health insurance*  
9 *issuer, respectively, shall employ an individual to offer*  
10 *price comparison guidance, or make available on an Inter-*  
11 *net website a price comparison tool, that (to the extent*  
12 *practicable) allows an individual enrolled under such plan*  
13 *or coverage, with respect to such plan year and such geo-*  
14 *graphic region, to compare the amount (determined by*  
15 *historic claims data of participating providers with respect*  
16 *to such plan or coverage) of cost-sharing (including*  
17 *deductibles, copayments, and coinsurance) that the indi-*  
18 *vidual would be responsible for paying under such plan*  
19 *or coverage with respect to the furnishing of a specific*  
20 *item or service by any such provider.”.*

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, or 2732”; and

4 (B) in paragraph (2), by striking “section  
5 2719A” and inserting “section 2719A, 2730,  
6 2731, or 2732”.

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.”.

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. REPORTING REQUIREMENTS REGARDING AIR AM-**  
16 **BULANCE SERVICES.**

17 (a) REPORTING REQUIREMENTS FOR PROVIDERS OF  
18 AIR AMBULANCE SERVICES.—

19 (1) IN GENERAL.—A provider of air ambulance  
20 services shall submit to the Secretary of Health and  
21 Human Services and the Secretary of Transpor-  
22 tation—

1 (A) not later than the date that is 90 days  
2 after the last day of the first plan year begin-  
3 ning on or after the date on which a final rule  
4 is promulgated pursuant to the rulemaking de-  
5 scribed in subsection (d), the information de-  
6 scribed in paragraph (2) with respect to such  
7 plan year; and

8 (B) not later than the date that is 90 days  
9 after the last day of the plan year immediately  
10 succeeding the plan year described in subpara-  
11 graph (A), such information with respect to  
12 such immediately succeeding plan year.

13 (2) INFORMATION DESCRIBED.—For purposes  
14 of paragraph (1), information described in this para-  
15 graph, with respect to a provider of air ambulance  
16 services, is each of the following:

17 (A) Cost data, as determined appropriate  
18 by the Secretary of Health and Human Serv-  
19 ices, in consultation with the Secretary of  
20 Transportation, for air ambulance services fur-  
21 nished by such provider, separated to the max-  
22 imum extent possible by air transportation costs  
23 associated with furnishing such air ambulance  
24 services and costs of medical services and sup-

1           plies associated with furnishing such air ambu-  
2           lance services.

3           (B) The number and location of all air am-  
4           bulance bases operated by such provider.

5           (C) The number and type of aircraft oper-  
6           ated by such provider.

7           (D) The number of air ambulance trans-  
8           ports, disaggregated by payor mix, including  
9           group health plans, health insurance issuers,  
10          and Government payors.

11          (E) The number of claims of such provider  
12          that have been denied payment by a group  
13          health plan or health insurance issuer and the  
14          reasons for any such denials.

15          (F) The number of emergency and non-  
16          emergency air ambulance transports,  
17          disaggregated by air ambulance base and type  
18          of aircraft.

19          (b) REPORTING REQUIREMENTS FOR GROUP  
20          HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

21                 (1) IN GENERAL.—Each group health plan and  
22          health insurance issuer offering health insurance  
23          coverage in the individual or group market shall sub-  
24          mit to the Secretary of Health and Human Serv-  
25          ices—



1 (A) not later than the date that is 90 days  
2 after the last day of the first plan year begin-  
3 ning on or after the date on which a final rule  
4 is promulgated pursuant to the rulemaking de-  
5 scribed in subsection (d), the information de-  
6 scribed in paragraph (2) with respect to such  
7 plan year; and

8 (B) not later than the date that is 90 days  
9 after the last day of the plan year immediately  
10 succeeding the plan year described in subpara-  
11 graph (A), such information with respect to  
12 such immediately succeeding plan year.

13 (2) INFORMATION DESCRIBED.—For purposes  
14 of paragraph (1), information described in this para-  
15 graph, with respect to a group health plan or a  
16 health insurance issuer offering health insurance  
17 coverage in the individual or group market, is each  
18 of the following:

19 (A) Claims data for air ambulance services  
20 furnished by providers of such services,  
21 disaggregated by each of the following factors:

22 (i) Whether such services were fur-  
23 nished on an emergent or nonemergent  
24 basis.

1 (ii) Whether the provider of such serv-  
2 ices is part of a hospital-owned or spon-  
3 sored program, municipality-sponsored pro-  
4 gram, hospital independent partnership  
5 (hybrid) program, or independent program.

6 (iii) Whether such services were fur-  
7 nished in a rural or urban area.

8 (iv) The type of aircraft (such as  
9 rotor transport or fixed wing transport)  
10 used to furnish such services.

11 (v) Whether the provider of such serv-  
12 ices has a contract with the plan or issuer,  
13 as applicable, to furnish such services  
14 under the plan or coverage, respectively.

15 (B) Such other information regarding pro-  
16 viders of air ambulance services as the Sec-  
17 retary of Health and Human Services may  
18 specify.

19 (c) PUBLICATION OF COMPREHENSIVE REPORT.—

20 (1) IN GENERAL.—Not later than the date that  
21 is one year after the date described in subsection  
22 (b)(1)(B), the Secretary of Health and Human Serv-  
23 ices, in consultation with the Secretary of Transpor-  
24 tation (referred to in this section as the “Secre-  
25 taries”), shall develop, and make publicly available

1 (subject to paragraph (3)), a comprehensive report  
2 summarizing the information submitted under sub-  
3 sections (a) and (b) and including each of the fol-  
4 lowing:

5 (A) The percentage of providers of air am-  
6 bulance services that are part of a hospital-  
7 owned or sponsored program, municipality-  
8 sponsored program, hospital-independent part-  
9 nership (hybrid) program, or independent pro-  
10 gram.

11 (B) An assessment of the extent of com-  
12 petition among providers of air ambulance serv-  
13 ices on the basis of price and services offered,  
14 and any changes in such competition over time.

15 (C) An assessment of the average charges  
16 for air ambulance services, amounts paid by  
17 group health plans and health insurance issuers  
18 offering health insurance coverage in the indi-  
19 vidual or group market to providers of air am-  
20 bulance services for furnishing such services,  
21 and amounts paid out-of-pocket by consumers,  
22 and any changes in such amounts paid over  
23 time.

24 (D) An assessment of the presence of air  
25 ambulance bases in, or with the capability to

1           serve, rural areas, and the relative growth in air  
2           ambulance bases in rural and urban areas over  
3           time.

4           (E) Any evidence of gaps in rural access to  
5           providers of air ambulance services.

6           (F) The percentage of providers of air am-  
7           bulance services that have contracts with group  
8           health plans or health insurance issuers offering  
9           health insurance coverage in the individual or  
10          group market to furnish such services under  
11          such plans or coverage, respectively.

12          (G) An assessment of whether there are in-  
13          stances of unfair, deceptive, or predatory prac-  
14          tices by providers of air ambulance services in  
15          collecting payments from patients to whom such  
16          services are furnished, such as referral of such  
17          patients to collections, lawsuits, and liens or  
18          wage garnishment actions.

19          (H) An assessment of whether there are  
20          instances of group health plans or health insur-  
21          ance issuers not providing substantial reasons  
22          for refusing to enter into contract negotiations  
23          with providers of air ambulance services

24          (I) An assessment of whether there are,  
25          within the air ambulance industry, instances of

1 unreasonable industry concentration, excessive  
2 market domination, or other conditions that  
3 would allow at least one provider of air ambu-  
4 lance services to unreasonably increase prices or  
5 exclude competition in air ambulance services in  
6 a given geographic region.

7 (J) An assessment of the frequency of pa-  
8 tient balance billing, patient referrals to collec-  
9 tions, lawsuits to collect balance bills, and liens  
10 or wage garnishment actions by providers of air  
11 ambulance services as part of a collections proc-  
12 ess across hospital-owned or sponsored pro-  
13 grams, municipality-sponsored programs, hos-  
14 pital-independent partnership (hybrid) pro-  
15 grams, or independent programs, providers of  
16 air ambulance services operated by public agen-  
17 cies (such as a State or county health depart-  
18 ment), and other independent providers of air  
19 ambulance services.

20 (K) An assessment of the frequency of  
21 claims appeals made by providers of air ambu-  
22 lance services to group health plans or health  
23 insurance issuers offering health insurance cov-  
24 erage in the individual or group market with re-

1           spect to air ambulance services furnished to en-  
2           rollees of such plans or coverage, respectively.

3           (L) Any other cost, quality, or other data  
4           relating to air ambulance services or the air  
5           ambulance industry, as determined necessary  
6           and appropriate by the Secretaries.

7           (2) OTHER SOURCES OF INFORMATION.—The  
8           Secretaries may incorporate information from inde-  
9           pendent experts or third-party sources in developing  
10          the comprehensive report required under paragraph  
11          (1).

12          (3) PROTECTION OF PROPRIETARY INFORMA-  
13          TION.—The Secretaries may not make publicly avail-  
14          able under this subsection any proprietary informa-  
15          tion.

16          (d) RULEMAKING.—Not later than the date that is  
17          one year after the date of the enactment of this Act, the  
18          Secretary of Health and Human Services, in consultation  
19          with the Secretary of Transportation, shall, through notice  
20          and comment rulemaking, specify the form and manner  
21          in which reports described in subsections (a) and (b) shall  
22          be submitted to such Secretaries, taking into consideration  
23          (as applicable and to the extent feasible) any recommenda-  
24          tions included in the report submitted by the Advisory  
25          Committee on Air Ambulance and Patient Billing under

1 section 418(e) of the FAA Reauthorization Act of 2018  
2 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

3 (e) CIVIL MONEY PENALTIES.—

4 (1) IN GENERAL.—Subject to paragraph (2), a  
5 provider of air ambulance services who fails to sub-  
6 mit all information required under subsection (a)(2)  
7 by the date described in subparagraph (A) or (B) of  
8 subsection (a)(1), as applicable, shall be subject to  
9 a civil money penalty of not more than \$10,000.

10 (2) EXCEPTION.—In the case of a provider of  
11 air ambulance services that submits only some of the  
12 information required under subsection (a)(2) by the  
13 date described in subparagraph (A) or (B) of sub-  
14 section (a)(1), as applicable, the Secretary of Health  
15 and Human Services may waive the civil money pen-  
16 alty imposed under paragraph (1) if such provider  
17 demonstrates a good faith effort in working with the  
18 Secretary to submit the remaining information re-  
19 quired under subsection (a)(2).

20 (3) PROCEDURE.—The provisions of section  
21 1128A of the Social Security Act (42 U.S.C. 1320a–  
22 7a), other than subsections (a) and (b) and the first  
23 sentence of subsection (c)(1), shall apply to civil  
24 money penalties under this subsection in the same

1 manner as such provisions apply to a penalty or pro-  
2 ceeding under such section.

3 (f) UNFAIR AND DECEPTIVE PRACTICES AND UN-  
4 FAIR METHODS OF COMPETITION.—The Secretary of  
5 Transportation may use any information submitted under  
6 subsection (a) in determining whether a provider of air  
7 ambulance services has violated section 41712(a) of title  
8 49, United States Code.

9 (g) UNDERSTANDING AIR AMBULANCE QUALITY AND  
10 PATIENT SAFETY.—Not later than 1 year after the date  
11 of the enactment of this Act, the Comptroller General of  
12 the United States shall conduct a study and submit to  
13 Congress a report on options to establish quality, patient  
14 safety, service reliability, and clinical capability standards  
15 for each clinical capability level of air ambulances. Such  
16 report shall include analysis and recommendations, as ap-  
17 propriate, to Congress regarding each of the following with  
18 respect to air ambulance services:

19 (1) Qualifications of different clinical capability  
20 levels and tiering of such levels.

21 (2) Patient safety and quality standards.

22 (3) Options for improving service reliability  
23 during poor weather, night conditions, or other ad-  
24 verse conditions.



1           (4) Differences between air ambulance vehicle  
2           types, services, and technologies, and other flight ca-  
3           pability standards, and the impact of such dif-  
4           ferences on patient safety.

5           (5) Clinical triage criteria for air ambulances.

6           (h) DEFINITIONS.—In this section, the terms “group  
7           health plan”, “health insurance coverage”, and “health in-  
8           surance issuer” have the meanings given such terms in  
9           section 2791 of the Public Health Service Act (42 U.S.C.  
10          300gg–91).

11       **SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.**

12          Not later than 24 months after the date of the enact-  
13          ment of this Act, the Comptroller General of the United  
14          States shall submit to Congress a report summarizing the  
15          effects of the provisions of this Act, including the amend-  
16          ments made by such provisions, on changes during such  
17          period in health care provider networks of group health  
18          plans and health insurance coverage offered by a health  
19          insurance issuer in the group or individual market, in fee  
20          schedules and amounts for health care services, and to  
21          contracted rates under such plans or coverage. Such re-  
22          port shall—

23               (1) to the extent practicable, sample a statis-  
24               tically significant group of national health care pro-  
25               viders; and

1 (2) examine—

2 (A) provider network participation, includ-  
3 ing nonparticipating providers furnishing items  
4 and services at participating facilities;

5 (B) health care provider group network  
6 participation, including specialty, size, and own-  
7 ership; and

8 (C) the impact of State surprise billing  
9 laws and network adequacy standards on par-  
10 ticipation of health care providers and facilities  
11 in provider networks of group health plans and  
12 of health insurance coverage offered by health  
13 insurance issuers in the group or individual  
14 market.

15 **SEC. 12. TRANSITIONAL RULE ALLOWING DEDUCTION FOR**  
16 **SURPRISE BILLING EXPENSES BELOW AGI**  
17 **FLOOR.**

18 (a) IN GENERAL.—Section 213 of the Internal Rev-  
19 enue Code of 1986 is amended by adding at the end the  
20 following new subsection:

21 “(g) TRANSITIONAL RULE ALLOWING DEDUCTION  
22 FOR SURPRISE BILLING EXPENSES BELOW AGI  
23 FLOOR.—

24 “(1) IN GENERAL.—In addition to the deduc-  
25 tion allowed by subsection (a) for any taxable year,

1       there shall be allowed as a deduction an amount  
2       equal to the lesser of—

3               “(A) the excess of—

4                       “(i) the surprise billing expenses  
5                       which would be allowed as a deduction for  
6                       such taxable year under subsection (a) if  
7                       such subsection were applied without re-  
8                       gard to the limitation based on the tax-  
9                       payer’s adjusted gross income, over

10                      “(ii) \$600, or

11                      “(B) the applicable percentage of the tax-  
12                      payer’s adjusted gross income.

13               “(2) SURPRISE BILLING EXPENSES.—For pur-  
14               poses of this subsection, the term ‘surprise billing  
15               expenses’ means expenses paid for medical care of  
16               an individual who is a participant, beneficiary, or en-  
17               rollee in a group health plan or in group or indi-  
18               vidual health insurance coverage offered by a health  
19               insurance issuer (as such terms are defined in sec-  
20               tion 2791 of the Public Health Service Act), if—

21                      “(A) benefits are provided for such medical  
22                      care under such plan or coverage, and

23                      “(B) such medical care—

24                               “(i) is furnished by a provider without  
25                               a contractual relationship with such plan

1 or coverage with respect to the furnishing  
2 of such medical care during a visit at a fa-  
3 cility with a contractual relationship with  
4 such plan or coverage, or

5 “(ii) is furnished in an emergency de-  
6 partment of a hospital or an independent  
7 freestanding emergency department.

8 “(3) APPLICABLE PERCENTAGE.—For purposes  
9 of this section, the term ‘applicable percentage’  
10 means, with respect to any taxpayer for any taxable  
11 year, the percentage in effect under subsection (a)  
12 with respect to such taxpayer for such taxable year.

13 “(4) LIMITATIONS.—Surprise billing expenses  
14 shall be taken into account under paragraph (1) only  
15 if such expenses are paid during the period begin-  
16 ning on January 1, 2020, and ending on the date  
17 which is 1 year after the day before the date speci-  
18 fied in section 2(a)(5) of the Consumer Protections  
19 Against Surprise Medical Bills Act of 2020.”.

20 (b) CONFORMING AMENDMENTS.—Sections 105(f),  
21 162(l)(3), and 7702B(e)(2) of such Code are each amend-  
22 ed by striking “213(a)” and inserting “213”.

1           (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years ending after De-  
3 cember 31, 2019.

