[DISCUSSION DRAFT]

SEC. ___. .

DIVISION _____

SEC. 1. TABLE OF CONTENTS.

The table of contents of the file is as follows: [temporary]

TITLE I—NO SURPRISES ACT

SEC. 101. SHORT TITLE.

This title may be cited as the ''No Surprises Act''.

SEC. 102. HEALTH INSURANCE REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING.

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

"PART D—ADDITIONAL COVERAGE PROVISIONS

"SEC. 2799A–1. PREVENTING SURPRISE MEDICAL BILLS.

"(a) COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

"(A) without the need for any prior authorization determination;

"(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

"(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

"(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

"(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

"(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in para-

graph (3)(H)) for such services, plan or coverage, and year;

''(iv) the group health plan or health insurance issuer, respectively, pays directly to such provider or facility, respectively (in a time and manner that ensures such provider or facility can comply with section 2799B–10 and, if applicable, in accordance with the timing requirement described in subsection (c)(6)) the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

''(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with re-

spect to emergency services furnished by a participating provider or a participating emergency facility; and

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

''(2) AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary

or applicable State authority to ensure that—

''(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

''(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

''(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

''(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage; and

''(II) may audit any group health plan or health insurance issuer offering group or individual health insurance coverage if the Secretary has received any complaint about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

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

''(B) RULEMAKING.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking—

''(i) the methodology the group health plan or health insurance issuer offering group or individual health insurance coverage shall use to determine the qualifying payment amount, differentiating by indi-

vidual market, large group market, and small group market;

''(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

''(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332; and

''(iv) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering group or individual health insurance coverage.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher

acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

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

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

''(B) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a

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

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as

applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799B–1, in the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items

and services described in clause (i), items and services—

"(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

"(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

"(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services

described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

"(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

"(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799B–2(d) with respect to such items and services.

"(cc) Such an individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

''(dd) Such other conditions, as specified by the Secretary, such as conditions relating coordinating care transitions to participating providers and facilities.

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent freestanding emergency department' means a health care facility that—

''(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

''(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

''(E) QUALIFYING PAYMENT AMOUNT.—

''(i) IN GENERAL.—The term 'qualifying payment amount' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group or individual health insurance coverage—

''(I) for an item or service furnished during 2022, the median of the

contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city aver-

age) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'qualifying payment amount' means, with respect to a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

''(I) for the first year in which such group health plan, group health

insurance coverage, or individual health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan or coverage and furnished during such first year; and

''(II) for each subsequent year such group health plan, group health insurance coverage, or individual health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering

group or individual health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'qualifying payment amount'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively,

through use of any database that is determined, in accordance with rule-making described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subse-

quent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

"(iv) INSURANCE MARKET.—For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

"(I) The individual market.

"(II) The large group market (other than plans described in subclause (IV)).

"(III) The small group market (other than plans described in subclause (IV)).

"(IV) In the case of a self-insured group health plan, other self-insured group health plans.

"(v) DEFINITIONS.—For purposes of this subparagraph:

"(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance

issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

''(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

''(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which the sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous

to such first subsequent year; and

''(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

''(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to a group health plan or group or individual health insurance issuer offering health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relation-

ship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health in-

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

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer—

''(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

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

that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or

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

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

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

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

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

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

''(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

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

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

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

''(L) COST-SHARING.—The term 'cost-sharing' includes copayments, coinsurance, and deductibles.

''(b) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group or individual health insurance coverage furnished to a participant, beneficiary, or enrollee of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799B–2(d)) with respect to a

visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

''(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

''(C) shall pay directly, in accordance with timing consistent with the requirements under section 2799B–10 and, if applicable, in accordance with the timing requirement described in subsection (c)(6), to such provider furnishing

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

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group

health plan or health insurance issuer offering group or individual health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or group or individual health insurance coverage, is each of the following:

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act).

''(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act.

''(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

''(c) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering group or individual health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.''.

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

"SEC. 2799A–7. OTHER PATIENT PROTECTIONS.

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

"(b) ACCESS TO PEDIATRIC CARE.—

"(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such pro-

vider participates in the network of the plan or issuer.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

''(c) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authoriza-

tion and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

''(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or health insurance coverage that—

''(A) provides coverage for obstetric or gynecologic care; and

''(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

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

''(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.''.

(3) CONFORMING AMENDMENTS.—

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

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

(B) Section 2722 of the Public Health Service Act (42 U.S.C. 300gg–21) is amended—

(i) in subsection (a)(1), by inserting ''and part D'' after ''subparts 1 and 2'';

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

(iii) in subsection (c)(1), by inserting ''and part D'' after ''subparts 1 and 2'';

(iv) in subsection (c)(2), by inserting ''and part D'' after ''subparts 1 and 2'';

(v) in subsection (c)(3), by inserting ''and part D'' after ''this part''; and

(vi) in subsection (d), in the matter preceding paragraph (1), by inserting ''and part D'' after ''this part''.

(C) Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended—

(i) in subsection (a)(1), by inserting ''and part D'' after ''this part'';

(ii) in subsection (a)(2), by inserting ''or part D'' after ''this part'';

(iii) in subsection (b)(1), by inserting ''or part D'' after ''this part'';

(iv) in subsection (b)(2)(A), by inserting ''or part D'' after ''this part''; and

(v) in subsection (b)(2)(C)(ii), by inserting ''and part D'' after ''this part''.

(D) Section 2724 of the Public Health Service Act (42 U.S.C. 300gg–23) is amended—

(i) in subsection (a)(1)—

(I) by striking ''this part and part C insofar as it relates to this part'' and inserting ''this part, part D, and part C insofar as it relates to this part or part D''; and

(II) by inserting ''or part D'' after ''requirement of this part'';

(ii) in subsection (a)(2), by inserting ''or part D'' after ''this part''; and

(iii) in subsection (c), by inserting ''or part D'' after ''this part (other than section 2704)''.

(b) ERISA AMENDMENTS.—

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

''SEC. 716. PREVENTING SURPRISE MEDICAL BILLS.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group health in-

surance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

''(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with re-

spect to such plan or coverage, respectively;

''(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

''(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

''(iv) the group health plan or health insurance issuer, respectively, pays directly to such provider or facility, respectively (in a time and manner that ensures such provider or facility can comply with section 2799B–10 of the Public Health Service Act and, if applicable, in accordance with the timing requirement described in subsection (c)(6)) the amount by which the out-of-network rate (as defined in para-

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

''(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of this Act and section 9815 of the Internal Revenue Code

of 1986, and other than applicable cost-sharing).

''(2) REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall establish through rulemaking—

''(A) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the qualifying payment amount, differentiating by large group market, and small group market;

''(B) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

''(C) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

''(D) a process to receive complaints of violations of the requirements described in sub-

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

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

''(3) DEFINITIONS.—In this subpart:

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient depart-

ment that provides emergency services (as defined in subparagraph (C)(i)).

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

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hos-

pital or of an independent free-standing emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent free-standing emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799B–1 of the Public Health Service Act, in

the case of a participant, beneficiary, or enrollee who is in a group health plan or group health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

''(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

''(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant, beneficiary, or enrollee is stabilized and as

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

''(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

''(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

''(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section

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

''(cc) Such an individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

''(dd) Such other conditions, as specified by the Secretary, such as conditions relating coordinating care transitions to participating providers and facilities.

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent freestanding emergency department' means a health care facility that—

''(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

''(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

''(E) QUALIFYING PAYMENT AMOUNT.—

''(i) IN GENERAL.—The term 'qualifying payment amount' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group health insurance coverage—

''(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans

or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'qualifying payment amount' means, with respect to a sponsor of a group health plan or health insurance issuer offering group health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

''(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

''(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, in-

creased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'qualifying payment amount'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this

subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the

first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

''(iv) INSURANCE MARKET.—For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

''(I) The large group market (other than plans described in subclause (III)).

''(II) The small group market (other than plans described in subclause (III)).

''(III) In the case of a self-insured group health plan, other self-insured group health plans.

"(v) DEFINITIONS.—For purposes of this subparagraph:

"(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

"(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer—

"(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019,

the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

''(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

''(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to a group health plan or health insurance issuer offering group health insurance coverage, an item or service for which coverage was not offered in

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

"(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

"(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

"(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency

department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group

health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer—

''(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

''(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)) for such item or service; or

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer, a State law that provides for

a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 514) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or emergency facility.

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

''(K) OUT-OF-NETWORK RATE.—The term 'out-of-network rate' means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan or group health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or facility—

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

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

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

''(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

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

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

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

''(L) COST-SHARING.—The term 'cost-sharing' includes copayments, coinsurance, and deductibles.

''(b) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group health insurance coverage furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 2799B–2(d) of the Public Health Service Act) with

respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

''(A) shall not impose on such participant or beneficiary a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

''(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

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

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

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with re-

spect to an item or service and a group health plan or health insurance issuer offering group health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group health plan or group health insurance coverage, is each of the following:

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act).

''(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act.

''(V) Any other facility, specified by the Secretary, that provides items

or services for which coverage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

''(c) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.''.

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

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

"SEC. 722. OTHER PATIENT PROTECTIONS.

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

''(b) ACCESS TO PEDIATRIC CARE.—

''(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or group health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

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

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

''(c) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

ance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

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

''(A) provides coverage for obstetric or gynecologic care; and

''(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

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

''(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.''.

(3) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following:

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

(c) IRC AMENDMENTS.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9816. PREVENTING SURPRISE MEDICAL BILLS.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan shall cover emergency services (as defined in paragraph (3)(C))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

''(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan;

''(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

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

by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan, and year;

''(iv) the group health plan pays directly to such provider or facility, respectively (in a time and manner that ensures such provider or facility can comply with section 2799B–10 of the Public Health Service Act and, if applicable, in accordance with the timing requirement described in subsection (c)(6)) the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

''(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible and out-of-pocket maxi-

mums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of the Public Health Service Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of this Act, and other than applicable cost-sharing).

''(2) AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Labor, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans are au-

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

''(I) such plans are in compliance with the requirement of applying a qualifying payment amount under this section; and

''(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan described in clause (ii) of such paragraph (3)(E).

''(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

''(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans; and

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

erage, respectively, that involves the compliance of the plan with either of the requirements described in subclauses (I) and (II) of such clause.

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

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

''(i) the methodology the group health plan shall use to determine the qualifying payment amount, differentiating by large group market and small group market;

''(ii) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

''(iii) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 332 of the Public Health Service Act; and

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

Such rulemaking shall take into account payments that are made by such plan that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appro-

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

''(3) DEFINITIONS.—In this subchapter:

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

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

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (re-

gardless of the department of the hospital in which such further examination or treatment is furnished).

''(ii) INCLUSION OF ADDITIONAL SERVICES.—

''(I) IN GENERAL.—For purposes of this subsection and section 2799B–1 of the Public Health Service Act, in the case of a participant, beneficiary, or enrollee in a group health plan who is furnished services described in clause (i) with respect to an emergency medical condition, the term 'emergency services' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

''(aa) for which benefits are provided or covered under the plan; and

''(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department

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

''(II) CONDITIONS.—For purposes of subclause (I), the conditions described in this subclause, with respect to a participant, beneficiary, or enrollee who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

''(aa) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

''(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 2799B–2(d) with respect to such items and services.

''(cc) Such an individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 2799B–2 and to provide informed consent under such section, in accordance with applicable State law.

''(dd) Such other conditions, as specified by the Secretary, such as conditions relating coordinating care transitions to participating providers and facilities.

''(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'inde-

pendent freestanding emergency department' means a health care facility that—

''(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

''(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

''(E) QUALIFYING PAYMENT AMOUNT.—

''(i) IN GENERAL.—The term 'qualifying payment amount' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan—

''(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan (determined with respect to all such plans of such sponsor that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan)

under such plans on January 31, 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

''(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) NEW PLANS AND COVERAGE.—The term 'qualifying payment amount' means, with respect to a sponsor of a group health plan in a geographic region in which such sponsor, respectively, did not offer any group health plan or health insurance coverage during 2019—

''(I) for the first year in which such group health plan is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

''(II) for each subsequent year such group health plan is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(iii) INSUFFICIENT INFORMATION; NEWLY COVERED ITEMS AND SERVICES.—In the case of a sponsor of a group health plan that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term 'qualifying payment amount'—

''(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan), means such rate for such item or service determined by the sponsor

through use of any database that is determined, in accordance with rule-making described in paragraph (2)(B), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

''(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to 'furnished during 2022' shall be treated as a reference to furnished during such first sufficient information year, the reference to 'on January 31, 2019' shall be treated as a reference to in such sufficient information year, and the increase described in such clause shall not be applied; and

''(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to 'furnished during 2023 or a subsequent year'

shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

''(iv) INSURANCE MARKET.—For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

''(I) The large group market (other than plans described in subclause (III)).

''(II) The small group market (other than plans described in subclause (III)).

''(III) In the case of a self-insured group health plan, other self-insured group health plans.

''(v) DEFINITIONS.—For purposes of this subparagraph:

''(I) FIRST COVERAGE YEAR.—The term 'first coverage year' means, with respect to a group health plan and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year

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

''(II) FIRST SUFFICIENT INFORMATION YEAR.—The term 'first sufficient information year' means, with respect to a group health plan—

''(aa) in the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

''(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan for which the sponsor has sufficient

information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

"(III) NEWLY COVERED ITEM OR SERVICE.—The term 'newly covered item or service' means, with respect to a group health plan, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

"(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

"(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the

plan for furnishing such item or service under the plan.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a group health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan, with respect to the furnishing of such an item or service at such facility.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan—

''(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

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

that does not have in effect a specified State law, with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E)) for such year and determined in accordance with rulemaking described in paragraph (2)(B)) for such item or service; or

''(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that the State approves under such system for such item or service so furnished.

''(I) SPECIFIED STATE LAW.—The term 'specified State law' means, with respect to a State, an item or service furnished by a nonparticipating provider or emergency facility during a year and a group health plan, a State law that provides for a method for determining the total amount payable under such a plan (to the extent such State law applies to such plan, subject to section 514) in the case of a participant or beneficiary covered under such plan and re-

ceiving such item or service from such a nonparticipating provider or emergency facility.

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

''(K) OUT-OF-NETWORK RATE.—The term 'out-of-network rate' means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a group health plan receiving such item or service from a nonparticipating provider or facility—

''(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan; such a nonparticipating provider or emergency facility; and such an item or service, the amount determined in accordance with such law;

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

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

''(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

''(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified independent entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

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

such system for such item or service so furnished.

''(L) COST-SHARING.—The term 'cost-sharing' includes copayments, coinsurance, and deductibles.

''(b) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

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

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

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

''(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan, and year;

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

''(D) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this section:

''(A) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a group health plan, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan, with respect to the furnishing of such an item or service at the facility.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause, with respect to a group

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

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

''(II) A hospital outpatient department.

''(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act).

''(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act.

''(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

''(B) VISIT.—The term 'visit' shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, re-

gardless of whether or not the provider furnishing such items or services is at the facility.

''(c) CERTAIN ACCESS FEES TO CERTAIN DATABASES.—In the case of a sponsor of a group health plan that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor shall cover the cost for access to such database.''.

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

''SEC. 9822. OTHER PATIENT PROTECTIONS.

''(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

''(b) ACCESS TO PEDIATRIC CARE.—

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

enrollee under a group health plan if the plan requires or provides for the designation of a participating primary care provider for the child, the plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of pediatric care.

''(c) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) GENERAL RIGHTS.—

''(A) DIRECT ACCESS.—A group health plan described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's policies

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

''(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

''(2) APPLICATION OF PARAGRAPH.—A group health plan described in this paragraph is a group health plan that—

''(A) provides coverage for obstetric or gynecologic care; and

''(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

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

''(A) waive any exclusions of coverage under the terms and conditions of the plan with respect to coverage of obstetrical or gynecological care; or

''(B) preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.''.

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

''Sec. 9815. Additional market reforms.
''Sec. 9816. Preventing surprise medical bills.
''Sec. 9822. Other patient protections.''.

(d) ADDITIONAL APPLICATION PROVISIONS.—

(1) APPLICATION TO FEHB.—

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

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

Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections. The provisions of sections 2799B–1, 2799B–2, 2799B–3, 2799B–5, and 2799B–11 of the Public Health Service Act shall apply to a health care provider and facility and an air ambulance provider described in such respective sections with respect to an enrollee in a health benefits plan under this chapter in the same manner as such provisions apply to such a provider and facility with respect to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer, as described in such sections.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply with respect to contracts entered into or renewed for contract years beginning on or after January 1, 2022.

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

''(5) APPLICATION OF ADDITIONAL PROVISIONS.—Sections 2799A–1, 2799A–2, and 2799A–7

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

(3) RULE OF CONSTRUCTION.—Nothing in this title, including the amendments made by this title may be construed as modifying, reducing, or eliminating—

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

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

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

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

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

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during

the 30-day period beginning on the day the provider or facility receives a response from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the pro-

vider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

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

subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR item or service'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to

such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

''(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF ITEMS AND SERVICES.—

''(A) IN GENERAL.—Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and

services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the mediated dispute process. Such items and services may be so considered only if—

''(i) such items and services to be included in such determination are furnished by the same provider or facility;

''(ii) payment for such items and services is required to be made by the same health plan;

''(iii) are related to the treatment of a similar condition; and

''(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

''(B) TREATMENT OF BUNDLED PAYMENTS.—In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

''(4) CERTIFICATION AND SELECTION OF IDR ENTITIES.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified—

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

''(ii) is not—

''(I) a group health plan or health insurance issuer offering group

or individual health insurance coverage, provider, or facility;

''(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

''(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

''(iii) carries out the responsibilities of such an entity in accordance with this subsection;

''(iv) meets appropriate indicators of fiscal integrity;

''(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

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

subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

''(vii) meets such other requirements as determined appropriate by the Secretary.

''(B) PERIOD OF CERTIFICATION.—Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

''(C) REVOCATION.—A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

''(D) PETITION FOR DENIAL OR WITHDRAWAL.—The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group or individual health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this

paragraph for failure of meeting a requirement of this subsection.

''(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

''(F) SELECTION OF CERTIFIED IDR ENTITY.—The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method—

''(i) that allows for the group health plan or health insurance issuer offering group or individual health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such deter-

mination, an entity certified under this paragraph that—

''(I) is not a party to such determination or an employee or agent of such a party;

''(II) does not have a material familial, financial, or professional relationship with such a party; and

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

''(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation—

''(I) select such an entity that satisfies subclauses (I) through (III) of item (i)); and

''(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to a qualified IDR item or service, the certified independent entity with respect to a determination under this subsection for such item or service shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

''(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

"(C) CONSIDERATIONS IN DETERMINATION.—

"(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

"(I) the offers under subparagraph (B)(i);

"(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

"(III) information on any circumstance described in clause (ii), such information requested in subparagraph (B)(i)(II), and any addi-

tional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group or individual health insurance coverage the following:

''(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

''(II) The market share held by the out-of-network health care provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

"(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

"(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

"(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

"(D) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges or the

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

''(E) EFFECTS OF DETERMINATION.—

''(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A)—

''(I) shall be binding; and

''(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

''(ii) SUSPENSION OF CERTAIN SUBSEQUENT IDR REQUESTS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period fol-

lowing such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

''(iii) SUBSEQUENT SUBMISSION OF REQUESTS PERMITTED.—In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 2-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

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

clause (ii), the Secretary shall examine the impact of the application of such clause and whether the application of such clause delays payment determinations, impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress a report on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

''(F) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage and submitted to a certified IDR entity—

''(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

''(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

''(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

''(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

''(A) PUBLICATION OF INFORMATION.—For each calendar quarter in 2022 and each

calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services—

''(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

''(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

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

''(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

''(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

''(vi) the amount of expenditures made by the Secretary during such cal-

endar quarter to carry out the IDR process;

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

''(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

''(B) INFORMATION.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group or individual health insurance coverage—

''(i) a description of each item and service included with respect to such notification;

''(ii) the geography in which the items and services with respect to such notification were provided;

''(iii) the amount of the offer submitted under paragraph (5)(B) by the

group health plan or health insurance issuer (as applicable) and by the non-participating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

''(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

''(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

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

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with re-

spect to such determination in an amount described in subparagraph (B) for such year.

''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.''.

(b) ERISA.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 102, is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives a response from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the

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

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such infor-

mation as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR item or service'), a certified IDR entity under paragraph (4) determines, subject to sub-

paragraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

"(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect to such item or service pursuant to subsection (b) of such section.

"(3) TREATMENT OF BATCHING OF ITEMS AND SERVICES.—

"(A) IN GENERAL.—Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the mediated dispute process. Such items and services may be so considered only if—

"(i) such items and services to be included in such determination are furnished by the same provider or facility;

"(ii) payment for such items and services is required to be made by the same health plan;

"(iii) are related to the treatment of a similar condition; and

"(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

"(B) TREATMENT OF BUNDLED PAYMENTS.—In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

"(4) CERTIFICATION AND SELECTION OF IDR ENTITIES.—

"(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and Sec-

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

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

''(ii) is not—

''(I) a group health plan or health insurance issuer offering group health insurance coverage, provider, or facility;

''(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

''(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

''(iii) carries out the responsibilities of such an entity in accordance with this subsection;

''(iv) meets appropriate indicators of fiscal integrity;

''(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

''(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

''(vii) meets such other requirements as determined appropriate by the Secretary.

''(B) PERIOD OF CERTIFICATION.—Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

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

under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

''(D) PETITION FOR DENIAL OR WITHDRAWAL.—The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

''(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

''(F) SELECTION OF CERTIFIED IDR ENTITY.—The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method—

''(i) that allows for the group health plan or health insurance issuer offering group health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that—

''(I) is not a party to such determination or an employee or agent of such a party;

''(II) does not have a material familial, financial, or professional relationship with such a party; and

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

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

business days after such date of initiation—

''(I) select such an entity that satisfies subclauses (I) through (III) of item (i)); and

''(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to a qualified IDR item or service, the certified independent entity with respect to a determination under this subsection for such item or service shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for

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

''(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

''(C) CONSIDERATIONS IN DETERMINATION.—

''(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

''(I) the offers under subparagraph (B)(i);

''(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same

geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

''(III) information on any circumstance described in clause (ii), such information requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group health insurance coverage the following:

''(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the con-

sensus-based entity authorized in section 1890 of the Social Security Act).

''(II) The market share held by the out-of-network health care provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

''(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

''(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

''(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan

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

''(D) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges or the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799B–1 or 2799B–2 (as applicable) not applied.

''(E) EFFECTS OF DETERMINATION.—

''(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A)—

''(I) shall be binding; and

''(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

''(ii) SUSPENSION OF CERTAIN SUBSEQUENT IDR REQUESTS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

''(iii) SUBSEQUENT SUBMISSION OF REQUESTS PERMITTED.—In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notifica-

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

''(iv) REPORT.—Not later than 4 years after the date of implementation of clause (ii), the Secretary shall examine the impact of the application of such clause and whether the application of such clause delays payment determinations, impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress a report on whether any group health plans or health insurance issuers offering group health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including

recommendations on ways to discourage such a pattern or practice.

''(F) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group health insurance coverage and submitted to a certified IDR entity—

''(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

''(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

''(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with

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

''(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

''(A) PUBLICATION OF INFORMATION.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services—

''(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

''(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

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

''(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

''(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

''(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

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

''(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

''(B) INFORMATION.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency fa-

cility, group health plan, or health insurance issuer offering group health insurance coverage—

''(i) a description of each item and service included with respect to such notification;

''(ii) the geography in which the items and services with respect to such notification were provided;

''(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

''(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

''(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

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

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insur-

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

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.''.

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

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan, in a State described in subsection (a)(3)(K)(ii) with respect to such plan and provider or facility, and for which a payment is required to be made by the plan pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan may, during the 30-day period beginning on the day the provider or facility receives a response from the plan regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such

provider or facility and plan for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or

service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan submits a notification

under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR item or service'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan for such item or service furnished by such provider or facility.

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of

the entity selected with respect to such determination.

''(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF ITEMS AND SERVICES.—

''(A) IN GENERAL.—Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the mediated dispute process. Such items and services may be so considered only if—

''(i) such items and services to be included in such determination are furnished by the same provider or facility;

''(ii) payment for such items and services is required to be made by the same health plan;

''(iii) are related to the treatment of a similar condition; and

''(iv) such items and services were furnished during the 30 day period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

''(B) TREATMENT OF BUNDLED PAYMENTS.—In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

''(4) CERTIFICATION AND SELECTION OF IDR ENTITIES.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified—

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

''(ii) is not—

''(I) a group health plan, provider, or facility;

''(II) an affiliate or a subsidiary of such a group health plan, provider, or facility; or

''(III) an affiliate or subsidiary of a professional or trade association of such group health plans or of providers or facilities;

''(iii) carries out the responsibilities of such an entity in accordance with this subsection;

''(iv) meets appropriate indicators of fiscal integrity;

''(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

''(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

''(vii) meets such other requirements as determined appropriate by the Secretary.

''(B) PERIOD OF CERTIFICATION.—Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

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

under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

''(D) PETITION FOR DENIAL OR WITHDRAWAL.—The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

''(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

''(F) SELECTION OF CERTIFIED IDR ENTITY.—The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method—

''(i) that allows for the group health plan and the nonparticipating provider or

the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that—

''(I) is not a party to such determination or an employee or agent of such a party;

''(II) does not have a material familial, financial, or professional relationship with such a party; and

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

''(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation—

''(I) select such an entity that satisfies subclauses (I) through (III) of item (i)); and

''(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to a qualified IDR item or service, the certified independent entity with respect to a determination under this subsection for such item or service shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this

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

''(ii) notify the provider or facility and the group health plan party to such determination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certifed IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such

offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

"(C) CONSIDERATIONS IN DETERMINATION.—

"(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

"(I) the offers under subparagraph (B)(i);

"(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

"(III) information on any circumstance described in clause (ii),

such information requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, or group health plan, the following:

''(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

''(II) The market share held by the out-of-network health care provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

''(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

''(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

''(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

''(D) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges or the

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

''(E) EFFECTS OF DETERMINATION.—

''(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A)—

''(I) shall be binding; and

''(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

''(ii) SUSPENSION OF CERTAIN SUBSEQUENT IDR REQUESTS.—In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period fol-

lowing such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

''(iii) SUBSEQUENT SUBMISSION OF REQUESTS PERMITTED.—In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 2-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

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

clause (ii), the Secretary shall examine the impact of the application of such clause and whether the application of such clause delays payment determinations, impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress a report on whether any group health plans or types of such plans have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

''(F) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, or group health plan and submitted to a certified IDR entity—

''(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall

be responsible for paying all fees charged by such entity; and

''(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

''(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

''(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

''(A) PUBLICATION OF INFORMATION.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Health and Human Services—

''(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

''(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

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

''(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

''(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

''(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

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

"(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

"(B) INFORMATION.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, or group health plan—

"(i) a description of each item and service included with respect to such notification;

"(ii) the geography in which the items and services with respect to such notification were provided;

"(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as

a percentage of the qualifying payment amount;

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

''(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

''(vi) the identity of the group health plan, provider, or facility, with respect to the notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

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

"(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

"(8) ADMINISTRATIVE FEE.—

"(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

"(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a man-

ner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.''.

SEC. 104. HEALTH CARE PROVIDER REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by inserting after part D, as added by section 102, the following:

''PART E—HEALTH CARE PROVIDER REQUIREMENTS

''SEC. 2799B–1. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022,

emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

''(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not hold the participant, beneficiary, or enrollee liable for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for such services (as determined in accordance with clauses (ii) and (iii) of section 2799A–1(a)(1)(C), of section 9816(a)(1)(C) of the Internal Revenue Code of 1986, and of section 716(a)(1)(C) of the Employee Retirement Income Security Act of 1974, as applicable); and

''(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical

condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing requirement for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2799A–1(a)(1)(C), of section 9816(a)(1)(C) of the Internal Revenue Code of 1986, and of section 716(a)(1)(C) of the Employee Retirement Income Security Act of 1974, as applicable).

''(b) DEFINITION.—In this section, the term 'visit' shall have such meaning as applied to such term for purposes of section 2799A–1(b).

"SEC. 2799B–2. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 2799B–1 applies) for which benefits are provided under the plan or coverage

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

''(b) EXCEPTION.—

''(1) IN GENERAL.—Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (d).

''(2) ANCILLARY SERVICES DESCRIBED.—For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

''(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or nonphysician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

''(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

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

''(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

''(3) EXCEPTION.—The Secretary may, through rulemaking, establish a list (and update such list periodically) of advanced diagnostic laboratory tests, which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

''(c) CLARIFICATION.—In the case of a nonparticipating provider that satisfies the notice and consent cri-

teria of subsection (d) with respect to an item or service (referred to in this subsection as a 'covered item or service'), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

''(d) NOTICE AND CONSENT TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—

''(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

''(A) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 72

hours prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior to the date on which the individual is furnished such items or services (or, in the case that the participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant, beneficiary, or enrollee, (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

''(i) contains the information required under paragraph (2);

''(ii) clearly states that consent to receive such items and services from such

nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and

''(iii) is available in the 15 most common languages in the geographic region of the applicable facility;

''(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility; and

''(C) provides a signed copy of such consent to the participant, beneficiary, or enrollee

through mail or email (as selected by the participant, beneficiary, or enrollee).

''(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(i), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, is each of the following:

''(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

''(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

''(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

''(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

''(3) CONSENT DESCRIBED TO BE TREATED BY A NONPARTICIPATING PROVIDER OR NONPARTICIPATING FACILITY.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary, in consultation with the Secretary of Labor, through guidance that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that —

''(A) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—

''(i) provided with the written notice under paragraph (1)(A);

''(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

''(iii) provided the opportunity to receive the written notice under paragraph (1)(A) in the form selected by the participant, beneficiary or enrollee; and

''(B) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (1)(A) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility.

''(4) RULE OF CONSTRUCTION.—The consent described in paragraph (3), with respect to a partici-

pant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

''(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(A)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 7-year period after the date on which such item or service is so furnished.

''(f) DEFINITIONS.—In this section:

''(1) The terms 'nonparticipating provider' and 'participating provider' have the meanings given

such terms, respectively, in subsection (a)(3) of section 2799A–1.

''(2) The term 'participating health care facility' has the meaning given such term in subsection (b)(2) of section 2799A–1.

''(3) The term 'nonparticipating facility' means—

''(A) with respect to emergency services (as defined in section 2799A–1(a)(3)(C)(i)) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

''(B) with respect to services described in section 2799A–1(a)(3)(C)(ii) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or

issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

''(4) The term 'participating facility' means—

''(A) with respect to emergency services (as defined in clause (i) of section 2799A–1(a)(3)(C)) that are not described in clause(ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

''(B) with respect to services that pursuant to clause (ii) of section 2799A–1(a)(3)(C), of section 9816(a)(3) of the Internal Revenue Code of 1986, and of section 716(a)(3) of the Employee Retirement Income Security Act of 1974, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health

insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

"SEC. 2799B–3. PROVIDER REQUIREMENTS WITH RESPECT TO DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.

''Beginning not later than January 1, 2022, each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer a one-page notice (either postal or electronic mail, as specified by the participant, beneficiary, or enrollee) containing information on—

''(1) the requirements and prohibitions of such provider or facility under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(2) any other applicable State law requirements on such provider or facility regarding the

amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

''SEC. 2799B–4. ENFORCEMENT.

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements (including as applied through section 2799B–11) of this part or, in the case of air ambu-

lance providers, section 2799B–5 to satisfy such requirements applicable to the provider or facility.

''(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements to which paragraph (1) applies with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

''(3) NOTIFICATION OF APPLICABLE SECRETARY.—A State may notify the Secretary of Labor, Secretary of Health and Human Services, or the Secretary of the Treasury, as applicable, of instances of violations of sections 2799A–1, 2799A–2, or 2799A–5 with respect to participants, beneficiaries, or enrollees under a group health plan or group or individual health insurance coverage, as applicable offered by a health insurance issuer and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

''(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—If a provider or facility is found by the Secretary to be in violation of a requirement to which subsection (a)(1) applies, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

''(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

''(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and provide a response to such complaints within 60 days of receipt of such complaints.

''(4) EXCEPTION.—The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, section 2799B–1, 2799B–2, or 2799B–10 (or, in the case of a provider of air ambulance services, section 2799B–5) (including as such respective section is applied through section 2799B–11) with respect to a participant, beneficiary, or enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

''(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

''(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such require-

ment or prohibition prevents the application of a requirement or prohibition of such a section.''.

(b) SECRETARY OF LABOR ENFORCEMENT.—

(1) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

''SEC. 522. COORDINATION OF ENFORCEMENT REGARDING VIOLATIONS OF CERTAIN HEALTH CARE PROVIDER REQUIREMENTS; COMPLAINT PROCESS.

''(a) INVESTIGATING VIOLATIONS.—Upon receiving a notice from a State or the Secretary of Health and Human Services of violations of sections 2799A–1 or 2799A–2 of the Public Health Service Act, the Secretary of Labor shall identify patterns of such violations with respect to participants or beneficiaries under a group health plan or group health insurance coverage offered by a health insurance issuer and conduct an investigation pursuant to section 504 where appropriate, as determined by the Secretary. The Secretary shall coordinate with States and the Secretary of Health and Human Services, in accordance with section 506 and with section 104 of Health Insurance Portability and Accountability Act of 1996, where appropriate, as determined by the Secretary, to ensure that ap-

propriate measures have been taken to correct such violations retrospectively and prospectively with respect to participants or beneficiaries under a group health plan or group health insurance coverage offered by a health insurance issuer.

''(b) COMPLAINT PROCESS.— Not later than January 1, 2022, the Secretary shall ensure a process under which the Secretary—

''(1) may receive complaints from participants and beneficiaries of group health plans or group health insurance coverage offered by a health insurance issuer relating to alleged violations of the sections specified in subsection (a); and

''(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.''.

(2) TECHNICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 521 the following new item:

''Sec. 522. Coordination of enforcement regarding violations of certain health care provider requirements; complaint process.''.

SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS.

(a) GROUP HEALTH PLANS AND INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.—

(1) PHSA AMENDMENTS.—Part D of title XXVII of the Public Health Service Act, as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A–1 the following:

"SEC. 2799A–2. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee who is in a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the plan or coverage shall pay, in accordance with, if applicable, subsection (b)(5)(F), directly to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the out-of-network rate (as defined in section 2799A–1(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

''(b) DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, in a State described in subsection section 2799A–1(a)(3)(K)(ii) with respect to such plan or coverage and provider, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives a response from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group or individual health insurance coverage that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant

to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group or individual health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 2799A–1(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

"(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 with respect

to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 2799A–1(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 2799A–1(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 2799A–1(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 2799A–1(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section

2799A–1(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to qualified IDR air ambulance services, the certified independent entity with respect to a determination under this subsection for such services shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

''(ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such deter-

mination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such services furnished by such provider; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

"(C) CONSIDERATIONS IN DETERMINATION.—

"(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

"(I) the offers under subparagraph (B)(i);

"(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

"(III) information on any circumstance described in clause (ii), such information requested in subparagraph (B)(i)(II), and any addi-

tional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(A) of a nonparticipating provider, group health plan, or health insurance issuer the following:

''(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

''(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

''(iii) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges or the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 not applied.

"(D) EFFECTS OF DETERMINATION.—The provisions of section 2799A–1(c)(5)(D)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 2799A–1(c)(5)(D), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

"(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 2799A–1(c)(5)(E) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 2799A–1(c), the parties to such notification and a determination made under section 2799A–1(c)(5)(A).

"(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to an air ambulance service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

"(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

"(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Health and Human Services—

"(i) the number of notifications submitted under the IDR process during such calendar quarter;

"(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

"(iii) the information described in subparagraph (B) with respect to each no-

tification with respect to which such a determination was so made.

''(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

''(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

''(vi) the total amount of fees paid under paragraph (7) during such calendar quarter; and

''(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E)during such calendar quarter.

''(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group or individual health insurance coverage—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

''(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

''(v) ambulance vehicle type, including the clinical capability level of such vehicle;

''(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

''(C) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a

fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'air ambulance service' means medical transport by helicopter or airplane for patients.''.

(2) ERISA AMENDMENT.—

(A) IN GENERAL.—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 102(b) and further amended by the previous provisions of this title, is fur-

ther amended by inserting after section 716 the following:

"SEC. 717. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee who is in a group health plan or group health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 716(a)(3)(G)) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if

such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the plan or coverage shall pay, in accordance with, if applicable, subsection (b)(5)(F), directly to such provider furnishing such services to such participant, beneficiary, or enrollee the amount by which the out-of-network rate (as defined in section 716(a)(3)(K)) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

''(b) DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group health insurance coverage, in a State described in subsection section 716(a)(3)(K)(ii) with respect to such plan or

coverage and provider, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives a response from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open nego-

tiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

"(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date

on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 716(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

''(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 of the Public Health Service Act with respect to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 716(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance serv-

ices in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 716(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 716(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 716(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 716(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to qualified IDR air ambulance services, the certified independent entity with respect to a determination under this subsection for such services shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

''(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group health

insurance coverage party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such services furnished by such provider; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

''(C) CONSIDERATIONS IN DETERMINATION.—

''(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

''(I) the offers under subparagraph (B)(i);

''(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items and services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

''(III) information on any circumstance described in clause (ii), such information requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(A) of a nonparticipating

provider, group health plan, or health insurance issuer the following:

''(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

''(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider

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

''(iii) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges or the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 of the Public Health Service Act not applied.

''(D) EFFECTS OF DETERMINATION.—The provisions of section 716(c)(5)(D)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 716(c)(5)(D), the notification submitted with respect to such determina-

tion, the items and services with respect to such notification, and the parties to such notification.

"(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 716(c)(5)(E) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 716(c), the parties to such notification and a determination made under section 716(c)(5)(A).

"(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance services for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

"(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

"(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Labor—

"(i) the number of notifications submitted under the IDR process during such calendar quarter;

"(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

"(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

"(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

"(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

"(vi) the total amount of fees paid under paragraph (7) during such calendar quarter; and

''(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E)during such calendar quarter.

''(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group health insurance coverage—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

''(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer

submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

''(v) ambulance vehicle type, including the clinical capability level of such vehicle;

''(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

''(C) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.

''(c) DEFINITION.—For purposes of this section:

''(1) AIR AMBULANCE SERVICES.—The term 'air ambulance service' means medical transport by helicopter or airplane for patients.

''(2) QUALIFYING PAYMENT AMOUNT.—The term 'qualifying payment amount' has the meaning given such term in section 716(b)(3).

''(3) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' has the meaning given such term in section 716(b)(3).''.

(3) IRC AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 102(c) and further amended by the previous provisions of this title, is further amended by inserting after section 9816 the following:

''SEC. 9817. ENDING SURPRISE AIR AMBULANCE BILLS.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee in a group health plan who receives

air ambulance services from a nonparticipating provider (as defined in section 9816(a)(3)(G)) with respect to such plan, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan—

''(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

''(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

''(3) the plan shall pay, in accordance with, if applicable, subsection (b)(5)(F), directly to such provider furnishing such services to such participant, beneficiary, or enrollee at least the amount by which the recognized amount (as defined in and deter-

mined pursuant to section 9816(a)(3)(H)(ii)) for such services and year involved exceeds the cost-sharing amount imposed under the plan for such services (as determined in accordance with paragraphs (1) and (2)).

''(b) DETERMINATION OF OUT-OF-NETWORK RATES TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE RESOLUTION PROCESS.—

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan, in a State described in subsection section 9816(a)(3)(K)(ii) with respect to such plan and provider, and for which a payment is required to be made by the plan pursuant to subsection (a)(3), the provider or plan may, during the 30-day period beginning on the day the provider receives a response from the plan regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan for purposes of determining, during the open negotiation period, an amount agreed on by such

provider, and such plan for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

''(B) ACCESSING INDEPENDENT DISPUTE RESOLUTION PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such services. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notifica-

tion (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

''(2) INDEPENDENT DISPUTE RESOLUTION PROCESS AVAILABLE IN CASE OF FAILED OPEN NEGOTIATIONS.—

''(A) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the 'IDR process') under which, in the case of air ambulance services with respect to which a provider or group health plan submits a notification under paragraph (1)(B) (in this subsection referred to as a 'qualified IDR air ambulance services'), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in ac-

cordance with the succeeding provisions of this subsection, the amount of payment under the plan for such services furnished by such provider.

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 9816(a)(3)(K)(ii) as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

''(C) CLARIFICATION.—A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a no-

tification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 2799B–2 of the Public Health Service Act with respect to such item or service pursuant to subsection (b) of such section.

''(3) TREATMENT OF BATCHING OF SERVICES.—The provisions of section 9816(c)(3) shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 9816(c) with respect to items and services described in such section.

''(4) IDR ENTITIES.—

''(A) ELIGIBILITY.—An IDR entity certified under this subsection is an IDR entity certified under section 9816(c)(4).

''(B) SELECTION OF CERTIFIED IDR ENTITY.—The provisions of subparagraph (F) of section 9816(c)(4) shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the

same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 9816(c) of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'certified IDR entity' with respect to such determination.

''(5) PAYMENT DETERMINATION.—

''(A) IN GENERAL.—Not later than 30 days after the date of selection of the certified IDR entity, with respect to qualified IDR air ambulance services, the certified independent entity with respect to a determination under this subsection for such services shall—

''(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

''(ii) notify the provider or facility and the group health plan party to such deter-

mination of the offer selected under clause (i).

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan party to such determination—

''(i) shall each submit to the certified independent entity with respect to such determination—

''(I) an offer for a payment amount for such services furnished by such provider; and

''(II) such information as requested by the certified IDR entity relating to such offer; and

''(ii) may submit to the certified independent entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

''(C) CONSIDERATIONS IN DETERMINATION.—

"(i) IN GENERAL.—In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

"(I) the offers under subparagraph (B)(i);

"(II) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

"(III) information on any circumstance described in clause (ii), such information requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(i)(III).

''(ii) ADDITIONAL CIRCUMSTANCES.—For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(A) of a nonparticipating provider, or group health plan the following:

''(I) The quality and outcomes measurements of the provider that furnished such services.

''(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

''(III) The training, experience, and quality of the medical personnel that furnished such services.

''(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

''(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

''(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan to enter into network agreements and, if applicable, contracted rates between the provider and the plan during the previous 4 plan years.

''(iii) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges or the amount that would have been billed by such provider with respect to such services had the provisions of section 2799B–5 of the Public Health Service Act not applied.

''(D) EFFECTS OF DETERMINATION.—The provisions of section 9816(c)(5)(D)) shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such deter-

mination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 9816(c)(5)(D), the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

''(E) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—The provisions of section 9816(c)(5)(E) shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 9816(c), the parties to such notification and a determination made under section 9816(c)(5)(A).

''(6) TIMING OF PAYMENT.—Payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance services for which a payment amount is determined under open negotiations

under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

''(7) PUBLICATION OF INFORMATION RELATING TO THE IDR PROCESS.—

''(A) IN GENERAL.—For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of the Treasury—

''(i) the number of notifications submitted under the IDR process during such calendar quarter;

''(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

''(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.

''(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

''(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

''(vi) the total amount of fees paid under paragraph (7) during such calendar quarter; and

''(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E)during such calendar quarter.

''(B) INFORMATION WITH RESPECT TO REQUESTS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, or group health plan—

''(i) a description of each air ambulance service included in such notification;

''(ii) the geography in which the services included in such notification were provided;

''(iii) the amount of the offer submitted under paragraph (2) by the group health plan and by the nonparticipating

provider expressed as a percentage of the qualifying payment amount;

''(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

''(v) ambulance vehicle type, including the clinical capability level of such vehicle;

''(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

''(vii) the length of time in making each determination;

''(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

''(ix) any other information specified by the Secretary.

''(C) IDR ENTITY REQUIREMENTS.—For 2022 and each subsequent year, an IDR entity,

as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

''(D) CLARIFICATION.—The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

''(8) ADMINISTRATIVE FEE.—

''(A) IN GENERAL.—Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

''(B) AMOUNT OF FEE.—The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid

under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

''(9) WAIVER AUTHORITY.—The Secretary may modify any deadline or other timing required specified under this subsection (other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary.

''(c) DEFINITIONS.—For purposes of this section:

''(1) AIR AMBULANCE SERVICES.—The term 'air ambulance service' means medical transport by helicopter or airplane for patients.

''(2) QUALIFYING PAYMENT AMOUNT.—The term 'qualifying payment amount' has the meaning given such term in section 9816(b)(3).

''(3) NONPARTICIPTING PROVIDER.—The term 'nonparticipating provider' has the meaning given such term in section 9816(b)(3).''.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 102(c)(3), is further amended by inserting after the item relating to section 9816 the following new item:

''Sec. 9817. Ending surprise air ambulance bills.''.

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

(b) AIR AMBULANCE PROVIDER BALANCE BILLING.—Part E of title XXVII of the Public Health Service Act, as added and amended by section 104, is further amended by adding at the end the following new section:

"SEC. 2799B–5. AIR AMBULANCE SERVICES.

''In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished on or after January 1, 2022, air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider (as defined in section 2799A–1(a)(3)(G)) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 2799A–2(a), section 717(a) of the Employee Retirement Income Security Act of 1974, or section 9817(a) of the Internal Revenue Code of 1986, as applicable).''.

SEC. 106. REPORTING REQUIREMENTS REGARDING AIR AMBULANCE SERVICES.

(a) REPORTING REQUIREMENTS FOR PROVIDERS OF AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—A provider of air ambulance services shall submit to the Secretary of Health and Human Services and the Secretary of Transportation—

(A) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in subsection (d), the information described in paragraph (2) with respect to such plan year; and

(B) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in subparagraph (A), such information with respect to such immediately succeeding plan year.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), information described in this paragraph, with respect to a provider of air ambulance services, is each of the following:

(A) Cost data, as determined appropriate by the Secretary of Health and Human Serv-

ices, in consultation with the Secretary of Transportation, for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services.

(B) The number and location of all air ambulance bases operated by such provider.

(C) The number and type of aircraft operated by such provider.

(D) The number of air ambulance transports, disaggregated by payor mix, including—

(i)(I) group health plans;

(II) health insurance issuers; and

(III) State and Federal Government payors; and

(ii) uninsured individuals.

(E) The number of claims of such provider that have been denied payment by a group health plan or health insurance issuer and the reasons for any such denials.

(F) The number of emergency and non-emergency air ambulance transports,

disaggregated by air ambulance base and type of aircraft.

(G) Such other information regarding air ambulance services as the Secretary of Health and Human Services may specify.

(b) REPORTING REQUIREMENTS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

(1) PHSA.—Part D of title XXVII of the Public Health Service Act, as added by section 102(a)(1), is amended by adding after section 2799A–7, as added by section 102(a)(2)(A) of this Act, the following new section:

"SEC. 2799A–8. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary—

''(1) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the plan year immediately suc-

ceeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

''(C) Whether the transport in which the services were furnished originated in a rural or urban area.

''(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

''(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

''(2) Such other information regarding providers of air ambulance services as the Secretary may specify.''.

(2) ERISA.—

(A) IN GENERAL.—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding after section 722, as added by section 102(b)(2)(A) of this Act, the following new section:

''SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan and health insurance issuer offering group health insurance coverage shall submit to the Secretary—

''(1) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

''(C) Whether the transport in which the services were furnished originated in a rural or urban area.

''(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

''(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

''(2) Such other information regarding providers of air ambulance services as the Secretary may specify.''.

(B) CLERICAL AMENDMENT.—The table of contents of the Employee Retirement Income Security Act of 1974 is amended by adding after the item relating to section 722, as added by section 102(b) the following:

''Sec. 723. Air ambulance report requirements.''.

(3) IRC.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding after section 9822, as added by section 102(c)(2)(A) of this Act, the following new section:

''SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.

''(a) IN GENERAL.—Each group health plan shall submit to the Secretary—

''(1) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

''(2) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

''(b) INFORMATION DESCRIBED.—For purposes of subsection (a), information described in this subsection, with respect to a group health plan is each of the following:

''(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

''(A) Whether such services were furnished on an emergent or nonemergent basis.

''(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program,

independent program, or tribally operated program in Alaska.

''(C) Whether the transport in which the services were furnished originated in a rural or urban area.

''(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

''(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

''(2) Such other information regarding providers of air ambulance services as the Secretary may specify.''.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding after the item relating to section 9822, as added by section 102(c), the following new item:

''Sec. 9823. Air ambulance report requirements.''.

(c) PUBLICATION OF COMPREHENSIVE REPORT.—

(1) IN GENERAL.—Not later than the date that is one year after the date described in subsection (a)(2) of section 2799A–8 of the Public Health

Service Act, of section 723 of the Employee Retirement Income Security Act of 1974, and of section 9823 of the Internal Revenue Code of 1986, as such sections are added by subsection (b), the Secretary of Health and Human Services, in consultation with the Secretary of Transportation (referred to in this section as the ''Secretaries''), shall develop, and make publicly available (subject to paragraph (3)), a comprehensive report summarizing the information submitted under subsection (a) and the amendments made by subsection (b) and including each of the following:

(A) The percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program.

(B) An assessment of the extent of competition among providers of air ambulance services on the basis of price and services offered, and any changes in such competition over time.

(C) An assessment of the average charges for air ambulance services, amounts paid by group health plans and health insurance issuers

offering group or individual health insurance coverage to providers of air ambulance services for furnishing such services, and amounts paid out-of-pocket by consumers, and any changes in such amounts paid over time.

(D) An assessment of the presence of air ambulance bases in, or with the capability to serve, rural areas, and the relative growth in air ambulance bases in rural and urban areas over time.

(E) Any evidence of gaps in rural access to providers of air ambulance services.

(F) The percentage of providers of air ambulance services that have contracts with group health plans or health insurance issuers offering group or individual health insurance coverage to furnish such services under such plans or coverage, respectively.

(G) An assessment of whether there are instances of unfair, deceptive, or predatory practices by providers of air ambulance services in collecting payments from patients to whom such services are furnished, such as referral of such patients to collections, lawsuits, and liens or wage garnishment actions.

(H) An assessment of whether there are, within the air ambulance industry, instances of unreasonable industry concentration, excessive market domination, or other conditions that would allow at least one provider of air ambulance services to unreasonably increase prices or exclude competition in air ambulance services in a given geographic region.

(I) An assessment of the frequency of patient balance billing, patient referrals to collections, lawsuits to collect balance bills, and liens or wage garnishment actions by providers of air ambulance services as part of a collections process across hospital-owned or sponsored programs, municipality-sponsored programs, hospital-independent partnership (hybrid) programs, tribally operated programs in Alaska, or independent programs, providers of air ambulance services operated by public agencies (such as a State or county health department), and other independent providers of air ambulance services.

(J) An assessment of the frequency of claims appeals made by providers of air ambulance services to group health plans or health

insurance issuers offering group or individual health insurance coverage with respect to air ambulance services furnished to enrollees of such plans or coverage, respectively.

(K) Any other cost, quality, or other data relating to air ambulance services or the air ambulance industry, as determined necessary and appropriate by the Secretaries.

(2) OTHER SOURCES OF INFORMATION.—The Secretaries may incorporate information from independent experts or third-party sources in developing the comprehensive report required under paragraph (1).

(3) PROTECTION OF PROPRIETARY INFORMATION.—The Secretaries may not make publicly available under this subsection any proprietary information.

(d) RULEMAKING.—Not later than the date that is one year after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, shall, through notice and comment rulemaking, specify the form and manner in which reports described in subsection (a) and in the amendments made by subsection (b) shall be submitted to such Secretaries, taking into consideration (as applica-

ble and to the extent feasible) any recommendations included in the report submitted by the Advisory Committee on Air Ambulance and Patient Billing under section 418(e) of the FAA Reauthorization Act of 2018 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

(e) CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—Subject to paragraph (2), a provider of air ambulance services who fails to submit all information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, shall be subject to a civil money penalty of not more than $10,000.

(2) EXCEPTION.—In the case of a provider of air ambulance services that submits only some of the information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, the Secretary of Health and Human Services may waive the civil money penalty imposed under paragraph (1) if such provider demonstrates a good faith effort (as defined by the Secretary pursuant to regulation) in working with the Secretary to submit the remaining information required under subsection (a)(2).

(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–

7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under such section.

(f) UNFAIR AND DECEPTIVE PRACTICES AND UNFAIR METHODS OF COMPETITION.—The Secretary of Transportation may use any information submitted under subsection (a) in determining whether a provider of air ambulance services has violated section 41712(a) of title 49, United States Code.

(g) ADVISORY COMMITTEE ON AIR AMBULANCE QUALITY AND PATIENT SAFETY.—

(1) ESTABLISHMENT.—Not later than the date that is 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, shall establish an Advisory Committee on Air Ambulance Quality and Patient Safety (referred to in this subsection as the ''Committee'') for the purpose of reviewing options to establish quality, patient safety, service reliability, and clinical capability standards for each clinical capability level of air ambulances.

(2) MEMBERSHIP.—The Committee shall be composed of the following members:

(A) The Secretary of Health and Human Services, or a designee of the Secretary, who shall serve as the Chair of the Committee.

(B) The Secretary of Transportation, or a designee of the Secretary.

(C) One representative, to be appointed by the Secretary of Health and Human Services, of each of the following:

(i) State health insurance regulators.

(ii) Health care providers.

(iii) Group health plans and health insurance issuers offering group or individual health insurance coverage.

(iv) Patient advocacy groups.

(v) Accrediting bodies with experience in quality measures.

(D) Three representatives of the air ambulance industry, to be appointed by the Secretary of Transportation.

(E) Additional three representatives not covered under subparagraphs (A) through (D), as determined necessary and appropriate by the Secretary of Health and Human Services.

(3) FIRST MEETING.—Not later than the date that is 90 days after the date of the enactment of this Act, the Committee shall hold its first meeting.

(4) DUTIES.—The Committee shall study and make recommendations, as appropriate, to Congress regarding each of the following with respect to air ambulance services:

(A) Qualifications of different clinical capability levels and tiering of such levels.

(B) Patient safety and quality standards.

(C) Options for improving service reliability during poor weather, night conditions, or other adverse conditions.

(D) Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

(E) Clinical triage criteria for air ambulances.

(5) REPORT.—Not later than the date that is 180 days after the date of the first meeting of the Committee, the Committee, in consultation with relevant experts and stakeholders, as appropriate, shall develop and make publicly available a report on any recommendations submitted to Congress under para-

graph (4). The Committee may update such report, as determined appropriate by the Committee.

(h) DEFINITIONS.—In this section, the terms ''group health plan'', ''health insurance coverage'', ''individual health insurance coverage'', ''group health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 107. TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.

(a) PHSA.—Section 2799A–1 of the Public Health Service Act, as added by section 102(a) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan or a health insurance issuer offering group or individual health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

''(1) Any deductible applicable to such plan or coverage.

''(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage''.

(b) ERISA.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 102(b) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

''(1) Any deductible applicable to such plan or coverage.

''(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage''.

(c) IRC.—Section 9816 of the Internal Revenue Code of 1986, as added by section 102(c) and amended by section 103, is further amended by adding at the end the following new subsection:

''(e) TRANSPARENCY REGARDING IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET LIMITATIONS.—A group health plan providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan the following:

''(1) Any deductible applicable to such plan.

''(2) Any out-of-pocket maximum limitation applicable to such plan.

''(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan for furnishing items and services under such plan.''.

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

SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PROVIDER DISCRIMINATION.

Not later than six months after the date of the enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall issue a proposed rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)). The Secretaries shall accept and consider public comments on any proposed rule issued pursuant to this subsection for a period of 60 days after the date of such issuance. Not later than 6 months after the date of the conclusion of the comment period, the Secretaries shall issue a final rule implementing the protections of section 2706(a) of the Public Health Service Act (42 U.S.C. 300gg-5(a)).

SEC. 109. REPORTS.

(a) REPORTS IN CONSULTATION WITH FTC AND AG.—Not later than January 1, 2023, and annually thereafter for each of the following 4 years, the Secretary of Health and Human Services, in consultation with the Federal Trade Commission and the Attorney General, shall—

(1) conduct a study on the effects of the provisions of, including amendments made by, this Act on—

(A) any patterns of vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage;

(B) overall health care costs; and

(C) access to health care items and services, including specialty services, in rural areas and health professional shortage areas, as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e);

(2) for purposes of the reports under paragraph (3), in consultation with the Secretary of Labor and the Secretary of the Treasury, make recommendations for the effective enforcement of subsections (a)(1)(C)(iv) and (b)(1)(C) of section 2799A–1 of

the Public Health Service Act, subsections (a)(1)(C)(iv) and (b)(1)(C) of section 716 of the Employee Retirement Income Security Act of 1974, and subsections (a)(1)(C)(iv) and (b)(1)(C) of section 9816 of the Internal Revenue Code of 1986, including with respect to potential challenges to addressing anti-competitive consolidation of health care facilities, providers, group health plans, or health insurance issuers offering group or individual health insurance coverage; and

(3) submit a report on such study and including such recommendations to the Committees on Energy and Commerce; on Education and Labor; on Ways and Means; and on the Judiciary of the House of Representatives and the Committees on Health, Education, Labor, and Pensions; on Commerce, Science, and Transportation; on Finance; and on the Judiciary of the Senate.

(b) GAO REPORT ON IMPACT OF SURPRISE BILLING PROVISIONS.—Not later than January 1, 2025, the Comptroller General of the United States shall submit to Congress a report summarizing the effects of the provisions of this Act, including the amendments made by such provisions, on changes during the period since the date on the enactment of this Act in health care provider networks of

group health plans and group and individual health insurance coverage offered by a health insurance issuer, in fee schedules and amounts for health care services, and to contracted rates under such plans or coverage. Such report shall—

(1) to the extent practicable, sample a statistically significant group of national health care providers;

(2) examine—

(A) provider network participation, including nonparticipating providers furnishing items and services at participating facilities;

(B) health care provider group network participation, including specialty, size, and ownership;

(C) the impact of State surprise billing laws and network adequacy standards on participation of health care providers and facilities in provider networks of group health plans and of group and individual health insurance coverage offered by health insurance issuers; and

(D) access to providers, including in rural and medically underserved communities and health professional shortage areas (as defined in section 332 of the Public Health Service

Act), and the extent of provider shortages in such communities and areas;

(3) to the extent practicable, sample a statistically significant group of national health insurance plans and issuers and examine—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs with respect to group health plans or group or individual health insurance coverage;

(B) the adequacy of provider networks with respect to such plans or coverage; and

(C) categories of providers of ancillary services, as defined in section 2719(A)(i)(3), for which such plans have no or a limited number of in-network providers; and

(4) such other relevant effects of such provisions and amendments.

(c) GAO REPORT ON ADEQUACY OF PROVIDER NETWORKS.—Not later than January 1, 2023, the Comptroller General of the United States shall submit to Congress, and make publicly available, a report on the adequacy of provider networks in group health plans and group and individual health insurance coverage, including

legislative recommendations to improve the adequacy of such networks.

(d) GAO REPORT ON IDR PROCESS AND POTENTIAL FINANCIAL RELATIONSHIPS.—Not later than December 31, 2023, the Comptroller General of the United States shall conduct a study and submit to Congress a report on the IDR process established under this section. Such study and report shall include an analysis of potential financial relationships between providers and facilities that utilize the IDR process established by the amendments made by this Act and private equity investment firms.

SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS.

(a) In applying the provisions of section 2719(b) of the Public Health Service Act (42 U.S.C. 300gg–19(b)) to group health plans and health insurance issuers offering group or individual health insurance coverage, the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, shall require, beginning not later than January 1, 2022, the external review process described in paragraph (1) of such section to apply with respect to any adverse determination by such a plan or issuer under section 2799A-1 or 2799A-2, section 716

or 717 of the Employee Retirement Income Security Act of 1974, or section 9816 or 9817 of the Internal Revenue Code of 1986, including with respect to whether an item or service that is the subject to such a determination is an item or service to which such respective section applies.

(b) Definitions—The terms ''group health plan''; ''health insurance issuer''; ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code, as applicable.

SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH PLAN REQUIREMENT FOR FAIR AND HONEST ADVANCE COST ESTIMATE.

(a) PHSA AMENDMENT.—Section 2799A–1 of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by section 102 and as further amended by the previous provisions of this title, is further amended by adding at the end the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, with respect to a notifica-

tion submitted under section 2799B–6 by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

''(1) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service and—

''(A) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service; and

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities.

''(2) The good faith estimate included in the notification received from the provider or facility (if applicable).

''(3) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or of participating providers, as applicable, who are able to furnish such items and services involved.

''(9) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.''.

(b) IRC AMENDMENTS.—Section 9816 of the Internal Revenue Code of 1986, as added by section 102 and further amended by the previous provisions of this title,

is further amended by inserting after subsection (e) the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each group health plan shall, with respect to a notification submitted under section 2799B–6 by a health care provider or health care facility to the plan for a participant, beneficiary, or enrollee under plan scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

''(1) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan with respect to the furnishing of such item or service and—

''(A) in the case the provider or facility is a participating provider or facility with respect

to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service; and

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan, a description of how such individual may obtain information on providers and facilities that, with respect to such plan, are participating providers and facilities.

''(2) The good faith estimate included in the notification received from the provider or facility (if applicable).

''(3) A good faith estimate of the amount the plan is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-

of-pocket maximums) under the plan (as of the date of such notification).

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or of participating providers, as applicable, who are able to furnish such items and services involved.

''(9) Any other information or disclaimer the plan determines appropriate that is consistent with information and disclaimers required under this section.''.

(c) ERISA AMENDMENTS.—Section 716 of the Employee Retirement Income Security Act of 1974, as added

by section 102 and further amended by the previous amendments of this title, is further amended by adding at the end the following new subsection:

''(f) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each group health plan, or a health insurance issuer offering group health insurance coverage shall, with respect to a notification submitted under section 2799B–6 by a health care provider or health care facility to the plan or issuer for a participant, beneficiary, or enrollee under plan or coverage scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant, beneficiary, or enrollee), 3 business days) after the date on which the plan or coverage receives such notification (or such request), provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

''(1) Whether or not the provider or facility is a participating provider or a participating facility

with respect to the plan or coverage with respect to the furnishing of such item or service and—

''(A) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service; and

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities.

''(2) The good faith estimate included in the notification received from the provider or facility (if applicable).

''(3) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing for which the participant, bene-

ficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or

of participating providers, as applicable, who are able to furnish such items and services involved.

''(9) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.''.

SEC. 112. PATIENT PROTECTIONS THROUGH TRANSPARENCY AND PATIENT-PROVIDER DISPUTE RESOLUTION.

Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and further amended by the previous provisions of this title, is further amended by adding at the end the following new sections:

''SEC. 2799B–6. PROVISION OF INFORMATION UPON REQUEST AND FOR SCHEDULED APPOINTMENTS.

''Each health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the

date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

''(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

''(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service) to—

''(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

''(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

"SEC. 2799B–7. PATIENT-PROVIDER DISPUTE RESOLUTION.

"(a) IN GENERAL.—Not later than July 1, 2021, the Secretary shall establish a process (in this subsection referred to as the 'patient-provider dispute resolution process') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 2799B–6, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term 'uninsured individual' means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance cov-

erage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

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

''(1) a method to select to make such determination an entity certified under subsection (d) that—

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

''(B) does not have a material familial, financial, or professional relationship with such a party; and

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

''(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the 'selected dispute resolution entity' with respect to such determination.

''(c) ADMINISTRATIVE FEE.—The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

''(d) CERTIFICATION.—The Secretary shall establish or recognize a process to certify entities under this subparagraph. Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 2799A–1(c).''.

SEC. 113. ENSURING CONTINUITY OF CARE.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended, in the part D, as added and amended by section 102(a) and further amended by the previous provisions of this title, by inserting after section 2799A–2 the following new section:

''SEC. 2799A-3. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

''(A) such contractual relationship is terminated (as defined in subsection (b));

''(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider

or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

''(i) the 90-day period beginning on such date; or

''(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

''(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that is—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or

nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.''.

(b) INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102(c) and 105(a)(3), is further amended by inserting after section 9817 the following new section:

''SEC. 9818. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan for furnishing items and services under such plan, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

''(A) such contractual relationship is terminated (as defined in paragraph (b));

''(B) benefits provided under such plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan—

''(A) notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

''(i) the 90-day period beginning on such date; or

''(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

''(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan—

''(A) in the case of an acute illness, a condition that is serious enough to require special-

ized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter, as amended by the previous sections, is further amended by inserting after the item relating to section 9817 the following new item:

''Sec. 9818. Continuity of care.''.

(c) EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 102(c) and further amended by the previous provisions of this title, is further

amended by inserting after section 717 the following new section:

"SEC. 718. CONTINUITY OF CARE.

"(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

"(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

"(A) such contractual relationship is terminated (as defined in paragraph (b));

"(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan or

such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

''(i) the 90-day period beginning on such date; or

''(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

''(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group health insurance coverage—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 716 the following new item:

''Sec. 718. Continuity of care.''.

(d) PROVIDER REQUIREMENT.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and further amended by the previous provisions of this title, is further amended by adding at the end the following new section:

''SEC. 2799B–8. CONTINUITY OF CARE.

''A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided

under a group health plan or group or individual health insurance coverage pursuant to section 2799A–3, section 9818 of the Internal Revenue Code of 1986, or section 718 of the Employee Retirement Income Security Act of 1974—

''(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 2799A–3, 9818, or 718) for such items and services as payment in full for such items and services; and

''(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.''.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended, in the part D, as added and amended by section 102 and further amended by the previous provisions

of this title, by inserting after section 2799A–3 the following new section:

"SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan or a health insurance issuer offering group or individual health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year and such geographic region, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(b) INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102, 105, and 113, is further amended by inserting after section 9818 the following new section:

"SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that

(to the extent practicable) allows an individual enrolled under such plan, with respect to such plan year and such geographic region, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan with respect to the furnishing of a specific item or service by any such provider.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter, as amended by the previous sections, is further amended by inserting after the item relating to section 9818 the following new item:

''Sec. 9819. Maintenance of price comparison tool.''.

(c) EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, and 113, is further amended by inserting after section 718 the following new section:

''SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.

''A group health plan or a health insurance issuer offering group health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an indi-

vidual enrolled under such plan or coverage, with respect to such plan year and such geographic region, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 716 the following new item:

''Sec. 719. Maintenance of price comparison tool.''.

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

SEC. 115. STATE ALL PAYER CLAIMS DATABASES.

(a) GRANTS TO STATES.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

''SEC. 320B. STATE ALL PAYER CLAIMS DATABASES.

''(a) IN GENERAL.—The Secretary shall make one-time grants to eligible States for the purposes described in subsection (b).

''(b) USES.—A State may use a grant received under subsection (a) for one of the following purposes:

''(1) To establish a State All Payer Claims Database.

''(2) To improve an existing State All Payer Claims Databases.

''(c) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary specifies, including, with respect to a State All Payer Claims Database, at least specifics on how the State will ensure uniform data collection and the privacy and security of such data.

''(d) GRANT PERIOD AND AMOUNT.—Grants awarded under this section shall be for a period of 3-years, and in an amount of $2,500,000, of which $1,000,000 shall be made available to the State for each of the first 2 years of the grant period, and $500,000 shall be made available to the State for the third year of the grant period.

''(e) AUTHORIZED USERS.—

''(1) APPLICATION.—An entity desiring authorization for access to a State All Payer Claims Database that has received a grant under this section shall submit to the State All Payer Claims Database an application for such access, which shall include—

''(A) in the case of an entity requesting access for research purposes—

''(i) a description of the uses and methodologies for evaluating health system performance using such data; and

''(ii) documentation of approval of the research by an institutional review board, if applicable for a particular plan of research; or

''(B) in the case of an entity such as an employer, health insurance issuer, third-party administrator, or health care provider, requesting access for the purpose of quality improvement or cost-containment, a description of the intended uses for such data.

''(2) REQUIREMENTS.—

''(A) ACCESS FOR RESEARCH PURPOSES.—Upon approval of an application for research purposes under paragraph (1)(A), the authorized user shall enter into a data use and confidentiality agreement with the State All Payer Claims Database that has received a grant under this subsection, which shall include a prohibition on attempts to reidentify and disclose individually identifiable health information and proprietary financial information.

''(B) CUSTOMIZED REPORTS.—Employers and employer organizations may request customized reports from a State All Payer Claims Database that has received a grant under this section, at cost, subject to the requirements of this section with respect to privacy, security, and proprietary financial information.

''(C) NON-CUSTOMIZED REPORTS.—A State All Payer Claims Database that has received a grant under this section shall make available to all authorized users aggregate data sets available through the State All Payer Claims Database, free of charge.

''(3) WAIVERS.—The Secretary may waive the requirements of this subsection of a State All Payer Claims Database to provide access of entities to such database if such State All Payer Claims Database is substantially in compliance with this subsection.

''(f) EXPANDED ACCESS.—

''(1) MULTI-STATE APPLICATIONS.—The Secretary may prioritize applications submitted by a State whose application demonstrates that the State will work with other State All Payer Claims Databases to establish a single application for access to data by authorized users across multiple States.

''(2) EXPANSION OF DATA SETS.—The Secretary may prioritize applications submitted by a State whose application demonstrates that the State will implement the reporting format for self-insured group health plans described in section 735 of the Employee Retirement Income Security Act of 1974.

''(g) DEFINITIONS.—In this section—

''(1) the term 'individually identifiable health information' has the meaning given such term in section 1171(6) of the Social Security Act;

''(2) the term 'proprietary financial information' means data that would disclose the terms of a specific contract between an individual health care provider or facility and a specific group health plan, managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act) or other managed care organization, or health insurance issuer offering group or individual health insurance coverage; and

''(3) the term 'State All Payer Claims Database' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2022 and 2023, and $25,000,000 for fiscal year 2024, to remain available until expended.''.

(b) STANDARDIZED REPORTING FORMAT.—

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following:

''SEC. 735. STANDARDIZED REPORTING FORMAT.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary shall establish a standardized reporting format for the reporting, by self-insured group health plans to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans or coverage in the standardized reporting format.

''(b) CONSULTATION.—

''(1) ADVISORY COMMITTEE.—Not later than 90 days after the date of enactment of this section,

the Secretary shall convene an Advisory Committee (referred to in this section as the 'Committee'), consisting of 15 members to advise the Secretary regarding the format and guidance described in paragraph (1).

''(2) MEMBERSHIP.—

''(A) APPOINTMENT.—In accordance with subparagraph (B), not later than 90 days after the date of enactment this section, the Secretary, in coordination with the Secretary of Health and Human Services, shall appoint under subparagraph (B)(iii), and the Comptroller General of the United States shall appoint under subparagraph (B)(iv), members who have distinguished themselves in the fields of health services research, health economics, health informatics, data privacy and security, or the governance of State All Payer Claims Databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, or third-party administrators of group health plans. Such members shall serve 3-year terms on a

staggered basis. Vacancies on the Committee shall be filled by appointment consistent with this paragraph not later than 3 months after the vacancy arises.

''(B) COMPOSITION.—The Committee shall be comprised of—

''(i) the Assistant Secretary of Employee Benefits and Security Administration of the Department of Labor, or a designee of such Assistant Secretary;

''(ii) the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, or a designee of such Assistant Secretary;

''(iii) members appointed by the Secretary, in coordination with the Secretary of Health and Human Services, including—

''(I) 1 member to serve as the chair of the Committee;

''(II) 1 representative of the Centers for Medicare & Medicaid Services;

''(III) 1 representative of the Agency for Healthcare Research and Quality;

''(IV) 1 representative of the Office for Civil Rights of the Department of Health and Human Services with expertise in data privacy and security;

''(V) 1 representative of the National Center for Health Statistics;

''(VI) 1 representative of the Office of the National Coordinator for Health Information Technology; and

''(VII) 1 representative of a State All-Payer Claims Database;

''(iv) members appointed by the Comptroller General of the United States, including—

''(I) 1 representative of an employer that sponsors a group health plan;

''(II) 1 representative of an employee organization that sponsors a group health plan;

''(III) 1 academic researcher with expertise in health economics or health services research;

''(IV) 1 consumer advocate; and

''(V) 2 additional members.

''(3) REPORT.—Not later than 180 days after the date of enactment of this section, the Committee shall report to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Labor of the House of Representatives. Such report shall include recommendations on the establishment of the format and guidance described in subsection (a).

''(c) STATE ALL PAYER CLAIMS DATABASE.—In this section, the term 'State All Payer Claims Database' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $5,000,000 for fiscal year 2021, to remain available until expended or until the date described in subsection (e).

''(e) SUNSET.—Beginning on the date on which the report is submitted under subsection (b)(3), this section shall have no force or effect.''.

SEC. 116. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PHSA.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A–4 the following:

"SEC. 2799A–5. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall—

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

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

''(D) include in any directory (other than the database described in subparagraph (C) containing provider directory information with

respect to such plan or such coverage the information described in paragraph (5).

''(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

''(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

''(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

''(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of

an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

''(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

''(4) DATABASE.—The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage, a database on the public website of such plan or issuer that contains—

''(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

''(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group or individual

health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

''(b) COST-SHARING FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such

participant, beneficiary, or enrollee and item or service, the plan or coverage—

"(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

"(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

"(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

"(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such

item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

''(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with

respect to which the requirements under section 2799A–1 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under section 2799A-1; and

''(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has

violated any requirement described in paragraph (1) with respect to such individual.''.

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, 113, and 114, is further amended by inserting after section 719 the following:

''SEC. 720. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall—

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

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

''(D) include in any directory (other than the database described in subparagraph (C) containing provider directory information with

respect to such plan or such coverage the information described in paragraph (5).

''(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, a process—

''(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

''(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

''(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of

an individual enrolled under a group health plan or group health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

''(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

''(4) DATABASE.—The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group health insurance coverage, a database on the public website of such plan or issuer that contains—

''(A) a list of each health care provider and health care facility with which such plan or

such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

''(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital contact information of

each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories, to the extent such State law applies to such plan, coverage, or issuer, subject to section 514.

''(b) COST-SHARING FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such partici-

pant, beneficiary, or enrollee and item or service, the plan or coverage—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

''(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

''(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant, beneficiary, or enrollee of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

''(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such

item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

"(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

"(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each expla-

nation of benefits for an item or service with respect to which the requirements under section 2799A–1 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under section 2799A-1; and

''(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has

violated any requirement described in paragraph (1) with respect to such individual.''.

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 102, 105, 113, and 114, is further amended by inserting after section 9819 the following:

''SEC. 9820. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, each group health plan shall—

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

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

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

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

''(A) under which, not less frequently than once every 90 days, such plan verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

''(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

''(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 2799B–9.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility

has a contractual relationship to furnish items and services under such plan, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

''(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

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

''(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan; and

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a print

directory containing provider directory information with respect to a group health plan, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan should consult the database described in paragraph (4) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

''(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan has a contractual relationship for furnishing items and services under such plan.

''(7) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

''(b) COST-SHARING FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a group health plan by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service, the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan had such item or service been furnished by a participating provider; and

''(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

''(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished

to a participant, beneficiary, or enrollee of a group health plan by a nonparticipating provider or a nonparticipating facility, are the following:

''(A) The participant, beneficiary, or enrollee received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) The information was not provided, in accordance with subsection (a), to the participant, beneficiary, or enrollee and the participant, beneficiary, or enrollee requested through the response protocol described in subsection (a)(3) of the plan information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

''(c) DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING.—For plan years beginning on or after January 1, 2022, each group health plan shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 2799A–1 applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799B–1 and 2799B–2 (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan after receiving payment from the plan for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

"(C) the requirements applied under section 2799A-1; and

"(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.".

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 719 the following new item:

"720. Protecting patients and improving the accuracy of provider directory information.".

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 9819 the following new item:

"9820. Protecting patients and improving the accuracy of provider directory information.".

(e) PROVIDER REQUIREMENTS.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added by section 104 and as further amended

by the previous provisions of this title, is further amended by adding at the end the following:

"SEC. 2799B–9. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

''(a) PROVIDER BUSINESS PROCESSES.—Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 2799A–5(a)(1). Such providers shall submit provider directory information to a plan or issuers, at a minimum—

''(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

''(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

''(3) when there are material changes to the content of provider directory information of the provider or facility described in section 2799A–5(a)(1); and

''(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

''(b) REFUNDS TO ENROLLEES.—If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 2799A–5(b), and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

''(c) LIMITATION.—Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

''(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 2799A–5(a); or

''(2) that the plan or issuer bear financial responsibility, including under section 2799A–5(b), for

providing inaccurate network status information to an enrollee.

''(d) DEFINITION.—For purposes of this section, the term 'provider directory information' includes the names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers, and the names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.''.

SEC. 117. TIMELY BILLS FOR PATIENTS.

(a) FACILITIES AND PRACTITIONERS REQUIREMENTS.—

(1) IN GENERAL.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by the previous provisions of this title, is further amended by adding at the end the following:

''SEC. 2799B–10. PROVIDER PROVISION OF TIMELY BILLS FOR PATIENTS.

''(a) PROVISION OF LIST OF SERVICES.—Health care facilities, or in the case of practitioners providing services

outside of such a facility, practitioners, shall provide to an individual a list of services rendered to such individual during the visit to such facility or practitioner, and, in the case of a facility, the name of the practitioner for each such service, upon discharge or end of the visit or by postal or electronic communication as soon as practicable and not later than 15 calendar days after the discharge or date of visit.

''(b) ADJUDICATION OF BILLS.—In the case of services provided to an individual covered by a group health plan or group or individual health insurance coverage offered by a health insurance issuer, subject to 2799A–6(b), section 721(b) of the Employee Retirement Income Security Act of 1974, or section 9821(b) of the Internal Revenue Code of 1986, as applicable—

''(1) the health care facility, or in the case of a practitioner providing services outside of such a facility, the practitioner, shall submit to the group health plan or health insurance issuer the bill with respect to such services not later than 30 calendar days after discharge or date of visit of the individual; and

''(2) the health care facility or practitioner, as applicable under paragraph (1), shall, not later than 30 calendar days after transmission of the informa-

tion as described in section 2799A–6(a), section 721(a) of the Employee Retirement Income Security Act of 1974, or section 9821(a) of the Internal Revenue Code of 1986, as applicable, send to the individual, using such information, the cost-sharing obligation applied for such services (which in the case of such services for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) of section 2799A–1, of 716 of the Employee Retirement Income Security Act of 1974, or of section 9816 of the Internal Revenue Code of 1986, subsection (b)(1) of such sections, or subsection (a) of section 2799A–2, of 717 of the Employee Retirement Income Security Act of 1974, or of section 9817 of the Internal Revenue Code of 1986, shall be in accordance with such respective subsection).

''(c) PAYMENT AFTER BILLING.—No patient may be required to pay a bill for health care services any earlier than 45 days after the postmark date of a bill for such services.

''(d) REFUND REQUIREMENT.—

''(1) IN GENERAL.—If a facility or practitioner bills a patient after the 90-calendar-day period described pursuant to subsection (b), in addition to

being subject to any penalty under section 2799B–4, such facility or practitioner shall refund the patient for the full amount paid in response to such bill with interest, at a rate determined by the Secretary.

''(2) EXEMPTIONS.—The Secretary may exempt a practitioner or facility from the penalties under paragraph (1) or extend the periods specified in subsection (b) for compliance with such subsection if a practitioner or facility—

''(A) makes a good-faith attempt to send a bill within the periods specified in subsection (b) but is unable to do so because of an incorrect address; or

''(B) experiences extenuating circumstances (as defined by the Secretary), such as a hurricane or cyberattack, that may reasonably delay delivery of a timely bill.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit applicability of the appeals process under section 2719 to coverage determinations or claims subject to the requirements of this section. The periods described in subsections (b) and (c) shall be tolled during any period during which a claim is subject to an appeal under section 2719, provided that, in the case of

such an appeal by the provider, the patient is informed of such appeal.''.

(2) RULEMAKING.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations to implement section 2799B–10 of the Public Health Service Act, as added by paragraph (1). Such regulations shall include—

(A) a definition of the term ''extenuating circumstance'' for purposes of subsection (d)(3)(B) of such section 2799B–10; and

(B) a definition of the term ''date of service'' for purposes of subsection (b)(1), with respect to providers submitting global packages for services provided on multiple visits.

(b) GROUP HEALTH PLAN AND HEALTH INSURANCE ISSUER REQUIREMENTS.—

(1) PHSA.—Part D of title XXVII of the Public Health Service Act, as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A–5 the following:

''SEC. 2799A–6. TIMELY BILLS FOR PATIENTS.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a group health plan or health insurance issuer of-

fering group or individual health insurance coverage that receives a bill as described in section 2799B–10(b)(1) from a facility or practitioner, the group health plan or issuer shall, not later than 30 calendar days after such bill is transmitted by the facility or practitioner, send to the facility or practitioner, as applicable under such section, the following information:

''(1) In the case the bill is with respect to services for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) of section 2799A–1, of 716 of the Employee Retirement Income Security Act of 1974, or of section 9816 of the Internal Revenue Code of 1986, subsection (b)(1) of such sections, or subsection (a) of section 2799A–2, of 717 of the Employee Retirement Income Security Act of 1974, or of section 9817 of the Internal Revenue Code of 1986, an initial response to such bill, including the cost-sharing amount applicable with respect to such bill, in accordance with such respective subsection.

''(2) In the case the bill is with respect to services not described in paragraph (1), the completed adjudicated bill by the plan or coverage, including the cost-sharing amount applicable with respect to such bill.

''(b) CLARIFICATION.—A provider or a group health plan or health insurance issuer may establish in a contract the timeline for submission by either party to the other party of billing information, adjudication, sending of remittance information, or any other coordination required between the provider and the plan or issuer necessary for meeting the deadlines described in subsection (a) and section 2799B–10(b) as long as such timeline results in the 90-calendar day period described in section 2799B–10(d)(1)(B).

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to limit applicability of the appeals process under section 2719 to coverage determinations or claims subject to the requirements of this section. Any timeline established under subsection (a) or (b) shall be tolled during any period during which a claim is subject to an appeal under section 2719, provided that, in the case of such an appeal by the provider, the patient is informed of such appeal. A group health plan or health insurance issuer that knows or should have known that denials of a claim would lead to noncompliance by providers with section 2799B–10 may be found to be in violation of this part.''.

(2) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Secu-

rity Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, 113, 114, and 116, is further amended by inserting after section 720 the following:

"SEC. 721. TIMELY BILLS FOR PATIENTS.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a group health plan or health insurance issuer offering group health insurance coverage that receives a bill as described in section 2799B–10(b)(1) of the Public Health Service Act from a facility or practitioner, the group health plan or issuer shall, not later than 30 calendar days after such bill is transmitted by the facility or practitioner, send to the facility or practitioner, as applicable under such section, the following information:

''(1) In the case the bill is with respect to services for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) of section 716, of section 2799A–1 of the Public Health Service Act, or of section 9816 of the Internal Revenue Code of 1986, subsection (b)(1) of such sections, or subsection (a) of section 717, of section 2799A–2 of the Public Health Service Act, or of section 9817 of the Internal Revenue Code of 1986, an initial response to such bill, including the cost-shar-

ing amount applicable with respect to such bill, in accordance with such respective subsection.

''(2) In the case the bill is with respect to services not described in paragraph (1), the completed adjudicated bill by the plan or coverage, including the cost-sharing amount applicable with respect to such bill.

''(b) CLARIFICATION.—A provider or a group health plan or health insurance issuer may establish in a contract the timeline for submission by either party to the other party of billing information, adjudication, sending of remittance information, or any other coordination required between the provider and the plan or issuer necessary for meeting the deadlines described in subsection (a) and section 2799B–10(b) of the Public Health Service Act as long as such timeline results in the 90-calendar day period described in section 2799B–10(d)(1)(B) of such Act.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to limit applicability of the appeals process under section 2719 of the Public Health Service Act or section 503 to coverage determinations or claims subject to the requirements of this section. Any timeline established under subsection (a) or (b) shall be tolled during any period during which a claim is subject to an appeal under section 2719 of the Public Health

Service Act or section 503, provided that, in the case of such an appeal by the provider, the patient is informed of such appeal. A group health plan or health insurance issuer that knows or should have known that denials of a claim would lead to noncompliance by providers with section 2799B–10 of the Public Health Service Act may be found to be in violation of this subpart.''.

(3) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by the sections 102, 105, 113, 114, and 116, is further amended by inserting after section 9820 the following:

''SEC. 9821. TIMELY BILLS FOR PATIENTS.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a group health plan that receives a bill as described in section 2799B–10(b)(1) of the Public Health Service Act from a facility or practitioner, the group health plan shall, not later than 30 calendar days after such bill is transmitted by the facility or practitioner, send to the facility or practitioner, as applicable under such section, the following information:

''(1) In the case the bill is with respect to services for which a payment is required to be made by the plan pursuant to subsection (a)(1) of section 716, of section 2799A–1 of the Public Health Serv-

ice Act, or of section 9816 of the Internal Revenue Code of 1986, subsection (b)(1) of such sections, or subsection (a) of section 717, of section 2799A–2 of the Public Health Service Act, or of section 9817 of the Internal Revenue Code of 1986, an initial response to such bill, including the cost-sharing amount applicable with respect to such bill, in accordance with such respective subsection.

''(2) In the case the bill is with respect to services not described in paragraph (1), the completed adjudicated bill by the plan, including the cost-sharing amount applicable with respect to such bill.

''(b) CLARIFICATION.—A provider or a group health plan may establish in a contract the timeline for submission by either party to the other party of billing information, adjudication, sending of remittance information, or any other coordination required between the provider and the plan necessary for meeting the deadlines described in subsection (a) and section 2799B–10(b) of the Public Health Service Act as long as such timeline results in the 90-calendar day period described in section 2799B–10(d)(1)(B) of such Act.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to limit applicability of the appeals process under section 2719 of the Public Health

Service Act to coverage determinations or claims subject to the requirements of this section. Any timeline established under subsection (a) or (b) shall be tolled during any period during which a claim is subject to an appeal under section 2719 of the Public Health Service Act, provided that, in the case of such an appeal by the provider, the patient is informed of such appeal. A group health plan that knows or should have known that denials of a claim would lead to noncompliance by providers with section 2799B–10 of the Public Health Service Act may be found to be in violation of this chapter.''.

(4) CLERICAL AMENDMENTS.—

(A) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 720 the following new item:

''721. Timely bills for patients.''.

(B) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by the previous provisions of this title, is further amended by inserting after the item relating to section 9820 the following new item:

''9821. Timely bills for patients.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply beginning 6 months after the date of the enactment of this Act.

SEC. 118. ADVISORY COMMITTEE ON GROUND AMBULANCE AND PATIENT BILLING.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Labor, Secretary of Health and Human Services, and the Secretary of the Treasury (the Secretaries) shall jointly establish an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

(b) COMPOSITION OF THE ADVISORY COMMITTEE.—The advisory committee shall be composed of the following members:

(1) The Secretary of Labor, or the Secretary's designee.

(2) The Secretary of Health and Human Services, or the Secretary's designee.

(3) The Secretary of the Treasury, or the Secretary's designee.

(4) One representative, to be appointed jointly by the Secretaries, for each of the following:

(A) Each relevant Federal agency, as determined by the Secretaries.

(B) State insurance regulators.

(C) Health insurance providers.

(D) Patient advocacy groups.

(E) Consumer advocacy groups.

(F) State and local governments.

(G) Physician specializing in emergency, trauma, cardiac, or stroke.

(5) Three representatives, to be appointed jointly by the Secretaries, to represent the various segments of the ground ambulance industry.

(6) Up to an additional 2 representatives otherwise not described in paragraphs (1) through (5), as determined necessary and appropriate by the Secretaries.

(c) CONSULTATION.—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders, including those not otherwise included under subsection (b), while conducting the review described in subsection (a).

(d) RECOMMENDATIONS.—The advisory committee shall make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement au-

thorities of the Departments of Labor, Health and Human Services, and the Treasury and State authorities, and the prevention of balance billing to consumers. The recommendations shall address, at a minimum—

(1) options, best practices, and identified standards to prevent instances of balance billing;

(2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and

(3) legislative options for Congress to prevent balance billing.

(e) REPORT.—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretaries, and the Committees on Education and Labor, Energy and Commerce, and Ways and Means of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions a report containing the recommendations made under subsection (d).