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6 **TITLE I—NO SURPRISES ACT**

7 **SEC. 101. SHORT TITLE.**

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

1 **SEC. 102. HEALTH INSURANCE REQUIREMENTS REGARD-**
2 **ING SURPRISE MEDICAL BILLING.**

3 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

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

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

10 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

20 “(A) without the need for any prior au-
21 thorization determination;

22 “(B) whether the health care provider fur-
23 nishing such services is a participating provider
24 or a participating emergency facility, as appli-
25 cable, with respect to such services;

1 “(C) in a manner so that, if such services
2 are provided to a participant, beneficiary, or en-
3 rollee by a nonparticipating provider or a non-
4 participating emergency facility—

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

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

20 “(iii) such cost-sharing requirement is
21 calculated as if the total amount that
22 would have been charged for such services
23 by such participating provider or partici-
24 pating emergency facility were equal to the
25 recognized amount (as defined in para-

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

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

16 “(v) any cost-sharing payments made
17 by the participant, beneficiary, or enrollee
18 with respect to such emergency services so
19 furnished shall be counted toward any in-
20 network deductible or out-of-pocket maxi-
21 mums applied under the plan or coverage,
22 respectively (and such in-network deduct-
23 ible and out-of-pocket maximums shall be
24 applied) in the same manner as if such
25 cost-sharing payments were made with re-

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

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

13 “(2) AUDIT PROCESS AND REGULATIONS FOR
14 QUALIFYING PAYMENT AMOUNTS.—

15 “(A) AUDIT PROCESS.—

16 “(i) IN GENERAL.—Not later than
17 July 1, 2021, the Secretary, in consulta-
18 tion with the Secretary of Labor and the
19 Secretary of the Treasury, shall establish
20 through rulemaking a process, in accord-
21 ance with clause (ii), under which group
22 health plans and health insurance issuers
23 offering group or individual health insur-
24 ance coverage are audited by the Secretary

1 or applicable State authority to ensure
2 that—

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

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

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

17 “(I) shall conduct audits de-
18 scribed in such clause, with respect to
19 a year (beginning with 2022), of a
20 sample with respect to such year of
21 claims data from not more than 25
22 group health plans and health insur-
23 ance issuers offering group or indi-
24 vidual health insurance coverage; and

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

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

17 “(B) RULEMAKING.—Not later than July
18 1, 2021, the Secretary, in consultation with the
19 Secretary of Labor and the Secretary of the
20 Treasury, shall establish through rulemaking—

21 “(i) the methodology the group health
22 plan or health insurance issuer offering
23 group or individual health insurance cov-
24 erage shall use to determine the qualifying
25 payment amount, differentiating by indi-

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

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

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

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

20 Such rulemaking shall take into account pay-
21 ments that are made by such plan or issuer, re-
22 spectively, that are not on a fee-for-service
23 basis. Such methodology may account for rel-
24 evant payment adjustments that take into ac-
25 count quality or facility type (including higher

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

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

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

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

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

4 “(C) EMERGENCY SERVICES.—

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

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

22 “(II) within the capabilities of
23 the staff and facilities available at the
24 hospital or the independent free-
25 standing emergency department, as

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

11 “(ii) INCLUSION OF ADDITIONAL
12 SERVICES.—

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

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

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

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

20 “(II) CONDITIONS.—For pur-
21 poses of subclause (I), the conditions
22 described in this subclause, with re-
23 spect to a participant, beneficiary, or
24 enrollee who is stabilized and fur-
25 nished additional items and services

1 described in subclause (I) after such
2 stabilization by a provider or facility
3 described in subclause (I), are the fol-
4 lowing;

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

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

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

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

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

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

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

17 “(E) QUALIFYING PAYMENT AMOUNT.—

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

24 “(I) for an item or service fur-
25 nished during 2022, the median of the

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

1 age) over 2019, such percentage in-
2 crease over 2020, and such percentage
3 increase over 2021; and

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

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

24 “(I) for the first year in which
25 such group health plan, group health

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

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

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

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

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

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

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

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

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

1 quent year’ shall be treated as a ref-
2 erence to furnished during the year
3 after such first sufficient information
4 year or a subsequent year.

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

9 “(I) The individual market.

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

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

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

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

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

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

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

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

1 to such first subsequent year;
2 and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 “(2) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

10 “(1) GENERAL RIGHTS.—

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

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

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

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

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

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

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

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

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

12 (3) CONFORMING AMENDMENTS.—

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

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

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

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

- 1 (ii) in subsection (b), by inserting
2 “and part D” after “subparts 1 and 2”;
3 (iii) in subsection (c)(1), by inserting
4 “and part D” after “subparts 1 and 2”;
5 (iv) in subsection (c)(2), by inserting
6 “and part D” after “subparts 1 and 2”;
7 (v) in subsection (c)(3), by inserting
8 “and part D” after “this part”; and
9 (vi) in subsection (d), in the matter
10 preceding paragraph (1), by inserting “and
11 part D” after “this part”.

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

- 15 (i) in subsection (a)(1), by inserting
16 “and part D” after “this part”;
17 (ii) in subsection (a)(2), by inserting
18 “or part D” after “this part”;
19 (iii) in subsection (b)(1), by inserting
20 “or part D” after “this part”;
21 (iv) in subsection (b)(2)(A), by insert-
22 ing “or part D” after “this part”; and
23 (v) in subsection (b)(2)(C)(ii), by in-
24 serting “and part D” after “this part”.

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

4 (i) in subsection (a)(1)—

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

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

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

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

17 (b) ERISA AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(3) DEFINITIONS.—In this subpart:

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

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

3 “(B) EMERGENCY MEDICAL CONDITION.—

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

14 “(C) EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(E) QUALIFYING PAYMENT AMOUNT.—

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

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

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

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

1 “(ii) NEW PLANS AND COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(I) FIRST COVERAGE YEAR.—

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

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

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

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

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

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

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

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

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

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

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

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

10 “(i) NONPARTICIPATING PROVIDER.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(2) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

6 “(1) GENERAL RIGHTS.—

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

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

1 ance issuer described in paragraph (2) shall
2 treat the provision of obstetrical and gynecological
3 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.

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

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

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

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

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

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

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

 “Sec. 715. Additional market reforms.

 “Sec. 716. Preventing surprise medical bills.

 “Sec. 722. Other patient protections.”.

10 (c) IRC AMENDMENTS.—

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

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

15 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

17 “(A) AUDIT PROCESS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(C) EMERGENCY SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(E) QUALIFYING PAYMENT AMOUNT.—

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

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

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

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

1 “(ii) NEW PLANS AND COVERAGE.—

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

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

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

1 “(iii) INSUFFICIENT INFORMATION;
2 NEWLY COVERED ITEMS AND SERVICES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 that does not have in effect a specified
2 State law, with respect to such plan; such
3 a nonparticipating provider or emergency
4 facility; and such an item or service, the
5 amount that is the qualifying payment
6 amount (as defined in subparagraph (E))
7 for such year and determined in accord-
8 ance with rulemaking described in para-
9 graph (2)(B)) for such item or service; or
10 “(iii) in the case of such item or serv-
11 ice furnished in a State with an All-Payer
12 Model Agreement under section 1115A of
13 the Social Security Act, the amount that
14 the State approves under such system for
15 such item or service so furnished.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(2) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(b) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

14 “(1) GENERAL RIGHTS.—

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

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

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

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

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

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

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

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

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

10 (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
11 the end the following new item:
12 the end the following new item:
13 the end the following new item:

“Sec. 9815. Additional market reforms.

“Sec. 9816. Preventing surprise medical bills.

“Sec. 9822. Other patient protections.”.

14 (d) ADDITIONAL APPLICATION PROVISIONS.—

15 (1) APPLICATION TO FEHB.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(ii) is not—

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

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

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

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

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

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

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

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

1 subclause (I), (II), or (III) of subpara-
2 graph (F)(i) be eligible for selection; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(5) PAYMENT DETERMINATION.—

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

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

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

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

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

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

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

19 “(ii) may submit to the certified inde-
20 pendent entity with respect to such deter-
21 mination any information relating to such
22 offer submitted by either party, including
23 information relating to any circumstance
24 described in subparagraph (C)(ii).

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

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

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

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

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

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

3 “(ii) ADDITIONAL CIRCUMSTANCES.—

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

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

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

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

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

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

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

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

6 “(E) EFFECTS OF DETERMINATION.—

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

10 “(I) shall be binding; and

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

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

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

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

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

1 clause (ii), the Secretary shall examine the
2 impact of the application of such clause
3 and whether the application of such clause
4 delays payment determinations, impacts
5 early, alternative resolution of claims (such
6 as through open negotiations), and shall
7 submit to Congress a report on whether
8 any group health plans or health insurance
9 issuers offering group or individual health
10 insurance coverage or types of such plans
11 or coverage have a pattern or practice of
12 routine denial, low payment, or down-cod-
13 ing of claims, or otherwise abuse the 90-
14 day period described in such clause, includ-
15 ing recommendations on ways to discour-
16 age such a pattern or practice.

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

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

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

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

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

24 “(A) PUBLICATION OF INFORMATION.—

25 For each calendar quarter in 2022 and each

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

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

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

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

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

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

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

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

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

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

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

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

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

24 “(iii) the amount of the offer sub-
25 mitted under paragraph (5)(B) by the

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

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

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

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

22 “(vii) the length of time in making
23 each determination;

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

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

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

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

19 “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(5) PAYMENT DETERMINATION.—

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

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

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

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

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

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

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

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

4 “(ii) may submit to the certified inde-
5 pendent entity with respect to such deter-
6 mination any information relating to such
7 offer submitted by either party, including
8 information relating to any circumstance
9 described in subparagraph (C)(ii).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 “(I) shall be binding; and

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

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

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

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

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

1 recommendations on ways to discourage
2 such a pattern or practice.

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

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

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

22 “(6) TIMING OF PAYMENT.—Payment required
23 pursuant to subsection (a)(1) or (b)(1), with respect
24 to a qualified IDR item or service for which a deter-
25 mination is made under paragraph (5)(A) or with

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

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

9 “(A) PUBLICATION OF INFORMATION.—
10 For each calendar quarter in 2022 and each
11 calendar quarter in a subsequent year, the Sec-
12 retary shall make available on the public
13 website of the Department of Health and
14 Human Services—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(ii) is not—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 “(5) PAYMENT DETERMINATION.—

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

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

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

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

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

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

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

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

23 “(ii) may submit to the certified inde-
24 pendent entity with respect to such deter-
25 mination any information relating to such

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

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

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

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

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

24 “(III) information on any cir-
25 cumstance described in clause (ii),

1 such information requested in sub-
2 paragraph (B)(i)(II), and any addi-
3 tional information provided in sub-
4 paragraph (B)(i)(III).

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

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

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

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

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

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

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

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

6 “(E) EFFECTS OF DETERMINATION.—

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

10 “(I) shall be binding; and

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

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

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

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

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

1 clause (ii), the Secretary shall examine the
2 impact of the application of such clause
3 and whether the application of such clause
4 delays payment determinations, impacts
5 early, alternative resolution of claims (such
6 as through open negotiations), and shall
7 submit to Congress a report on whether
8 any group health plans or types of such
9 plans have a pattern or practice of routine
10 denial, low payment, or down-coding of
11 claims, or otherwise abuse the 90-day pe-
12 riod described in such clause, including
13 recommendations on ways to discourage
14 such a pattern or practice.

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

21 “(i) if such entity makes a determina-
22 tion with respect to such notification under
23 subparagraph (A), the party whose offer is
24 not chosen under such subparagraph shall

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

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

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

18 “(7) PUBLICATION OF INFORMATION RELATING
19 TO THE IDR PROCESS.—

20 “(A) PUBLICATION OF INFORMATION.—
21 For each calendar quarter in 2022 and each
22 calendar quarter in a subsequent year, the Sec-
23 retary shall make available on the public
24 website of the Department of Health and
25 Human Services—

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

4 “(ii) the size of the provider practices
5 and the size of the facilities submitting no-
6 tifications under paragraph (1)(B) during
7 such calendar quarter;

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

11 “(iv) the information described in sub-
12 paragraph (B) with respect to each notifi-
13 cation with respect to which such a deter-
14 mination was so made;

15 “(v) the number of times the payment
16 amount determined (or agreed to) under
17 this subsection exceeds the qualifying pay-
18 ment amount, specified by items and serv-
19 ices;

20 “(vi) the amount of expenditures
21 made by the Secretary during such cal-
22 endar quarter to carry out the IDR proc-
23 ess;

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

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

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

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

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

20 “(iii) the amount of the offer sub-
21 mitted under paragraph (5)(B) by the
22 group health plan and by the nonpartici-
23 pating provider or nonparticipating emer-
24 gency facility (as applicable) expressed as

1 a percentage of the qualifying payment
2 amount;

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

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

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

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

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

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

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

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

14 “(8) ADMINISTRATIVE FEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(b) EXCEPTION.—

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

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

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

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

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

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

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

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

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

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

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

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

1 hours prior to the date on which the individual
2 is to be furnished such items or services, pro-
3 vides to the participant, beneficiary, or enrollee
4 (or to an authorized representative of the par-
5 ticipant, beneficiary, or enrollee) not later than
6 72 hours prior to the date on which the indi-
7 vidual is furnished such items or services (or, in
8 the case that the participant, beneficiary, or en-
9 rollee makes such an appointment within 72
10 hours of when such items or services are to be
11 furnished, provides to the participant, bene-
12 ficiary, or enrollee (or to an authorized rep-
13 resentative of the participant, beneficiary, or
14 enrollee) on such date the appointment is
15 made), a written notice in paper or electronic
16 form, as selected by the participant, beneficiary,
17 or enrollee, (and including electronic notifica-
18 tion, as practicable) specified by the Secretary,
19 not later than July 1, 2021, through guidance
20 (which shall be updated as determined nec-
21 essary by the Secretary) that—

22 “(i) contains the information required
23 under paragraph (2);

24 “(ii) clearly states that consent to re-
25 ceive such items and services from such

1 nonparticipating provider or nonpartici-
2 pating facility is optional and that the par-
3 ticipant, beneficiary, or enrollee may in-
4 stead seek care from a participating pro-
5 vider or at a participating facility, with re-
6 spect to such plan or coverage, as applica-
7 ble, in which case the cost-sharing respon-
8 sibility of the participant, beneficiary, or
9 enrollee would not exceed such responsi-
10 bility that would apply with respect to such
11 an item or service that is furnished by a
12 participating provider or participating fa-
13 cility, as applicable with respect to such
14 plan; and

15 “(iii) is available in the 15 most com-
16 mon languages in the geographic region of
17 the applicable facility;

18 “(B) obtains from the participant, bene-
19 ficiary, or enrollee (or from such an authorized
20 representative) the consent described in para-
21 graph (3) to be treated by a nonparticipating
22 provider or nonparticipating facility; and

23 “(C) provides a signed copy of such con-
24 sent to the participant, beneficiary, or enrollee

1 through mail or email (as selected by the par-
2 ticipant, beneficiary, or enrollee).

3 “(2) INFORMATION REQUIRED UNDER WRITTEN
4 NOTICE.—For purposes of paragraph (1)(A)(i), the
5 information described in this paragraph, with re-
6 spect to a nonparticipating provider or nonpartici-
7 pating facility and a participant, beneficiary, or en-
8 rollee of a group health plan or group or individual
9 health insurance coverage offered by a health insur-
10 ance issuer, is each of the following:

11 “(A) Notification, as applicable, that the
12 health care provider is a nonparticipating pro-
13 vider with respect to the health plan or the
14 health care facility is a nonparticipating facility
15 with respect to the health plan.

16 “(B) Notification of the good faith esti-
17 mated amount that such provider or facility
18 may charge the participant, beneficiary, or en-
19 rollee for such items and services involved, in-
20 cluding a notification that the provision of such
21 estimate or consent to be treated under para-
22 graph (3) does not constitute a contract with
23 respect to the charges estimated for such items
24 and services.

1 “(C) In the case of a participating facility
2 and a nonparticipating provider, a list of any
3 participating providers at the facility who are
4 able to furnish such items and services involved
5 and notification that the participant, bene-
6 ficiary, or enrollee may be referred, at their op-
7 tion, to such a participating provider.

8 “(D) Information about whether prior au-
9 thorization or other care management limita-
10 tions may be required in advance of receiving
11 such items or services at the facility.

12 “(3) CONSENT DESCRIBED TO BE TREATED BY
13 A NONPARTICIPATING PROVIDER OR NONPARTICI-
14 PATING FACILITY.—For purposes of paragraph
15 (1)(B), the consent described in this paragraph, with
16 respect to a participant, beneficiary, or enrollee of a
17 group health plan or group or individual health in-
18 surance coverage offered by a health insurance
19 issuer who is to be furnished items or services by a
20 nonparticipating provider or nonparticipating facil-
21 ity, is a document specified by the Secretary, in con-
22 sultation with the Secretary of Labor, through guid-
23 ance that shall be signed by the participant, bene-
24 ficiary, or enrollee before such items or services are
25 furnished and that —

1 “(A) acknowledges (in clear and under-
2 standable language) that the participant, bene-
3 ficiary, or enrollee has been—

4 “(i) provided with the written notice
5 under paragraph (1)(A);

6 “(ii) informed that the payment of
7 such charge by the participant, beneficiary,
8 or enrollee may not accrue toward meeting
9 any limitation that the plan or coverage
10 places on cost-sharing, including an expla-
11 nation that such payment may not apply to
12 an in-network deductible applied under the
13 plan or coverage; and

14 “(iii) provided the opportunity to re-
15 ceive the written notice under paragraph
16 (1)(A) in the form selected by the partici-
17 pant, beneficiary or enrollee; and

18 “(B) documents the date on which the par-
19 ticipant, beneficiary, or enrollee received the
20 written notice under paragraph (1)(A) and the
21 date on which the individual signed such con-
22 sent to be furnished such items or services by
23 such provider or facility.

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

1 pant, beneficiary, or enrollee of a group health plan
2 or group or individual health insurance coverage of-
3 fered by a health insurance issuer, shall constitute
4 only consent to the receipt of the information pro-
5 vided pursuant to this subsection and shall not con-
6 stitute a contractual agreement of the participant,
7 beneficiary, or enrollee to any estimated charge or
8 amount included in such information.

9 “(e) RETENTION OF CERTAIN DOCUMENTS.—A non-
10 participating facility (with respect to such facility or any
11 nonparticipating provider at such facility) or a partici-
12 pating facility (with respect to nonparticipating providers
13 at such facility) that obtains from a participant, bene-
14 ficiary, or enrollee of a group health plan or group or indi-
15 vidual health insurance coverage offered by a health insur-
16 ance issuer (or an authorized representative of such par-
17 ticipant, beneficiary, or enrollee) a written notice in ac-
18 cordance with subsection (d)(1)(A)(ii), with respect to fur-
19 nishing an item or service to such participant, beneficiary,
20 or enrollee, shall retain such notice for at least a 7-year
21 period after the date on which such item or service is so
22 furnished.

23 “(f) DEFINITIONS.—In this section:

24 “(1) The terms ‘nonparticipating provider’ and
25 ‘participating provider’ have the meanings given

1 such terms, respectively, in subsection (a)(3) of sec-
2 tion 2799A–1.

3 “(2) The term ‘participating health care facil-
4 ity’ has the meaning given such term in subsection
5 (b)(2) of section 2799A–1.

6 “(3) The term ‘nonparticipating facility’
7 means—

8 “(A) with respect to emergency services (as
9 defined in section 2799A–1(a)(3)(C)(i)) and a
10 group health plan or group or individual health
11 insurance coverage offered by a health insur-
12 ance issuer, an emergency department of a hos-
13 pital, or an independent freestanding emergency
14 department, that does not have a contractual
15 relationship with the plan or issuer, respec-
16 tively, with respect to the furnishing of such
17 services under the plan or coverage, respec-
18 tively; and

19 “(B) with respect to services described in
20 section 2799A–1(a)(3)(C)(ii) and a group
21 health plan or group or individual health insur-
22 ance coverage offered by a health insurance
23 issuer, a hospital or an independent free-
24 standing emergency department, that does not
25 have a contractual relationship with the plan or

1 issuer, respectively, with respect to the fur-
2 nishing of such services under the plan or cov-
3 erage, respectively.

4 “(4) The term ‘participating facility’ means—

5 “(A) with respect to emergency services (as
6 defined in clause (i) of section 2799A–
7 1(a)(3)(C)) that are not described in clause(ii)
8 of such section and a group health plan or
9 group or individual health insurance coverage
10 offered by a health insurance issuer, an emer-
11 gency department of a hospital, or an inde-
12 pendent freestanding emergency department,
13 that has a direct or indirect contractual rela-
14 tionship with the plan or issuer, respectively,
15 with respect to the furnishing of such services
16 under the plan or coverage, respectively; and

17 “(B) with respect to services that pursuant
18 to clause (ii) of section 2799A–1(a)(3)(C), of
19 section 9816(a)(3) of the Internal Revenue
20 Code of 1986, and of section 716(a)(3) of the
21 Employee Retirement Income Security Act of
22 1974, as applicable are included as emergency
23 services (as defined in clause (i) of such section
24 and a group health plan or group or individual
25 health insurance coverage offered by a health

1 insurance issuer, a hospital or an independent
2 freestanding emergency department, that has a
3 contractual relationship with the plan or cov-
4 erage, respectively, with respect to the fur-
5 nishing of such services under the plan or cov-
6 erage, respectively.

7 **“SEC. 2799B-3. PROVIDER REQUIREMENTS WITH RESPECT**
8 **TO DISCLOSURE ON PATIENT PROTECTIONS**
9 **AGAINST BALANCE BILLING.**

10 “Beginning not later than January 1, 2022, each
11 health care provider and health care facility shall make
12 publicly available, and (if applicable) post on a public
13 website of such provider or facility and provide to individ-
14 uals who are participants, beneficiaries, or enrollees of a
15 group health plan or group or individual health insurance
16 coverage offered by a health insurance issuer a one-page
17 notice (either postal or electronic mail, as specified by the
18 participant, beneficiary, or enrollee) containing informa-
19 tion on—

20 “(1) the requirements and prohibitions of such
21 provider or facility under sections 2799B-1 and
22 2799B-2 (relating to prohibitions on balance billing
23 in certain circumstances);

24 “(2) any other applicable State law require-
25 ments on such provider or facility regarding the

1 amounts such provider or facility may, with respect
2 to an item or service, charge a participant, bene-
3 ficiary, or enrollee of a group health plan or group
4 or individual health insurance coverage offered by a
5 health insurance issuer with respect to which such
6 provider or facility does not have a contractual rela-
7 tionship for furnishing such item or service under
8 the plan or coverage, respectively, after receiving
9 payment from the plan or coverage, respectively, for
10 such item or service and any applicable cost-sharing
11 payment from such participant, beneficiary, or en-
12 rollee; and

13 “(3) information on contacting appropriate
14 State and Federal agencies in the case that an indi-
15 vidual believes that such provider or facility has vio-
16 lated any requirement described in paragraph (1) or
17 (2) with respect to such individual.

18 **“SEC. 2799B–4. ENFORCEMENT.**

19 “(a) STATE ENFORCEMENT.—

20 “(1) STATE AUTHORITY.—Each State may re-
21 quire a provider or health care facility (including a
22 provider of air ambulance services) subject to the re-
23 quirements (including as applied through section
24 2799B–11) of this part or, in the case of air ambu-

1 lance providers, section 2799B–5 to satisfy such re-
2 quirements applicable to the provider or facility.

3 “(2) FAILURE TO IMPLEMENT REQUIRE-
4 MENTS.—In the case of a determination by the Sec-
5 retary that a State has failed to substantially en-
6 force the requirements to which paragraph (1) ap-
7 plies with respect to applicable providers and facili-
8 ties in the State, the Secretary shall enforce such re-
9 quirements under subsection (b) insofar as they re-
10 late to violations of such requirements occurring in
11 such State.

12 “(3) NOTIFICATION OF APPLICABLE SEC-
13 RETARY.—A State may notify the Secretary of
14 Labor, Secretary of Health and Human Services, or
15 the Secretary of the Treasury, as applicable, of in-
16 stances of violations of sections 2799A–1, 2799A–2,
17 or 2799A–5 with respect to participants, bene-
18 ficiaries, or enrollees under a group health plan or
19 group or individual health insurance coverage, as ap-
20 plicable offered by a health insurance issuer and any
21 enforcement actions taken against providers or fa-
22 cilities as a result of such violations, including the
23 disposition of any such enforcement actions.

24 “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

1 “(1) IN GENERAL.—If a provider or facility is
2 found by the Secretary to be in violation of a re-
3 quirement to which subsection (a)(1) applies, the
4 Secretary may apply a civil monetary penalty with
5 respect to such provider or facility (including, as ap-
6 plicable, a provider of air ambulance services) in an
7 amount not to exceed \$10,000 per violation. The
8 provisions of subsections (c) (with the exception of
9 the first sentence of paragraph (1) of such sub-
10 section), (d), (e), (g), (h), (k), and (l) of section
11 1128A of the Social Security Act shall apply to a
12 civil monetary penalty or assessment under this sub-
13 section in the same manner as such provisions apply
14 to a penalty, assessment, or proceeding under sub-
15 section (a) of such section.

16 “(2) LIMITATION.—The provisions of para-
17 graph (1) shall apply to enforcement of a provision
18 (or provisions) specified in subsection (a)(1) only as
19 provided under subsection (a)(2).

20 “(3) COMPLAINT PROCESS.—The Secretary
21 shall, through rulemaking, establish a process to re-
22 ceive consumer complaints of violations of such pro-
23 visions and provide a response to such complaints
24 within 60 days of receipt of such complaints.

1 “(4) EXCEPTION.—The Secretary shall waive
2 the penalties described under paragraph (1) with re-
3 spect to a facility or provider (including a provider
4 of air ambulance services) who does not knowingly
5 violate, and should not have reasonably known it vio-
6 lated, section 2799B–1, 2799B–2, or 2799B–10 (or,
7 in the case of a provider of air ambulance services,
8 section 2799B–5) (including as such respective sec-
9 tion is applied through section 2799B–11) with re-
10 spect to a participant, beneficiary, or enrollee, if
11 such facility or practitioner, within 30 days of the
12 violation, withdraws the bill that was in violation of
13 such provision and reimburses the health plan or en-
14 rollee, as applicable, in an amount equal to the dif-
15 ference between the amount billed and the amount
16 allowed to be billed under the provision, plus inter-
17 est, at an interest rate determined by the Secretary.

18 “(5) HARDSHIP EXEMPTION.—The Secretary
19 may establish a hardship exemption to the penalties
20 under this subsection.

21 “(c) CONTINUED APPLICABILITY OF STATE LAW.—
22 The sections specified in subsection (a)(1) shall not be
23 construed to supersede any provision of State law which
24 establishes, implements, or continues in effect any require-
25 ment or prohibition except to the extent that such require-

1 ment or prohibition prevents the application of a require-
2 ment or prohibition of such a section.”.

3 (b) SECRETARY OF LABOR ENFORCEMENT.—

4 (1) IN GENERAL.—Part 5 of subtitle B of title
5 I of the Employee Retirement Income Security Act
6 of 1974 (29 U.S.C. 1131 et seq.) is amended by
7 adding at the end the following new section:

8 **“SEC. 522. COORDINATION OF ENFORCEMENT REGARDING**
9 **VIOLATIONS OF CERTAIN HEALTH CARE PRO-**
10 **VIDER REQUIREMENTS; COMPLAINT PROC-**
11 **ESS.**

12 “(a) INVESTIGATING VIOLATIONS.—Upon receiving a
13 notice from a State or the Secretary of Health and Human
14 Services of violations of sections 2799A–1 or 2799A–2 of
15 the Public Health Service Act, the Secretary of Labor
16 shall identify patterns of such violations with respect to
17 participants or beneficiaries under a group health plan or
18 group health insurance coverage offered by a health insur-
19 ance issuer and conduct an investigation pursuant to sec-
20 tion 504 where appropriate, as determined by the Sec-
21 retary. The Secretary shall coordinate with States and the
22 Secretary of Health and Human Services, in accordance
23 with section 506 and with section 104 of Health Insurance
24 Portability and Accountability Act of 1996, where appro-
25 priate, as determined by the Secretary, to ensure that ap-

1 appropriate measures have been taken to correct such viola-
2 tions retrospectively and prospectively with respect to par-
3 ticipants or beneficiaries under a group health plan or
4 group health insurance coverage offered by a health insur-
5 ance issuer.

6 “(b) COMPLAINT PROCESS.— Not later than January
7 1, 2022, the Secretary shall ensure a process under which
8 the Secretary—

9 “(1) may receive complaints from participants
10 and beneficiaries of group health plans or group
11 health insurance coverage offered by a health insur-
12 ance issuer relating to alleged violations of the sec-
13 tions specified in subsection (a); and

14 “(2) transmits such complaints to States or the
15 Secretary of Health and Human Services (as deter-
16 mined appropriate by the Secretary) for potential
17 enforcement actions.”.

18 (2) TECHNICAL AMENDMENT.—The table of
19 contents in section 1 of the Employee Retirement
20 Income Security Act of 1974 (29 U.S.C. 1001 et
21 seq.) is amended by inserting after the item relating
22 to section 521 the following new item:

“Sec. 522. Coordination of enforcement regarding violations of certain health
care provider requirements; complaint process.”.

1 **SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS.**

2 (a) GROUP HEALTH PLANS AND INDIVIDUAL AND
3 GROUP HEALTH INSURANCE COVERAGE.—

4 (1) PHSA AMENDMENTS.—Part D of title
5 XXVII of the Public Health Service Act, as added
6 and amended by section 102 and further amended
7 by the previous provisions of this title, is further
8 amended by inserting after section 2799A–1 the fol-
9 lowing:

10 **“SEC. 2799A–2. ENDING SURPRISE AIR AMBULANCE BILLS.**

11 “(a) IN GENERAL.—In the case of a participant, ben-
12 eficiary, or enrollee who is in a group health plan or group
13 or individual health insurance coverage offered by a health
14 insurance issuer and who receives air ambulance services
15 from a nonparticipating provider (as defined in section
16 2799A–1(a)(3)(G)) with respect to such plan or coverage,
17 if such services would be covered if provided by a partici-
18 pating provider (as defined in such section) with respect
19 to such plan or coverage—

20 “(1) the cost-sharing requirement with respect
21 to such services shall be the same requirement that
22 would apply if such services were provided by such
23 a participating provider, and any coinsurance or de-
24 ductible shall be based on rates that would apply for
25 such services if they were furnished by such a par-
26 ticipating provider;

1 “(2) such cost-sharing amounts shall be count-
2 ed towards the in-network deductible and in-network
3 out-of-pocket maximum amount under the plan or
4 coverage for the plan year (and such in-network de-
5 ductible shall be applied) with respect to such items
6 and services so furnished in the same manner as if
7 such cost-sharing payments were with respect to
8 items and services furnished by a participating pro-
9 vider; and

10 “(3) the plan or coverage shall pay, in accord-
11 ance with, if applicable, subsection (b)(5)(F), di-
12 rectly to such provider furnishing such services to
13 such participant, beneficiary, or enrollee the amount
14 by which the out-of-network rate (as defined in sec-
15 tion 2799A–1(a)(3)(K)) for such services and year
16 involved exceeds the cost-sharing amount imposed
17 under the plan or coverage, respectively, for such
18 services (as determined in accordance with para-
19 graphs (1) and (2)).

20 “(b) DETERMINATION OF OUT-OF-NETWORK RATES
21 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
22 RESOLUTION PROCESS.—

23 “(1) DETERMINATION THROUGH OPEN NEO-
24 TATION.—

1 “(A) IN GENERAL.—With respect to air
2 ambulance services furnished in a year by a
3 nonparticipating provider, with respect to a
4 group health plan or health insurance issuer of-
5 fering group or individual health insurance cov-
6 erage, in a State described in subsection section
7 2799A–1(a)(3)(K)(ii) with respect to such plan
8 or coverage and provider, and for which a pay-
9 ment is required to be made by the plan or cov-
10 erage pursuant to subsection (a)(3), the pro-
11 vider or plan or coverage may, during the 30-
12 day period beginning on the day the provider
13 receives a response from the plan or coverage
14 regarding a claim for payment for such service,
15 initiate open negotiations under this paragraph
16 between such provider and plan or coverage for
17 purposes of determining, during the open nego-
18 tiation period, an amount agreed on by such
19 provider, and such plan or coverage for pay-
20 ment (including any cost-sharing) for such serv-
21 ice. For purposes of this subsection, the open
22 negotiation period, with respect to air ambu-
23 lance services, is the 30-day period beginning
24 on the date of initiation of the negotiations with
25 respect to such services.

1 “(B) ACCESSING INDEPENDENT DISPUTE
2 RESOLUTION PROCESS IN CASE OF FAILED NE-
3 GOTIATIONS.—In the case of open negotiations
4 pursuant to subparagraph (A), with respect to
5 air ambulance services, that do not result in a
6 determination of an amount of payment for
7 such services by the last day of the open nego-
8 tiation period described in such subparagraph
9 with respect to such services, the provider or
10 group health plan or health insurance issuer of-
11 fering group or individual health insurance cov-
12 erage that was party to such negotiations may,
13 during the 2-day period beginning on the day
14 after such open negotiation period, initiate the
15 independent dispute resolution process under
16 paragraph (2) with respect to such item or
17 service. The independent dispute resolution
18 process shall be initiated by a party pursuant to
19 the previous sentence by submission to the
20 other party and to the Secretary of a notifica-
21 tion (containing such information as specified
22 by the Secretary) and for purposes of this sub-
23 section, the date of initiation of such process
24 shall be the date of such submission or such
25 other date specified by the Secretary pursuant

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

4 “(2) INDEPENDENT DISPUTE RESOLUTION
5 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-
6 GOTIATIONS.—

7 “(A) ESTABLISHMENT.—Not later than 1
8 year after the date of the enactment of this
9 subsection, the Secretary, jointly with the Sec-
10 retary of Labor and the Secretary of the Treas-
11 ury, shall establish by regulation one inde-
12 pendent dispute resolution process (referred to
13 in this subsection as the ‘IDR process’) under
14 which, in the case of air ambulance services
15 with respect to which a provider or group
16 health plan or health insurance issuer offering
17 group or individual health insurance coverage
18 submits a notification under paragraph (1)(B)
19 (in this subsection referred to as a ‘qualified
20 IDR air ambulance services’), a certified IDR
21 entity under paragraph (4) determines, subject
22 to subparagraph (B) and in accordance with
23 the succeeding provisions of this subsection, the
24 amount of payment under the plan or coverage
25 for such services furnished by such provider.

1 “(B) AUTHORITY TO CONTINUE NEGOTIA-
2 TIONS.—Under the independent dispute resolu-
3 tion process, in the case that the parties to a
4 determination for qualified IDR air ambulance
5 services agree on a payment amount for such
6 services during such process but before the date
7 on which the entity selected with respect to
8 such determination under paragraph (4) makes
9 such determination under paragraph (5), such
10 amount shall be treated for purposes of section
11 2799A–1(a)(3)(K)(ii) as the amount agreed to
12 by such parties for such services. In the case of
13 an agreement described in the previous sen-
14 tence, the independent dispute resolution proc-
15 ess shall provide for a method to determine how
16 to allocate between the parties to such deter-
17 mination the payment of the compensation of
18 the entity selected with respect to such deter-
19 mination.

20 “(C) CLARIFICATION.—A nonparticipating
21 provider may not, with respect to an item or
22 service furnished by such provider, submit a no-
23 tification under paragraph (1)(B) if such pro-
24 vider is exempt from the requirement under
25 subsection (a) of section 2799B–2 with respect

1 to such item or service pursuant to subsection
2 (b) of such section.

3 “(3) TREATMENT OF BATCHING OF SERV-
4 ICES.—The provisions of section 2799A–1(c)(3)
5 shall apply with respect to a notification submitted
6 under this subsection with respect to air ambulance
7 services in the same manner and to the same extent
8 such provisions apply with respect to a notification
9 submitted under section 2799A–1(c) with respect to
10 items and services described in such section.

11 “(4) IDR ENTITIES.—

12 “(A) ELIGIBILITY.—An IDR entity cer-
13 tified under this subsection is an IDR entity
14 certified under section 2799A–1(c)(4).

15 “(B) SELECTION OF CERTIFIED IDR ENTI-
16 TY.—The provisions of subparagraph (F) of
17 section 2799A–1(c)(4) shall apply with respect
18 to selecting an IDR entity certified pursuant to
19 subparagraph (A) with respect to the deter-
20 mination of the amount of payment under this
21 subsection of air ambulance services in the
22 same manner as such provisions apply with re-
23 spect to selecting an IDR entity certified under
24 such section with respect to the determination
25 of the amount of payment under section

1 2799A–1(c) of an item or service. An entity se-
2 lected pursuant to the previous sentence to
3 make a determination described in such sen-
4 tence shall be referred to in this subsection as
5 the ‘certified IDR entity’ with respect to such
6 determination.

7 “(5) PAYMENT DETERMINATION.—

8 “(A) IN GENERAL.—Not later than 30
9 days after the date of selection of the certified
10 IDR entity, with respect to qualified IDR air
11 ambulance services, the certified independent
12 entity with respect to a determination under
13 this subsection for such services shall—

14 “(i) taking into account the consider-
15 ations specified in subparagraph (C), select
16 one of the offers submitted under subpara-
17 graph (B) to be the amount of payment for
18 such services determined under this sub-
19 section for purposes of subsection (a)(3);
20 and

21 “(ii) notify the provider or facility and
22 the group health plan or health insurance
23 issuer offering group or individual health
24 insurance coverage party to such deter-

1 mination of the offer selected under clause
2 (i).

3 “(B) SUBMISSION OF OFFERS.—Not later
4 than 10 days after the date of selection of the
5 certified IDR entity with respect to a deter-
6 mination for qualified IDR air ambulance serv-
7 ices, the provider and the group health plan or
8 health insurance issuer offering group or indi-
9 vidual health insurance coverage party to such
10 determination—

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

14 “(I) an offer for a payment
15 amount for such services furnished by
16 such provider; and

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

20 “(ii) may submit to the certified inde-
21 pendent entity with respect to such deter-
22 mination any information relating to such
23 offer submitted by either party, including
24 information relating to any circumstance
25 described in subparagraph (C)(ii).

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

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

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

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

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

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

3 “(ii) ADDITIONAL CIRCUMSTANCES.—
4 For purposes of clause (i)(II), the cir-
5 cumstances described in this clause are,
6 with respect to air ambulance services in-
7 cluded in the notification submitted under
8 paragraph (1)(A) of a nonparticipating
9 provider, group health plan, or health in-
10 insurance issuer the following:

11 “(I) The quality and outcomes
12 measurements of the provider that
13 furnished such services.

14 “(II) The acuity of the individual
15 receiving such services or the com-
16 plexity of furnishing such services to
17 such individual.

18 “(III) The training, experience,
19 and quality of the medical personnel
20 that furnished such services.

21 “(IV) Ambulance vehicle type, in-
22 cluding the clinical capability level of
23 such vehicle.

1 “(V) Population density of the
2 pick up location (such as urban, sub-
3 urban, rural, or frontier).

4 “(VI) Demonstrations of good
5 faith efforts (or lack of good faith ef-
6 forts) made by the nonparticipating
7 provider or nonparticipating facility or
8 the plan or issuer to enter into net-
9 work agreements and, if applicable,
10 contracted rates between the provider
11 and the plan or issuer, as applicable,
12 during the previous 4 plan years.

13 “(iii) PROHIBITION ON CONSIDER-
14 ATION OF BILLED CHARGES.—In deter-
15 mining which offer is the payment amount
16 to be applied with respect to qualified IDR
17 air ambulance services furnished by a pro-
18 vider, the certified IDR entity with respect
19 to such determination shall not consider
20 usual and customary charges or the
21 amount that would have been billed by
22 such provider with respect to such services
23 had the provisions of section 2799B–5 not
24 applied.

1 “(D) EFFECTS OF DETERMINATION.—The
2 provisions of section 2799A–1(c)(5)(D)) shall
3 apply with respect to a determination of a cer-
4 tified IDR entity under subparagraph (A), the
5 notification submitted with respect to such de-
6 termination, the services with respect to such
7 notification, and the parties to such notification
8 in the same manner as such provisions apply
9 with respect to a determination of a certified
10 IDR entity under section 2799A–1(c)(5)(D),
11 the notification submitted with respect to such
12 determination, the items and services with re-
13 spect to such notification, and the parties to
14 such notification.

15 “(E) COSTS OF INDEPENDENT DISPUTE
16 RESOLUTION PROCESS.—The provisions of sec-
17 tion 2799A–1(c)(5)(E) shall apply to a notifica-
18 tion made under this subsection, the parties to
19 such notification, and a determination under
20 subparagraph (A) in the same manner and to
21 the same extent such provisions apply to a noti-
22 fication under section 2799A–1(c), the parties
23 to such notification and a determination made
24 under section 2799A–1(c)(5)(A).

1 “(6) TIMING OF PAYMENT.—Payment required
2 pursuant to subsection (a)(3), with respect to quali-
3 fied IDR air ambulance services for which a deter-
4 mination is made under paragraph (5)(A) or with
5 respect to an air ambulance service for which a pay-
6 ment amount is determined under open negotiations
7 under paragraph (1), shall be made directly to the
8 nonparticipating provider not later than 30 days
9 after the date on which such determination is made.

10 “(7) PUBLICATION OF INFORMATION RELATING
11 TO THE IDR PROCESS.—

12 “(A) IN GENERAL.—For each calendar
13 quarter in 2022 and each calendar quarter in a
14 subsequent year, the Secretary shall publish on
15 the public website of the Department of Health
16 and Human Services—

17 “(i) the number of notifications sub-
18 mitted under the IDR process during such
19 calendar quarter;

20 “(ii) the number of such notifications
21 with respect to which a final determination
22 was made under paragraph (5)(A);

23 “(iii) the information described in
24 subparagraph (B) with respect to each no-

1 tification with respect to which such a de-
2 termination was so made.

3 “(iv) the number of times the pay-
4 ment amount determined (or agreed to)
5 under this subsection exceeds the quali-
6 fying payment amount;

7 “(v) the amount of expenditures made
8 by the Secretary during such calendar
9 quarter to carry out the IDR process;

10 “(vi) the total amount of fees paid
11 under paragraph (7) during such calendar
12 quarter; and

13 “(vii) the total amount of compensa-
14 tion paid to certified IDR entities under
15 paragraph (5)(E)during such calendar
16 quarter.

17 “(B) INFORMATION WITH RESPECT TO RE-
18 QUESTS.—For purposes of subparagraph (A),
19 the information described in this subparagraph
20 is, with respect to a notification under the IDR
21 process of a nonparticipating provider, group
22 health plan, or health insurance issuer offering
23 group or individual health insurance coverage—

24 “(i) a description of each air ambu-
25 lance service included in such notification;

1 “(ii) the geography in which the serv-
2 ices included in such notification were pro-
3 vided;

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

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

18 “(v) ambulance vehicle type, including
19 the clinical capability level of such vehicle;

20 “(vi) the identity of the group health
21 plan or health insurance issuer or air am-
22 bulance provider with respect to such noti-
23 fication;

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

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

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

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

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

20 “(8) ADMINISTRATIVE FEE.—

21 “(A) IN GENERAL.—Each party to a deter-
22 mination under paragraph (5) to which an enti-
23 ty is selected under paragraph (4) in a year
24 shall pay to the Secretary, at such time and in
25 such manner as specified by the Secretary, a

1 fee for participating in the IDR process with re-
2 spect to such determination in an amount de-
3 scribed in subparagraph (B) for such year.

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

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

17 “(c) DEFINITION.—For purposes of this section, the
18 term ‘air ambulance service’ means medical transport by
19 helicopter or airplane for patients.”.

20 (2) ERISA AMENDMENT.—

21 (A) IN GENERAL.—Subpart B of part 7 of
22 title I of the Employee Retirement Income Se-
23 curity Act of 1974 (29 U.S.C. 1185 et seq.), as
24 amended by section 102(b) and further amend-
25 ed by the previous provisions of this title, is fur-

1 ther amended by inserting after section 716 the
2 following:

3 **“SEC. 717. ENDING SURPRISE AIR AMBULANCE BILLS.**

4 “(a) IN GENERAL.—In the case of a participant, ben-
5 eficiary, or enrollee who is in a group health plan or group
6 health insurance coverage offered by a health insurance
7 issuer and who receives air ambulance services from a non-
8 participating provider (as defined in section 716(a)(3)(G))
9 with respect to such plan or coverage, if such services
10 would be covered if provided by a participating provider
11 (as defined in such section) with respect to such plan or
12 coverage—

13 “(1) the cost-sharing requirement with respect
14 to such services shall be the same requirement that
15 would apply if such services were provided by such
16 a participating provider, and any coinsurance or de-
17 ductible shall be based on rates that would apply for
18 such services if they were furnished by such a par-
19 ticipating provider;

20 “(2) such cost-sharing amounts shall be count-
21 ed towards the in-network deductible and in-network
22 out-of-pocket maximum amount under the plan or
23 coverage for the plan year (and such in-network de-
24 ductible shall be applied) with respect to such items
25 and services so furnished in the same manner as if

1 such cost-sharing payments were with respect to
2 items and services furnished by a participating pro-
3 vider; and

4 “(3) the plan or coverage shall pay, in accord-
5 ance with, if applicable, subsection (b)(5)(F), di-
6 rectly to such provider furnishing such services to
7 such participant, beneficiary, or enrollee the amount
8 by which the out-of-network rate (as defined in sec-
9 tion 716(a)(3)(K)) for such services and year in-
10 volved exceeds the cost-sharing amount imposed
11 under the plan or coverage, respectively, for such
12 services (as determined in accordance with para-
13 graphs (1) and (2)).

14 “(b) DETERMINATION OF OUT-OF-NETWORK RATES
15 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE
16 RESOLUTION PROCESS.—

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

19 “(A) IN GENERAL.—With respect to air
20 ambulance services furnished in a year by a
21 nonparticipating provider, with respect to a
22 group health plan or health insurance issuer of-
23 fering group health insurance coverage, in a
24 State described in subsection section
25 716(a)(3)(K)(ii) with respect to such plan or

1 coverage and provider, and for which a payment
2 is required to be made by the plan or coverage
3 pursuant to subsection (a)(3), the provider or
4 plan or coverage may, during the 30-day period
5 beginning on the day the provider receives a re-
6 sponse from the plan or coverage regarding a
7 claim for payment for such service, initiate open
8 negotiations under this paragraph between such
9 provider and plan or coverage for purposes of
10 determining, during the open negotiation pe-
11 riod, an amount agreed on by such provider,
12 and such plan or coverage for payment (includ-
13 ing any cost-sharing) for such service. For pur-
14 poses of this subsection, the open negotiation
15 period, with respect to air ambulance services,
16 is the 30-day period beginning on the date of
17 initiation of the negotiations with respect to
18 such services.

19 “(B) ACCESSING INDEPENDENT DISPUTE
20 RESOLUTION PROCESS IN CASE OF FAILED NE-
21 GOTIATIONS.—In the case of open negotiations
22 pursuant to subparagraph (A), with respect to
23 air ambulance services, that do not result in a
24 determination of an amount of payment for
25 such services by the last day of the open nego-

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

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

1 “(A) ESTABLISHMENT.—Not later than 1
2 year after the date of the enactment of this
3 subsection, the Secretary, jointly with the Sec-
4 retary of Health and Human Services and the
5 Secretary of the Treasury, shall establish by
6 regulation one independent dispute resolution
7 process (referred to in this subsection as the
8 ‘IDR process’) under which, in the case of air
9 ambulance services with respect to which a pro-
10 vider or group health plan or health insurance
11 issuer offering group health insurance coverage
12 submits a notification under paragraph (1)(B)
13 (in this subsection referred to as a ‘qualified
14 IDR air ambulance services’), a certified IDR
15 entity under paragraph (4) determines, subject
16 to subparagraph (B) and in accordance with
17 the succeeding provisions of this subsection, the
18 amount of payment under the plan or coverage
19 for such services furnished by such provider.

20 “(B) AUTHORITY TO CONTINUE NEGOTIA-
21 TIONS.—Under the independent dispute resolu-
22 tion process, in the case that the parties to a
23 determination for qualified IDR air ambulance
24 services agree on a payment amount for such
25 services during such process but before the date

1 on which the entity selected with respect to
2 such determination under paragraph (4) makes
3 such determination under paragraph (5), such
4 amount shall be treated for purposes of section
5 716(a)(3)(K)(ii) as the amount agreed to by
6 such parties for such services. In the case of an
7 agreement described in the previous sentence,
8 the independent dispute resolution process shall
9 provide for a method to determine how to allo-
10 cate between the parties to such determination
11 the payment of the compensation of the entity
12 selected with respect to such determination.

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

22 “(3) TREATMENT OF BATCHING OF SERV-
23 ICES.—The provisions of section 716(c)(3) shall
24 apply with respect to a notification submitted under
25 this subsection with respect to air ambulance serv-

1 ices in the same manner and to the same extent
2 such provisions apply with respect to a notification
3 submitted under section 716(c) with respect to items
4 and services described in such section.

5 “(4) IDR ENTITIES.—

6 “(A) ELIGIBILITY.—An IDR entity cer-
7 tified under this subsection is an IDR entity
8 certified under section 716(c)(4).

9 “(B) SELECTION OF CERTIFIED IDR ENTI-
10 TY.—The provisions of subparagraph (F) of
11 section 716(c)(4) shall apply with respect to se-
12 lecting an IDR entity certified pursuant to sub-
13 paragraph (A) with respect to the determina-
14 tion of the amount of payment under this sub-
15 section of air ambulance services in the same
16 manner as such provisions apply with respect to
17 selecting an IDR entity certified under such
18 section with respect to the determination of the
19 amount of payment under section 716(c) of an
20 item or service. An entity selected pursuant to
21 the previous sentence to make a determination
22 described in such sentence shall be referred to
23 in this subsection as the ‘certified IDR entity’
24 with respect to such determination.

25 “(5) PAYMENT DETERMINATION.—

1 “(A) IN GENERAL.—Not later than 30
2 days after the date of selection of the certified
3 IDR entity, with respect to qualified IDR air
4 ambulance services, the certified independent
5 entity with respect to a determination under
6 this subsection for such services shall—

7 “(i) taking into account the consider-
8 ations specified in subparagraph (C), select
9 one of the offers submitted under subpara-
10 graph (B) to be the amount of payment for
11 such services determined under this sub-
12 section for purposes of subsection (a)(3);
13 and

14 “(ii) notify the provider or facility and
15 the group health plan or health insurance
16 issuer offering group health insurance cov-
17 erage party to such determination of the
18 offer selected under clause (i).

19 “(B) SUBMISSION OF OFFERS.—Not later
20 than 10 days after the date of selection of the
21 certified IDR entity with respect to a deter-
22 mination for qualified IDR air ambulance serv-
23 ices, the provider and the group health plan or
24 health insurance issuer offering group health

1 insurance coverage party to such determina-
2 tion—

3 “(i) shall each submit to the certified
4 independent entity with respect to such de-
5 termination—

6 “(I) an offer for a payment
7 amount for such services furnished by
8 such provider; and

9 “(II) such information as re-
10 quested by the certified IDR entity re-
11 lating to such offer; and

12 “(ii) may submit to the certified inde-
13 pendent entity with respect to such deter-
14 mination any information relating to such
15 offer submitted by either party, including
16 information relating to any circumstance
17 described in subparagraph (C)(ii).

18 “(C) CONSIDERATIONS IN DETERMINA-
19 TION.—

20 “(i) IN GENERAL.—In determining
21 which offer is the payment to be applied
22 pursuant to this paragraph, the certified
23 IDR entity, with respect to the determina-
24 tion for a qualified IDR air ambulance
25 service shall consider—

1 “(I) the offers under subpara-
2 graph (B)(i);

3 “(II) the qualifying payment
4 amounts (as defined in subsection
5 (a)(3)(E)) for the applicable year for
6 items and services that are com-
7 parable to the qualified IDR air am-
8 bulance service and that are furnished
9 in the same geographic region (as de-
10 fined by the Secretary for purposes of
11 such subsection) as such qualified
12 IDR air ambulance service; and

13 “(III) information on any cir-
14 cumstance described in clause (ii),
15 such information requested in sub-
16 paragraph (B)(i)(II), and any addi-
17 tional information provided in sub-
18 paragraph (B)(i)(III).

19 “(ii) ADDITIONAL CIRCUMSTANCES.—
20 For purposes of clause (i)(II), the cir-
21 cumstances described in this clause are,
22 with respect to air ambulance services in-
23 cluded in the notification submitted under
24 paragraph (1)(A) of a nonparticipating

1 provider, group health plan, or health in-
2 surance issuer the following:

3 “(I) The quality and outcomes
4 measurements of the provider that
5 furnished such services.

6 “(II) The acuity of the individual
7 receiving such services or the com-
8 plexity of furnishing such services to
9 such individual.

10 “(III) The training, experience,
11 and quality of the medical personnel
12 that furnished such services.

13 “(IV) Ambulance vehicle type, in-
14 cluding the clinical capability level of
15 such vehicle.

16 “(V) Population density of the
17 pick up location (such as urban, sub-
18 urban, rural, or frontier).

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

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

3 “(iii) PROHIBITION ON CONSIDER-
4 ATION OF BILLED CHARGES.—In deter-
5 mining which offer is the payment amount
6 to be applied with respect to qualified IDR
7 air ambulance services furnished by a pro-
8 vider, the certified IDR entity with respect
9 to such determination shall not consider
10 usual and customary charges or the
11 amount that would have been billed by
12 such provider with respect to such services
13 had the provisions of section 2799B–5 of
14 the Public Health Service Act not applied.

15 “(D) EFFECTS OF DETERMINATION.—The
16 provisions of section 716(c)(5)(D)) shall apply
17 with respect to a determination of a certified
18 IDR entity under subparagraph (A), the notifi-
19 cation submitted with respect to such deter-
20 mination, the services with respect to such noti-
21 fication, and the parties to such notification in
22 the same manner as such provisions apply with
23 respect to a determination of a certified IDR
24 entity under section 716(c)(5)(D), the notifica-
25 tion submitted with respect to such determina-

1 tion, the items and services with respect to such
2 notification, and the parties to such notifica-
3 tion.

4 “(E) COSTS OF INDEPENDENT DISPUTE
5 RESOLUTION PROCESS.—The provisions of sec-
6 tion 716(c)(5)(E) shall apply to a notification
7 made under this subsection, the parties to such
8 notification, and a determination under sub-
9 paragraph (A) in the same manner and to the
10 same extent such provisions apply to a notifica-
11 tion under section 716(c), the parties to such
12 notification and a determination made under
13 section 716(c)(5)(A).

14 “(6) TIMING OF PAYMENT.—Payment required
15 pursuant to subsection (a)(3), with respect to quali-
16 fied IDR air ambulance services for which a deter-
17 mination is made under paragraph (5)(A) or with
18 respect to air ambulance services for which a pay-
19 ment amount is determined under open negotiations
20 under paragraph (1), shall be made directly to the
21 nonparticipating provider not later than 30 days
22 after the date on which such determination is made.

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

1 “(A) IN GENERAL.—For each calendar
2 quarter in 2022 and each calendar quarter in a
3 subsequent year, the Secretary shall publish on
4 the public website of the Department of
5 Labor—

6 “(i) the number of notifications sub-
7 mitted under the IDR process during such
8 calendar quarter;

9 “(ii) the number of such notifications
10 with respect to which a final determination
11 was made under paragraph (5)(A);

12 “(iii) the information described in
13 subparagraph (B) with respect to each no-
14 tification with respect to which such a de-
15 termination was so made.

16 “(iv) the number of times the pay-
17 ment amount determined (or agreed to)
18 under this subsection exceeds the quali-
19 fying payment amount;

20 “(v) the amount of expenditures made
21 by the Secretary during such calendar
22 quarter to carry out the IDR process;

23 “(vi) the total amount of fees paid
24 under paragraph (7) during such calendar
25 quarter; and

1 “(vii) the total amount of compensa-
2 tion paid to certified IDR entities under
3 paragraph (5)(E)during such calendar
4 quarter.

5 “(B) INFORMATION WITH RESPECT TO RE-
6 QUESTS.—For purposes of subparagraph (A),
7 the information described in this subparagraph
8 is, with respect to a notification under the IDR
9 process of a nonparticipating provider, group
10 health plan, or health insurance issuer offering
11 group health insurance coverage—

12 “(i) a description of each air ambu-
13 lance service included in such notification;

14 “(ii) the geography in which the serv-
15 ices included in such notification were pro-
16 vided;

17 “(iii) the amount of the offer sub-
18 mitted under paragraph (2) by the group
19 health plan or health insurance issuer (as
20 applicable) and by the nonparticipating
21 provider expressed as a percentage of the
22 qualifying payment amount;

23 “(iv) whether the offer selected by the
24 certified IDR entity under paragraph (5)
25 to be the payment applied was the offer

1 submitted by such plan or issuer (as appli-
2 cable) or by such provider and the amount
3 of such offer so selected expressed as a
4 percentage of the qualifying payment
5 amount;

6 “(v) ambulance vehicle type, including
7 the clinical capability level of such vehicle;

8 “(vi) the identity of the group health
9 plan or health insurance issuer or air am-
10 bulance provider with respect to such noti-
11 fication;

12 “(vii) the length of time in making
13 each determination;

14 “(viii) the compensation paid to the
15 certified IDR entity with respect to the
16 settlement or determination; and

17 “(ix) any other information specified
18 by the Secretary.

19 “(C) IDR ENTITY REQUIREMENTS.—For
20 2022 and each subsequent year, an IDR entity,
21 as a condition of certification as an IDR entity,
22 shall submit to the Secretary such information
23 as the Secretary determines necessary for the
24 Secretary to carry out the provisions of this
25 paragraph.

1 “(D) CLARIFICATION.—The Secretary
2 shall ensure the public reporting under this
3 paragraph does not contain information that
4 would disclose privileged or confidential infor-
5 mation of a group health plan or health insur-
6 ance issuer offering group or individual health
7 insurance coverage or of a provider or facility.

8 “(8) ADMINISTRATIVE FEE.—

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

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

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

6 “(c) DEFINITION.—For purposes of this section:

7 “(1) AIR AMBULANCE SERVICES.—The term
8 ‘air ambulance service’ means medical transport by
9 helicopter or airplane for patients.

10 “(2) QUALIFYING PAYMENT AMOUNT.—The
11 term ‘qualifying payment amount’ has the meaning
12 given such term in section 716(b)(3).

13 “(3) NONPARTICIPATING PROVIDER.—The term
14 ‘nonparticipating provider’ has the meaning given
15 such term in section 716(b)(3).”.

16 (3) IRC AMENDMENTS.—

17 (A) IN GENERAL.—Subchapter B of chap-
18 ter 100 of the Internal Revenue Code of 1986,
19 as amended by section 102(c) and further
20 amended by the previous provisions of this title,
21 is further amended by inserting after section
22 9816 the following:

23 **“SEC. 9817. ENDING SURPRISE AIR AMBULANCE BILLS.**

24 “(a) IN GENERAL.—In the case of a participant, ben-
25 eficiary, or enrollee in a group health plan who receives

1 air ambulance services from a nonparticipating provider
2 (as defined in section 9816(a)(3)(G)) with respect to such
3 plan, if such services would be covered if provided by a
4 participating provider (as defined in such section) with re-
5 spect to such plan—

6 “(1) the cost-sharing requirement with respect
7 to such services shall be the same requirement that
8 would apply if such services were provided by such
9 a participating provider, and any coinsurance or de-
10 ductible shall be based on rates that would apply for
11 such services if they were furnished by such a par-
12 ticipating provider;

13 “(2) such cost-sharing amounts shall be count-
14 ed towards the in-network deductible and in-network
15 out-of-pocket maximum amount under the plan for
16 the plan year (and such in-network deductible shall
17 be applied) with respect to such items and services
18 so furnished in the same manner as if such cost-
19 sharing payments were with respect to items and
20 services furnished by a participating provider; and

21 “(3) the plan shall pay, in accordance with, if
22 applicable, subsection (b)(5)(F), directly to such pro-
23 vider furnishing such services to such participant,
24 beneficiary, or enrollee at least the amount by which
25 the recognized amount (as defined in and deter-

1 mined pursuant to section 9816(a)(3)(H)(ii)) for
2 such services and year involved exceeds the cost-
3 sharing amount imposed under the plan for such
4 services (as determined in accordance with para-
5 graphs (1) and (2)).

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

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

11 “(A) IN GENERAL.—With respect to air
12 ambulance services furnished in a year by a
13 nonparticipating provider, with respect to a
14 group health plan, in a State described in sub-
15 section section 9816(a)(3)(K)(ii) with respect to
16 such plan and provider, and for which a pay-
17 ment is required to be made by the plan pursu-
18 ant to subsection (a)(3), the provider or plan
19 may, during the 30-day period beginning on the
20 day the provider receives a response from the
21 plan regarding a claim for payment for such
22 service, initiate open negotiations under this
23 paragraph between such provider and plan for
24 purposes of determining, during the open nego-
25 tiation period, an amount agreed on by such

1 provider, and such plan for payment (including
2 any cost-sharing) for such service. For purposes
3 of this subsection, the open negotiation period,
4 with respect to air ambulance services, is the
5 30-day period beginning on the date of initi-
6 ation of the negotiations with respect to such
7 services.

8 “(B) ACCESSING INDEPENDENT DISPUTE
9 RESOLUTION PROCESS IN CASE OF FAILED NE-
10 GOTIATIONS.—In the case of open negotiations
11 pursuant to subparagraph (A), with respect to
12 air ambulance services, that do not result in a
13 determination of an amount of payment for
14 such services by the last day of the open nego-
15 tiation period described in such subparagraph
16 with respect to such services, the provider or
17 group health plan that was party to such nego-
18 tiations may, during the 2-day period beginning
19 on the day after such open negotiation period,
20 initiate the independent dispute resolution proc-
21 ess under paragraph (2) with respect to such
22 services. The independent dispute resolution
23 process shall be initiated by a party pursuant to
24 the previous sentence by submission to the
25 other party and to the Secretary of a notifica-

1 tion (containing such information as specified
2 by the Secretary) and for purposes of this sub-
3 section, the date of initiation of such process
4 shall be the date of such submission or such
5 other date specified by the Secretary pursuant
6 to regulations that is not later than the date of
7 receipt of such notification by both the other
8 party and the Secretary.

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

12 “(A) ESTABLISHMENT.—Not later than 1
13 year after the date of the enactment of this
14 subsection, the Secretary, jointly with the Sec-
15 retary of Health and Human Services and the
16 Secretary of Labor, shall establish by regulation
17 one independent dispute resolution process (re-
18 ferred to in this subsection as the ‘IDR proc-
19 ess’) under which, in the case of air ambulance
20 services with respect to which a provider or
21 group health plan submits a notification under
22 paragraph (1)(B) (in this subsection referred to
23 as a ‘qualified IDR air ambulance services’), a
24 certified IDR entity under paragraph (4) deter-
25 mines, subject to subparagraph (B) and in ac-

1 cordance with the succeeding provisions of this
2 subsection, the amount of payment under the
3 plan for such services furnished by such pro-
4 vider.

5 “(B) AUTHORITY TO CONTINUE NEGOTIA-
6 TIONS.—Under the independent dispute resolu-
7 tion process, in the case that the parties to a
8 determination for qualified IDR air ambulance
9 services agree on a payment amount for such
10 services during such process but before the date
11 on which the entity selected with respect to
12 such determination under paragraph (4) makes
13 such determination under paragraph (5), such
14 amount shall be treated for purposes of section
15 9816(a)(3)(K)(ii) as the amount agreed to by
16 such parties for such services. In the case of an
17 agreement described in the previous sentence,
18 the independent dispute resolution process shall
19 provide for a method to determine how to allo-
20 cate between the parties to such determination
21 the payment of the compensation of the entity
22 selected with respect to such determination.

23 “(C) CLARIFICATION.—A nonparticipating
24 provider may not, with respect to an item or
25 service furnished by such provider, submit a no-

1 tification under paragraph (1)(B) if such pro-
2 vider is exempt from the requirement under
3 subsection (a) of section 2799B–2 of the Public
4 Health Service Act with respect to such item or
5 service pursuant to subsection (b) of such sec-
6 tion.

7 “(3) TREATMENT OF BATCHING OF SERV-
8 ICES.—The provisions of section 9816(c)(3) shall
9 apply with respect to a notification submitted under
10 this subsection with respect to air ambulance serv-
11 ices in the same manner and to the same extent
12 such provisions apply with respect to a notification
13 submitted under section 9816(c) with respect to
14 items and services described in such section.

15 “(4) IDR ENTITIES.—

16 “(A) ELIGIBILITY.—An IDR entity cer-
17 tified under this subsection is an IDR entity
18 certified under section 9816(c)(4).

19 “(B) SELECTION OF CERTIFIED IDR ENTI-
20 TY.—The provisions of subparagraph (F) of
21 section 9816(c)(4) shall apply with respect to
22 selecting an IDR entity certified pursuant to
23 subparagraph (A) with respect to the deter-
24 mination of the amount of payment under this
25 subsection of air ambulance services in the

1 same manner as such provisions apply with re-
2 spect to selecting an IDR entity certified under
3 such section with respect to the determination
4 of the amount of payment under section
5 9816(c) of an item or service. An entity selected
6 pursuant to the previous sentence to make a de-
7 termination described in such sentence shall be
8 referred to in this subsection as the ‘certified
9 IDR entity’ with respect to such determination.

10 “(5) PAYMENT DETERMINATION.—

11 “(A) IN GENERAL.—Not later than 30
12 days after the date of selection of the certified
13 IDR entity, with respect to qualified IDR air
14 ambulance services, the certified independent
15 entity with respect to a determination under
16 this subsection for such services shall—

17 “(i) taking into account the consider-
18 ations specified in subparagraph (C), select
19 one of the offers submitted under subpara-
20 graph (B) to be the amount of payment for
21 such services determined under this sub-
22 section for purposes of subsection (a)(3);
23 and

24 “(ii) notify the provider or facility and
25 the group health plan party to such deter-

1 mination of the offer selected under clause
2 (i).

3 “(B) SUBMISSION OF OFFERS.—Not later
4 than 10 days after the date of selection of the
5 certified IDR entity with respect to a deter-
6 mination for qualified IDR air ambulance serv-
7 ices, the provider and the group health plan
8 party to such determination—

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

12 “(I) an offer for a payment
13 amount for such services furnished by
14 such provider; and

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

18 “(ii) may submit to the certified inde-
19 pendent entity with respect to such deter-
20 mination any information relating to such
21 offer submitted by either party, including
22 information relating to any circumstance
23 described in subparagraph (C)(ii).

24 “(C) CONSIDERATIONS IN DETERMINA-
25 TION.—

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

7 “(I) the offers under subpara-
8 graph (B)(i);

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

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

1 “(ii) ADDITIONAL CIRCUMSTANCES.—

2 For purposes of clause (i)(II), the cir-
3 cumstances described in this clause are,
4 with respect to air ambulance services in-
5 cluded in the notification submitted under
6 paragraph (1)(A) of a nonparticipating
7 provider, or group health plan the fol-
8 lowing:

9 “(I) The quality and outcomes
10 measurements of the provider that
11 furnished such services.

12 “(II) The acuity of the individual
13 receiving such services or the com-
14 plexity of furnishing such services to
15 such individual.

16 “(III) The training, experience,
17 and quality of the medical personnel
18 that furnished such services.

19 “(IV) Ambulance vehicle type, in-
20 cluding the clinical capability level of
21 such vehicle.

22 “(V) Population density of the
23 pick up location (such as urban, sub-
24 urban, rural, or frontier).

1 “(VI) Demonstrations of good
2 faith efforts (or lack of good faith ef-
3 forts) made by the nonparticipating
4 provider or nonparticipating facility or
5 the plan to enter into network agree-
6 ments and, if applicable, contracted
7 rates between the provider and the
8 plan during the previous 4 plan years.

9 “(iii) PROHIBITION ON CONSIDER-
10 ATION OF BILLED CHARGES.—In deter-
11 mining which offer is the payment amount
12 to be applied with respect to qualified IDR
13 air ambulance services furnished by a pro-
14 vider, the certified IDR entity with respect
15 to such determination shall not consider
16 usual and customary charges or the
17 amount that would have been billed by
18 such provider with respect to such services
19 had the provisions of section 2799B–5 of
20 the Public Health Service Act not applied.

21 “(D) EFFECTS OF DETERMINATION.—The
22 provisions of section 9816(c)(5)(D)) shall apply
23 with respect to a determination of a certified
24 IDR entity under subparagraph (A), the notifi-
25 cation submitted with respect to such deter-

1 mination, the services with respect to such noti-
2 fication, and the parties to such notification in
3 the same manner as such provisions apply with
4 respect to a determination of a certified IDR
5 entity under section 9816(c)(5)(D), the notifi-
6 cation submitted with respect to such deter-
7 mination, the items and services with respect to
8 such notification, and the parties to such notifi-
9 cation.

10 “(E) COSTS OF INDEPENDENT DISPUTE
11 RESOLUTION PROCESS.—The provisions of sec-
12 tion 9816(c)(5)(E) shall apply to a notification
13 made under this subsection, the parties to such
14 notification, and a determination under sub-
15 paragraph (A) in the same manner and to the
16 same extent such provisions apply to a notifica-
17 tion under section 9816(c), the parties to such
18 notification and a determination made under
19 section 9816(c)(5)(A).

20 “(6) TIMING OF PAYMENT.—Payment required
21 pursuant to subsection (a)(3), with respect to quali-
22 fied IDR air ambulance services for which a deter-
23 mination is made under paragraph (5)(A) or with
24 respect to air ambulance services for which a pay-
25 ment amount is determined under open negotiations

1 under paragraph (1), shall be made directly to the
2 nonparticipating provider not later than 30 days
3 after the date on which such determination is made.

4 “(7) PUBLICATION OF INFORMATION RELATING
5 TO THE IDR PROCESS.—

6 “(A) IN GENERAL.—For each calendar
7 quarter in 2022 and each calendar quarter in a
8 subsequent year, the Secretary shall publish on
9 the public website of the Department of the
10 Treasury—

11 “(i) the number of notifications sub-
12 mitted under the IDR process during such
13 calendar quarter;

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

17 “(iii) the information described in
18 subparagraph (B) with respect to each no-
19 tification with respect to which such a de-
20 termination was so made.

21 “(iv) the number of times the pay-
22 ment amount determined (or agreed to)
23 under this subsection exceeds the quali-
24 fying payment amount;

1 “(v) the amount of expenditures made
2 by the Secretary during such calendar
3 quarter to carry out the IDR process;

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

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

11 “(B) INFORMATION WITH RESPECT TO RE-
12 QUESTS.—For purposes of subparagraph (A),
13 the information described in this subparagraph
14 is, with respect to a notification under the IDR
15 process of a nonparticipating provider, or group
16 health plan—

17 “(i) a description of each air ambu-
18 lance service included in such notification;

19 “(ii) the geography in which the serv-
20 ices included in such notification were pro-
21 vided;

22 “(iii) the amount of the offer sub-
23 mitted under paragraph (2) by the group
24 health plan and by the nonparticipating

1 provider expressed as a percentage of the
2 qualifying payment amount;

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

11 “(v) ambulance vehicle type, including
12 the clinical capability level of such vehicle;

13 “(vi) the identity of the group health
14 plan or health insurance issuer or air am-
15 bulance provider with respect to such noti-
16 fication;

17 “(vii) the length of time in making
18 each determination;

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

22 “(ix) any other information specified
23 by the Secretary.

24 “(C) IDR ENTITY REQUIREMENTS.—For
25 2022 and each subsequent year, an IDR entity,

1 as a condition of certification as an IDR entity,
2 shall submit to the Secretary such information
3 as the Secretary determines necessary for the
4 Secretary to carry out the provisions of this
5 paragraph.

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

13 “(8) ADMINISTRATIVE FEE.—

14 “(A) IN GENERAL.—Each party to a deter-
15 mination under paragraph (5) to which an enti-
16 ty is selected under paragraph (4) in a year
17 shall pay to the Secretary, at such time and in
18 such manner as specified by the Secretary, a
19 fee for participating in the IDR process with re-
20 spect to such determination in an amount de-
21 scribed in subparagraph (B) for such year.

22 “(B) AMOUNT OF FEE.—The amount de-
23 scribed in this subparagraph for a year is an
24 amount established by the Secretary in a man-
25 ner such that the total amount of fees paid

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

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

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

11 “(1) AIR AMBULANCE SERVICES.—The term
12 ‘air ambulance service’ means medical transport by
13 helicopter or airplane for patients.

14 “(2) QUALIFYING PAYMENT AMOUNT.—The
15 term ‘qualifying payment amount’ has the meaning
16 given such term in section 9816(b)(3).

17 “(3) NONPARTICIPATING PROVIDER.—The term
18 ‘nonparticipating provider’ has the meaning given
19 such term in section 9816(b)(3).”.

20 (B) CLERICAL AMENDMENT.—The table of
21 sections for subchapter B of chapter 100 of the
22 Internal Revenue Code of 1986, as amended by
23 section 102(c)(3), is further amended by insert-
24 ing after the item relating to section 9816 the
25 following new item:

“Sec. 9817. Ending surprise air ambulance bills.”.

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

4 (b) AIR AMBULANCE PROVIDER BALANCE BILL-
5 ING.—Part E of title XXVII of the Public Health Service
6 Act, as added and amended by section 104, is further
7 amended by adding at the end the following new section:

8 **“SEC. 2799B-5. AIR AMBULANCE SERVICES.**

9 “In the case of a participant, beneficiary, or enrollee
10 with benefits under a group health plan or group or indi-
11 vidual health insurance coverage offered by a health insur-
12 ance issuer and who is furnished on or after January 1,
13 2022, air ambulance services (for which benefits are avail-
14 able under such plan or coverage) from a nonparticipating
15 provider (as defined in section 2799A-1(a)(3)(G)) with re-
16 spect to such plan or coverage, such provider shall not bill,
17 and shall not hold liable, such participant, beneficiary, or
18 enrollee for a payment amount for such service furnished
19 by such provider that is more than the cost-sharing
20 amount for such service (as determined in accordance with
21 paragraphs (1) and (2) of section 2799A-2(a), section
22 717(a) of the Employee Retirement Income Security Act
23 of 1974, or section 9817(a) of the Internal Revenue Code
24 of 1986, as applicable).”.

1 **SEC. 106. REPORTING REQUIREMENTS REGARDING AIR AM-**
2 **BULANCE SERVICES.**

3 (a) REPORTING REQUIREMENTS FOR PROVIDERS OF
4 AIR AMBULANCE SERVICES.—

5 (1) IN GENERAL.—A provider of air ambulance
6 services shall submit to the Secretary of Health and
7 Human Services and the Secretary of Transpor-
8 tation—

9 (A) not later than the date that is 90 days
10 after the last day of the first plan year begin-
11 ning on or after the date on which a final rule
12 is promulgated pursuant to the rulemaking de-
13 scribed in subsection (d), the information de-
14 scribed in paragraph (2) with respect to such
15 plan year; and

16 (B) not later than the date that is 90 days
17 after the last day of the plan year immediately
18 succeeding the plan year described in subpara-
19 graph (A), such information with respect to
20 such immediately succeeding plan year.

21 (2) INFORMATION DESCRIBED.—For purposes
22 of paragraph (1), information described in this para-
23 graph, with respect to a provider of air ambulance
24 services, is each of the following:

25 (A) Cost data, as determined appropriate
26 by the Secretary of Health and Human Serv-

1 ices, in consultation with the Secretary of
2 Transportation, for air ambulance services fur-
3 nished by such provider, separated to the max-
4 imum extent possible by air transportation costs
5 associated with furnishing such air ambulance
6 services and costs of medical services and sup-
7 plies associated with furnishing such air ambu-
8 lance services.

9 (B) The number and location of all air am-
10 bulance bases operated by such provider.

11 (C) The number and type of aircraft oper-
12 ated by such provider.

13 (D) The number of air ambulance trans-
14 ports, disaggregated by payor mix, including—

15 (i)(I) group health plans;

16 (II) health insurance issuers; and

17 (III) State and Federal Government
18 payors; and

19 (ii) uninsured individuals.

20 (E) The number of claims of such provider
21 that have been denied payment by a group
22 health plan or health insurance issuer and the
23 reasons for any such denials.

24 (F) The number of emergency and non-
25 emergency air ambulance transports,

1 disaggregated by air ambulance base and type
2 of aircraft.

3 (G) Such other information regarding air
4 ambulance services as the Secretary of Health
5 and Human Services may specify.

6 (b) REPORTING REQUIREMENTS FOR GROUP
7 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

8 (1) PHSA.—Part D of title XXVII of the Pub-
9 lic Health Service Act, as added by section
10 102(a)(1), is amended by adding after section
11 2799A–7, as added by section 102(a)(2)(A) of this
12 Act, the following new section:

13 **“SEC. 2799A–8. AIR AMBULANCE REPORT REQUIREMENTS.**

14 “(a) IN GENERAL.—Each group health plan and
15 health insurance issuer offering group or individual health
16 insurance coverage shall submit to the Secretary—

17 “(1) not later than the date that is 90 days
18 after the last day of the first plan year beginning on
19 or after the date on which a final rule is promul-
20 gated pursuant to the rulemaking described in sec-
21 tion 106(d) of the No Surprises Act, the information
22 described in subsection (b) with respect to such plan
23 year; and

24 “(2) not later than the date that is 90 days
25 after the last day of the plan year immediately suc-

1 ceeding the plan year described in paragraph (1),
2 such information with respect to such immediately
3 succeeding plan year.

4 “(b) INFORMATION DESCRIBED.—For purposes of
5 subsection (a), information described in this subsection,
6 with respect to a group health plan or a health insurance
7 issuer offering group or individual health insurance cov-
8 erage, is each of the following:

9 “(1) Claims data for air ambulance services
10 furnished by providers of such services,
11 disaggregated by each of the following factors:

12 “(A) Whether such services were furnished
13 on an emergent or nonemergent basis.

14 “(B) Whether the provider of such services
15 is part of a hospital-owned or sponsored pro-
16 gram, municipality-sponsored program, hospital
17 independent partnership (hybrid) program,
18 independent program, or tribally operated pro-
19 gram in Alaska.

20 “(C) Whether the transport in which the
21 services were furnished originated in a rural or
22 urban area.

23 “(D) The type of aircraft (such as rotor
24 transport or fixed wing transport) used to fur-
25 nish such services.

1 “(E) Whether the provider of such services
2 has a contract with the plan or issuer, as appli-
3 cable, to furnish such services under the plan or
4 coverage, respectively.

5 “(2) Such other information regarding pro-
6 viders of air ambulance services as the Secretary
7 may specify.”.

8 (2) ERISA.—

9 (A) IN GENERAL.—Subpart B of part 7 of
10 title I of the Employee Retirement Income Se-
11 curity Act of 1974 (29 U.S.C. 1185 et seq.) is
12 amended by adding after section 722, as added
13 by section 102(b)(2)(A) of this Act, the fol-
14 lowing new section:

15 **“SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.**

16 “(a) IN GENERAL.—Each group health plan and
17 health insurance issuer offering group health insurance
18 coverage shall submit to the Secretary—

19 “(1) not later than the date that is 90 days
20 after the last day of the first plan year beginning on
21 or after the date on which a final rule is promul-
22 gated pursuant to the rulemaking described in sec-
23 tion 106(d) of the No Surprises Act, the information
24 described in subsection (b) with respect to such plan
25 year; and

1 “(2) not later than the date that is 90 days
2 after the last day of the plan year immediately suc-
3 ceeding the plan year described in paragraph (1),
4 such information with respect to such immediately
5 succeeding plan year.

6 “(b) INFORMATION DESCRIBED.—For purposes of
7 subsection (a), information described in this subsection,
8 with respect to a group health plan or a health insurance
9 issuer offering group health insurance coverage, is each
10 of the following:

11 “(1) Claims data for air ambulance services
12 furnished by providers of such services,
13 disaggregated by each of the following factors:

14 “(A) Whether such services were furnished
15 on an emergent or nonemergent basis.

16 “(B) Whether the provider of such services
17 is part of a hospital-owned or sponsored pro-
18 gram, municipality-sponsored program, hospital
19 independent partnership (hybrid) program,
20 independent program, or tribally operated pro-
21 gram in Alaska.

22 “(C) Whether the transport in which the
23 services were furnished originated in a rural or
24 urban area.

1 “(D) The type of aircraft (such as rotor
2 transport or fixed wing transport) used to fur-
3 nish such services.

4 “(E) Whether the provider of such services
5 has a contract with the plan or issuer, as appli-
6 cable, to furnish such services under the plan or
7 coverage, respectively.

8 “(2) Such other information regarding pro-
9 viders of air ambulance services as the Secretary
10 may specify.”.

11 (B) CLERICAL AMENDMENT.—The table of
12 contents of the Employee Retirement Income
13 Security Act of 1974 is amended by adding
14 after the item relating to section 722, as added
15 by section 102(b) the following:

“Sec. 723. Air ambulance report requirements.”.

16 (3) IRC.—

17 (A) IN GENERAL.—Subchapter B of chap-
18 ter 100 of the Internal Revenue Code of 1986
19 is amended by adding after section 9822, as
20 added by section 102(c)(2)(A) of this Act, the
21 following new section:

22 **“SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.**

23 “(a) IN GENERAL.—Each group health plan shall
24 submit to the Secretary—

1 “(1) not later than the date that is 90 days
2 after the last day of the first plan year beginning on
3 or after the date on which a final rule is promul-
4 gated pursuant to the rulemaking described in sec-
5 tion 106(d) of the No Surprises Act, the information
6 described in subsection (b) with respect to such plan
7 year; and

8 “(2) not later than the date that is 90 days
9 after the last day of the plan year immediately suc-
10 ceeding the plan year described in paragraph (1),
11 such information with respect to such immediately
12 succeeding plan year.

13 “(b) INFORMATION DESCRIBED.—For purposes of
14 subsection (a), information described in this subsection,
15 with respect to a group health plan is each of the fol-
16 lowing:

17 “(1) Claims data for air ambulance services
18 furnished by providers of such services,
19 disaggregated by each of the following factors:

20 “(A) Whether such services were furnished
21 on an emergent or nonemergent basis.

22 “(B) Whether the provider of such services
23 is part of a hospital-owned or sponsored pro-
24 gram, municipality-sponsored program, hospital
25 independent partnership (hybrid) program,

1 independent program, or tribally operated pro-
2 gram in Alaska.

3 “(C) Whether the transport in which the
4 services were furnished originated in a rural or
5 urban area.

6 “(D) The type of aircraft (such as rotor
7 transport or fixed wing transport) used to fur-
8 nish such services.

9 “(E) Whether the provider of such services
10 has a contract with the plan or issuer, as appli-
11 cable, to furnish such services under the plan or
12 coverage, respectively.

13 “(2) Such other information regarding pro-
14 viders of air ambulance services as the Secretary
15 may specify.”.

16 (B) CLERICAL AMENDMENT.—The table of
17 sections for subchapter B of chapter 100 of the
18 Internal Revenue Code of 1986 is amended by
19 adding after the item relating to section 9822,
20 as added by section 102(c), the following new
21 item:

“Sec. 9823. Air ambulance report requirements.”.

22 (c) PUBLICATION OF COMPREHENSIVE REPORT.—

23 (1) IN GENERAL.—Not later than the date that
24 is one year after the date described in subsection
25 (a)(2) of section 2799A–8 of the Public Health

1 Service Act, of section 723 of the Employee Retirement
2 Income Security Act of 1974, and of section
3 9823 of the Internal Revenue Code of 1986, as such
4 sections are added by subsection (b), the Secretary
5 of Health and Human Services, in consultation with
6 the Secretary of Transportation (referred to in this
7 section as the “Secretaries”), shall develop, and
8 make publicly available (subject to paragraph (3)), a
9 comprehensive report summarizing the information
10 submitted under subsection (a) and the amendments
11 made by subsection (b) and including each of the
12 following:

13 (A) The percentage of providers of air am-
14 bulance services that are part of a hospital-
15 owned or sponsored program, municipality-
16 sponsored program, hospital-independent part-
17 nership (hybrid) program, or independent pro-
18 gram.

19 (B) An assessment of the extent of com-
20 petition among providers of air ambulance serv-
21 ices on the basis of price and services offered,
22 and any changes in such competition over time.

23 (C) An assessment of the average charges
24 for air ambulance services, amounts paid by
25 group health plans and health insurance issuers

1 offering group or individual health insurance
2 coverage to providers of air ambulance services
3 for furnishing such services, and amounts paid
4 out-of-pocket by consumers, and any changes in
5 such amounts paid over time.

6 (D) An assessment of the presence of air
7 ambulance bases in, or with the capability to
8 serve, rural areas, and the relative growth in air
9 ambulance bases in rural and urban areas over
10 time.

11 (E) Any evidence of gaps in rural access to
12 providers of air ambulance services.

13 (F) The percentage of providers of air am-
14 bulance services that have contracts with group
15 health plans or health insurance issuers offering
16 group or individual health insurance coverage to
17 furnish such services under such plans or cov-
18 erage, respectively.

19 (G) An assessment of whether there are in-
20 stances of unfair, deceptive, or predatory prac-
21 tices by providers of air ambulance services in
22 collecting payments from patients to whom such
23 services are furnished, such as referral of such
24 patients to collections, lawsuits, and liens or
25 wage garnishment actions.

1 (H) An assessment of whether there are,
2 within the air ambulance industry, instances of
3 unreasonable industry concentration, excessive
4 market domination, or other conditions that
5 would allow at least one provider of air ambu-
6 lance services to unreasonably increase prices or
7 exclude competition in air ambulance services in
8 a given geographic region.

9 (I) An assessment of the frequency of pa-
10 tient balance billing, patient referrals to collec-
11 tions, lawsuits to collect balance bills, and liens
12 or wage garnishment actions by providers of air
13 ambulance services as part of a collections proc-
14 ess across hospital-owned or sponsored pro-
15 grams, municipality-sponsored programs, hos-
16 pital-independent partnership (hybrid) pro-
17 grams, tribally operated programs in Alaska, or
18 independent programs, providers of air ambu-
19 lance services operated by public agencies (such
20 as a State or county health department), and
21 other independent providers of air ambulance
22 services.

23 (J) An assessment of the frequency of
24 claims appeals made by providers of air ambu-
25 lance services to group health plans or health

1 insurance issuers offering group or individual
2 health insurance coverage with respect to air
3 ambulance services furnished to enrollees of
4 such plans or coverage, respectively.

5 (K) Any other cost, quality, or other data
6 relating to air ambulance services or the air
7 ambulance industry, as determined necessary
8 and appropriate by the Secretaries.

9 (2) OTHER SOURCES OF INFORMATION.—The
10 Secretaries may incorporate information from inde-
11 pendent experts or third-party sources in developing
12 the comprehensive report required under paragraph
13 (1).

14 (3) PROTECTION OF PROPRIETARY INFORMA-
15 TION.—The Secretaries may not make publicly avail-
16 able under this subsection any proprietary informa-
17 tion.

18 (d) RULEMAKING.—Not later than the date that is
19 one year after the date of the enactment of this Act, the
20 Secretary of Health and Human Services, in consultation
21 with the Secretary of Transportation, shall, through notice
22 and comment rulemaking, specify the form and manner
23 in which reports described in subsection (a) and in the
24 amendments made by subsection (b) shall be submitted
25 to such Secretaries, taking into consideration (as applica-

1 ble and to the extent feasible) any recommendations in-
2 cluded in the report submitted by the Advisory Committee
3 on Air Ambulance and Patient Billing under section
4 418(e) of the FAA Reauthorization Act of 2018 (Public
5 Law 115–254; 49 U.S.C. 42301 note prec.).

6 (e) CIVIL MONEY PENALTIES.—

7 (1) IN GENERAL.—Subject to paragraph (2), a
8 provider of air ambulance services who fails to sub-
9 mit all information required under subsection (a)(2)
10 by the date described in subparagraph (A) or (B) of
11 subsection (a)(1), as applicable, shall be subject to
12 a civil money penalty of not more than \$10,000.

13 (2) EXCEPTION.—In the case of a provider of
14 air ambulance services that submits only some of the
15 information required under subsection (a)(2) by the
16 date described in subparagraph (A) or (B) of sub-
17 section (a)(1), as applicable, the Secretary of Health
18 and Human Services may waive the civil money pen-
19 alty imposed under paragraph (1) if such provider
20 demonstrates a good faith effort (as defined by the
21 Secretary pursuant to regulation) in working with
22 the Secretary to submit the remaining information
23 required under subsection (a)(2).

24 (3) PROCEDURE.—The provisions of section
25 1128A of the Social Security Act (42 U.S.C. 1320a–

1 7a), other than subsections (a) and (b) and the first
2 sentence of subsection (c)(1), shall apply to civil
3 money penalties under this subsection in the same
4 manner as such provisions apply to a penalty or pro-
5 ceeding under such section.

6 (f) UNFAIR AND DECEPTIVE PRACTICES AND UN-
7 FAIR METHODS OF COMPETITION.—The Secretary of
8 Transportation may use any information submitted under
9 subsection (a) in determining whether a provider of air
10 ambulance services has violated section 41712(a) of title
11 49, United States Code.

12 (g) ADVISORY COMMITTEE ON AIR AMBULANCE
13 QUALITY AND PATIENT SAFETY.—

14 (1) ESTABLISHMENT.—Not later than the date
15 that is 60 days after the date of the enactment of
16 this Act, the Secretary of Health and Human Serv-
17 ices, in consultation with the Secretary of Transpor-
18 tation, shall establish an Advisory Committee on Air
19 Ambulance Quality and Patient Safety (referred to
20 in this subsection as the “Committee”) for the pur-
21 pose of reviewing options to establish quality, patient
22 safety, service reliability, and clinical capability
23 standards for each clinical capability level of air am-
24 bulances.

1 (2) MEMBERSHIP.—The Committee shall be
2 composed of the following members:

3 (A) The Secretary of Health and Human
4 Services, or a designee of the Secretary, who
5 shall serve as the Chair of the Committee.

6 (B) The Secretary of Transportation, or a
7 designee of the Secretary.

8 (C) One representative, to be appointed by
9 the Secretary of Health and Human Services,
10 of each of the following:

11 (i) State health insurance regulators.

12 (ii) Health care providers.

13 (iii) Group health plans and health in-
14 surance issuers offering group or indi-
15 vidual health insurance coverage.

16 (iv) Patient advocacy groups.

17 (v) Accrediting bodies with experience
18 in quality measures.

19 (D) Three representatives of the air ambu-
20 lance industry, to be appointed by the Secretary
21 of Transportation.

22 (E) Additional three representatives not
23 covered under subparagraphs (A) through (D),
24 as determined necessary and appropriate by the
25 Secretary of Health and Human Services.

1 (3) FIRST MEETING.—Not later than the date
2 that is 90 days after the date of the enactment of
3 this Act, the Committee shall hold its first meeting.

4 (4) DUTIES.—The Committee shall study and
5 make recommendations, as appropriate, to Congress
6 regarding each of the following with respect to air
7 ambulance services:

8 (A) Qualifications of different clinical ca-
9 pability levels and tiering of such levels.

10 (B) Patient safety and quality standards.

11 (C) Options for improving service reli-
12 ability during poor weather, night conditions, or
13 other adverse conditions.

14 (D) Differences between air ambulance ve-
15 hicle types, services, and technologies, and other
16 flight capability standards, and the impact of
17 such differences on patient safety.

18 (E) Clinical triage criteria for air ambu-
19 lances.

20 (5) REPORT.—Not later than the date that is
21 180 days after the date of the first meeting of the
22 Committee, the Committee, in consultation with rel-
23 evant experts and stakeholders, as appropriate, shall
24 develop and make publicly available a report on any
25 recommendations submitted to Congress under para-

1 graph (4). The Committee may update such report,
2 as determined appropriate by the Committee.

3 (h) DEFINITIONS.—In this section, the terms “group
4 health plan”, “health insurance coverage”, “individual
5 health insurance coverage”, “group health insurance cov-
6 erage”, and “health insurance issuer” have the meanings
7 given such terms in section 2791 of the Public Health
8 Service Act (42 U.S.C. 300gg–91).

9 **SEC. 107. TRANSPARENCY REGARDING IN-NETWORK AND**
10 **OUT-OF-NETWORK DEDUCTIBLES AND OUT-**
11 **OF-POCKET LIMITATIONS.**

12 (a) PHSA.—Section 2799A–1 of the Public Health
13 Service Act, as added by section 102(a) and amended by
14 section 103, is further amended by adding at the end the
15 following new subsection:

16 “(e) TRANSPARENCY REGARDING IN-NETWORK AND
17 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
18 LIMITATIONS.—A group health plan or a health insurance
19 issuer offering group or individual health insurance cov-
20 erage and providing or covering any benefit with respect
21 to items or services shall include, in clear writing, on any
22 physical or electronic plan or insurance identification card
23 issued to the participants, beneficiaries, or enrollees in the
24 plan or coverage the following:

1 “(1) Any deductible applicable to such plan or
2 coverage.

3 “(2) Any out-of-pocket maximum limitation ap-
4 plicable to such plan or coverage.

5 “(3) A telephone number and Internet website
6 address through which such individual may seek con-
7 sumer assistance information, such as information
8 related to hospitals and urgent care facilities that
9 have in effect a contractual relationship with such
10 plan or coverage for furnishing items and services
11 under such plan or coverage”.

12 (b) ERISA.—Section 716 of the Employee Retirement
13 Income Security Act of 1974, as added by section 102(b)
14 and amended by section 103, is further amended by add-
15 ing at the end the following new subsection:

16 “(e) TRANSPARENCY REGARDING IN-NETWORK AND
17 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
18 LIMITATIONS.—A group health plan or a health insurance
19 issuer offering group health insurance coverage and pro-
20 viding or covering any benefit with respect to items or
21 services shall include, in clear writing, on any physical or
22 electronic plan or insurance identification card issued to
23 the participants, beneficiaries, or enrollees in the plan or
24 coverage the following:

1 “(1) Any deductible applicable to such plan or
2 coverage.

3 “(2) Any out-of-pocket maximum limitation ap-
4 plicable to such plan or coverage.

5 “(3) A telephone number and Internet website
6 address through which such individual may seek con-
7 sumer assistance information, such as information
8 related to hospitals and urgent care facilities that
9 have in effect a contractual relationship with such
10 plan or coverage for furnishing items and services
11 under such plan or coverage”.

12 (c) IRC.—Section 9816 of the Internal Revenue Code
13 of 1986, as added by section 102(c) and amended by sec-
14 tion 103, is further amended by adding at the end the
15 following new subsection:

16 “(e) TRANSPARENCY REGARDING IN-NETWORK AND
17 OUT-OF-NETWORK DEDUCTIBLES AND OUT-OF-POCKET
18 LIMITATIONS.—A group health plan providing or covering
19 any benefit with respect to items or services shall include,
20 in clear writing, on any physical or electronic plan or in-
21 surance identification card issued to the participants,
22 beneficiaries, or enrollees in the plan the following:

23 “(1) Any deductible applicable to such plan.

24 “(2) Any out-of-pocket maximum limitation ap-
25 plicable to such plan.

1 “(3) A telephone number and Internet website
2 address through which such individual may seek con-
3 sumer assistance information, such as information
4 related to hospitals and urgent care facilities that
5 have in effect a contractual relationship with such
6 plan for furnishing items and services under such
7 plan.”.

8 (d) EFFECTIVE DATE.—The amendments made by
9 this subsection shall apply with respect to plan years be-
10 ginning on or after January 1, 2022.

11 **SEC. 108. IMPLEMENTING PROTECTIONS AGAINST PRO-**
12 **VIDER DISCRIMINATION.**

13 Not later than six months after the date of the enact-
14 ment of this Act, the Secretary of Health and Human
15 Services, the Secretary of Labor, and the Secretary of the
16 Treasury shall issue a proposed rule implementing the
17 protections of section 2706(a) of the Public Health Service
18 Act (42 U.S.C. 300gg-5(a)). The Secretaries shall accept
19 and consider public comments on any proposed rule issued
20 pursuant to this subsection for a period of 60 days after
21 the date of such issuance. Not later than 6 months after
22 the date of the conclusion of the comment period, the Sec-
23 retaries shall issue a final rule implementing the protec-
24 tions of section 2706(a) of the Public Health Service Act
25 (42 U.S.C. 300gg-5(a)).

1 **SEC. 109. REPORTS.**

2 (a) REPORTS IN CONSULTATION WITH FTC AND
3 AG.—Not later than January 1, 2023, and annually
4 thereafter for each of the following 4 years, the Secretary
5 of Health and Human Services, in consultation with the
6 Federal Trade Commission and the Attorney General,
7 shall—

8 (1) conduct a study on the effects of the provi-
9 sions of, including amendments made by, this Act
10 on—

11 (A) any patterns of vertical or horizontal
12 integration of health care facilities, providers,
13 group health plans, or health insurance issuers
14 offering group or individual health insurance
15 coverage;

16 (B) overall health care costs; and

17 (C) access to health care items and serv-
18 ices, including specialty services, in rural areas
19 and health professional shortage areas, as de-
20 fined in section 332 of the Public Health Serv-
21 ice Act (42 U.S.C. 254e);

22 (2) for purposes of the reports under paragraph
23 (3), in consultation with the Secretary of Labor and
24 the Secretary of the Treasury, make recommenda-
25 tions for the effective enforcement of subsections
26 (a)(1)(C)(iv) and (b)(1)(C) of section 2799A–1 of

1 the Public Health Service Act, subsections
2 (a)(1)(C)(iv) and (b)(1)(C) of section 716 of the
3 Employee Retirement Income Security Act of 1974,
4 and subsections (a)(1)(C)(iv) and (b)(1)(C) of sec-
5 tion 9816 of the Internal Revenue Code of 1986, in-
6 cluding with respect to potential challenges to ad-
7 dressing anti-competitive consolidation of health care
8 facilities, providers, group health plans, or health in-
9 surance issuers offering group or individual health
10 insurance coverage; and

11 (3) submit a report on such study and including
12 such recommendations to the Committees on Energy
13 and Commerce; on Education and Labor; on Ways
14 and Means; and on the Judiciary of the House of
15 Representatives and the Committees on Health,
16 Education, Labor, and Pensions; on Commerce,
17 Science, and Transportation; on Finance; and on the
18 Judiciary of the Senate.

19 (b) GAO REPORT ON IMPACT OF SURPRISE BILLING
20 PROVISIONS.—Not later than January 1, 2025, the Comp-
21 troller General of the United States shall submit to Con-
22 gress a report summarizing the effects of the provisions
23 of this Act, including the amendments made by such provi-
24 sions, on changes during the period since the date on the
25 enactment of this Act in health care provider networks of

1 group health plans and group and individual health insur-
2 ance coverage offered by a health insurance issuer, in fee
3 schedules and amounts for health care services, and to
4 contracted rates under such plans or coverage. Such re-
5 port shall—

6 (1) to the extent practicable, sample a statis-
7 tically significant group of national health care pro-
8 viders;

9 (2) examine—

10 (A) provider network participation, includ-
11 ing nonparticipating providers furnishing items
12 and services at participating facilities;

13 (B) health care provider group network
14 participation, including specialty, size, and own-
15 ership;

16 (C) the impact of State surprise billing
17 laws and network adequacy standards on par-
18 ticipation of health care providers and facilities
19 in provider networks of group health plans and
20 of group and individual health insurance cov-
21 erage offered by health insurance issuers; and

22 (D) access to providers, including in rural
23 and medically underserved communities and
24 health professional shortage areas (as defined
25 in section 332 of the Public Health Service

1 Act), and the extent of provider shortages in
2 such communities and areas;

3 (3) to the extent practicable, sample a statis-
4 tically significant group of national health insurance
5 plans and issuers and examine—

6 (A) the effects of the provisions of, includ-
7 ing amendments made by, this Act on pre-
8 miums and out-of-pocket costs with respect to
9 group health plans or group or individual health
10 insurance coverage;

11 (B) the adequacy of provider networks
12 with respect to such plans or coverage; and

13 (C) categories of providers of ancillary
14 services, as defined in section 2719(A)(i)(3), for
15 which such plans have no or a limited number
16 of in-network providers; and

17 (4) such other relevant effects of such provi-
18 sions and amendments.

19 (c) GAO REPORT ON ADEQUACY OF PROVIDER NET-
20 WORKS.—Not later than January 1, 2023, the Comp-
21 troller General of the United States shall submit to Con-
22 gress, and make publicly available, a report on the ade-
23 quacy of provider networks in group health plans and
24 group and individual health insurance coverage, including

1 legislative recommendations to improve the adequacy of
2 such networks.

3 (d) GAO REPORT ON IDR PROCESS AND POTENTIAL
4 FINANCIAL RELATIONSHIPS.—Not later than December
5 31, 2023, the Comptroller General of the United States
6 shall conduct a study and submit to Congress a report
7 on the IDR process established under this section. Such
8 study and report shall include an analysis of potential fi-
9 nancial relationships between providers and facilities that
10 utilize the IDR process established by the amendments
11 made by this Act and private equity investment firms.

12 **SEC. 110. CONSUMER PROTECTIONS THROUGH APPLICA-**
13 **TION OF HEALTH PLAN EXTERNAL REVIEW**
14 **IN CASES OF CERTAIN SURPRISE MEDICAL**
15 **BILLS.**

16 (a) In applying the provisions of section 2719(b) of
17 the Public Health Service Act (42 U.S.C. 300gg–19(b))
18 to group health plans and health insurance issuers offer-
19 ing group or individual health insurance coverage, the Sec-
20 retary of Health and Human Services, Secretary of Labor,
21 and Secretary of the Treasury, shall require, beginning
22 not later than January 1, 2022, the external review proc-
23 ess described in paragraph (1) of such section to apply
24 with respect to any adverse determination by such a plan
25 or issuer under section 2799A-1 or 2799A-2, section 716

1 or 717 of the Employee Retirement Income Security Act
2 of 1974, or section 9816 or 9817 of the Internal Revenue
3 Code of 1986, including with respect to whether an item
4 or service that is the subject to such a determination is
5 an item or service to which such respective section applies.

6 (b) Definitions—The terms “group health plan”;
7 “health insurance issuer”; “group health insurance cov-
8 erage”, and “individual health insurance coverage” have
9 the meanings given such terms in section 2791 of the Pub-
10 lic Health Service Act (42 U.S.C. 300gg–91), section 733
11 of the Employee Retirement Income Security Act (29
12 U.S.C. 1191b), and section 9832 of the Internal Revenue
13 Code, as applicable.

14 **SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH**
15 **PLAN REQUIREMENT FOR FAIR AND HONEST**
16 **ADVANCE COST ESTIMATE.**

17 (a) PHSA AMENDMENT.—Section 2799A–1 of the
18 Public Health Service Act (42 U.S.C. 300gg–19a), as
19 added by section 102 and as further amended by the pre-
20 vious provisions of this title, is further amended by adding
21 at the end the following new subsection:

22 “(f) **ADVANCED EXPLANATION OF BENEFITS.**—Be-
23 ginning on January 1, 2022, each group health plan, or
24 a health insurance issuer offering group or individual
25 health insurance coverage shall, with respect to a notifica-

1 tion submitted under section 2799B–6 by a health care
2 provider or health care facility to the plan or issuer for
3 a participant, beneficiary, or enrollee under plan or cov-
4 erage scheduled to receive an item or service from the pro-
5 vider or facility, not later than 1 business day (or, in the
6 case such item or service was so scheduled at least 10
7 business days before such item or service is to be furnished
8 (or in the case of a request made to such plan or coverage
9 by such participant, beneficiary, or enrollee), 3 business
10 days) after the date on which the plan or coverage receives
11 such notification (or such request), provide to the partici-
12 pant, beneficiary, or enrollee (through mail or electronic
13 means, as requested by the participant, beneficiary, or en-
14 rollee) a notification (in clear and understandable lan-
15 guage) including the following:

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

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

1 “(B) in the case the provider or facility is
2 a nonparticipating provider or facility with re-
3 spect to such plan or coverage, a description of
4 how such individual may obtain information on
5 providers and facilities that, with respect to
6 such plan or coverage, are participating pro-
7 viders and facilities.

8 “(2) The good faith estimate included in the
9 notification received from the provider or facility (if
10 applicable).

11 “(3) A good faith estimate of the amount the
12 plan or coverage is responsible for paying for items
13 and services included in the estimate described in
14 paragraph (2).

15 “(4) A good faith estimate of the amount of
16 any cost-sharing for which the participant, bene-
17 ficiary, or enrollee would be responsible for such
18 item or service (as of the date of such notification).

19 “(5) A good faith estimate of the amount that
20 the participant, beneficiary, or enrollee has incurred
21 toward meeting the limit of the financial responsi-
22 bility (including with respect to deductibles and out-
23 of-pocket maximums) under the plan or coverage (as
24 of the date of such notification).

1 “(6) In the case such item or service is subject
2 to a medical management technique (including con-
3 current review, prior authorization, and step-therapy
4 or fail-first protocols) for coverage under the plan or
5 coverage, a disclaimer that coverage for such item or
6 service is subject to such medical management tech-
7 nique.

8 “(7) A disclaimer that the information provided
9 in the notification is only an estimate based on the
10 items and services reasonably expected, at the time
11 of scheduling (or requesting) the item or service, to
12 be furnished and is subject to change.

13 “(8) A statement that the individual may seek
14 such an item or service from a provider that is a
15 participating provider or a facility that is a partici-
16 pating facility and a list of participating facilities, or
17 of participating providers, as applicable, who are
18 able to furnish such items and services involved.

19 “(9) Any other information or disclaimer the
20 plan or coverage determines appropriate that is con-
21 sistent with information and disclaimers required
22 under this section.”.

23 (b) IRC AMENDMENTS.—Section 9816 of the Inter-
24 nal Revenue Code of 1986, as added by section 102 and
25 further amended by the previous provisions of this title,

1 is further amended by inserting after subsection (e) the
2 following new subsection:

3 “(f) ADVANCED EXPLANATION OF BENEFITS.—Be-
4 ginning on January 1, 2022, each group health plan shall,
5 with respect to a notification submitted under section
6 2799B–6 by a health care provider or health care facility
7 to the plan for a participant, beneficiary, or enrollee under
8 plan scheduled to receive an item or service from the pro-
9 vider or facility, not later than 1 business day (or, in the
10 case such item or service was so scheduled at least 10
11 business days before such item or service is to be furnished
12 (or in the case of a request made to such plan or coverage
13 by such participant, beneficiary, or enrollee), 3 business
14 days) after the date on which the plan receives such notifi-
15 cation (or such request), provide to the participant, bene-
16 ficiary, or enrollee (through mail or electronic means, as
17 requested by the participant, beneficiary, or enrollee) a no-
18 tification (in clear and understandable language) including
19 the following:

20 “(1) Whether or not the provider or facility is
21 a participating provider or a participating facility
22 with respect to the plan with respect to the fur-
23 nishing of such item or service and—

24 “(A) in the case the provider or facility is
25 a participating provider or facility with respect

1 to the plan or coverage with respect to the fur-
2 nishing of such item or service, the contracted
3 rate under such plan for such item or service;
4 and

5 “(B) in the case the provider or facility is
6 a nonparticipating provider or facility with re-
7 spect to such plan, a description of how such
8 individual may obtain information on providers
9 and facilities that, with respect to such plan,
10 are participating providers and facilities.

11 “(2) The good faith estimate included in the
12 notification received from the provider or facility (if
13 applicable).

14 “(3) A good faith estimate of the amount the
15 plan is responsible for paying for items and services
16 included in the estimate described in paragraph (2).

17 “(4) A good faith estimate of the amount of
18 any cost-sharing for which the participant, bene-
19 ficiary, or enrollee would be responsible for such
20 item or service (as of the date of such notification).

21 “(5) A good faith estimate of the amount that
22 the participant, beneficiary, or enrollee has incurred
23 toward meeting the limit of the financial responsi-
24 bility (including with respect to deductibles and out-

1 of-pocket maximums) under the plan (as of the date
2 of such notification).

3 “(6) In the case such item or service is subject
4 to a medical management technique (including con-
5 current review, prior authorization, and step-therapy
6 or fail-first protocols) for coverage under the plan,
7 a disclaimer that coverage for such item or service
8 is subject to such medical management technique.

9 “(7) A disclaimer that the information provided
10 in the notification is only an estimate based on the
11 items and services reasonably expected, at the time
12 of scheduling (or requesting) the item or service, to
13 be furnished and is subject to change.

14 “(8) A statement that the individual may seek
15 such an item or service from a provider that is a
16 participating provider or a facility that is a partici-
17 pating facility and a list of participating facilities, or
18 of participating providers, as applicable, who are
19 able to furnish such items and services involved.

20 “(9) Any other information or disclaimer the
21 plan determines appropriate that is consistent with
22 information and disclaimers required under this sec-
23 tion.”.

24 (c) ERISA AMENDMENTS.—Section 716 of the Em-
25 ployee Retirement Income Security Act of 1974, as added

1 by section 102 and further amended by the previous
2 amendments of this title, is further amended by adding
3 at the end the following new subsection:

4 “(f) ADVANCED EXPLANATION OF BENEFITS.—Be-
5 ginning on January 1, 2022, each group health plan, or
6 a health insurance issuer offering group health insurance
7 coverage shall, with respect to a notification submitted
8 under section 2799B–6 by a health care provider or health
9 care facility to the plan or issuer for a participant, bene-
10 ficiary, or enrollee under plan or coverage scheduled to
11 receive an item or service from the provider or facility,
12 not later than 1 business day (or, in the case such item
13 or service was so scheduled at least 10 business days be-
14 fore such item or service is to be furnished (or in the case
15 of a request made to such plan or coverage by such partici-
16 pant, beneficiary, or enrollee), 3 business days) after the
17 date on which the plan or coverage receives such notifica-
18 tion (or such request), provide to the participant, bene-
19 ficiary, or enrollee (through mail or electronic means, as
20 requested by the participant, beneficiary, or enrollee) a no-
21 tification (in clear and understandable language) including
22 the following:

23 “(1) Whether or not the provider or facility is
24 a participating provider or a participating facility

1 with respect to the plan or coverage with respect to
2 the furnishing of such item or service and—

3 “(A) in the case the provider or facility is
4 a participating provider or facility with respect
5 to the plan or coverage with respect to the fur-
6 nishing of such item or service, the contracted
7 rate under such plan for such item or service;
8 and

9 “(B) in the case the provider or facility is
10 a nonparticipating provider or facility with re-
11 spect to such plan or coverage, a description of
12 how such individual may obtain information on
13 providers and facilities that, with respect to
14 such plan or coverage, are participating pro-
15 viders and facilities.

16 “(2) The good faith estimate included in the
17 notification received from the provider or facility (if
18 applicable).

19 “(3) A good faith estimate of the amount the
20 health plan is responsible for paying for items and
21 services included in the estimate described in para-
22 graph (2).

23 “(4) A good faith estimate of the amount of
24 any cost-sharing for which the participant, bene-

1 ficiary, or enrollee would be responsible for such
2 item or service (as of the date of such notification).

3 “(5) A good faith estimate of the amount that
4 the participant, beneficiary, or enrollee has incurred
5 toward meeting the limit of the financial responsi-
6 bility (including with respect to deductibles and out-
7 of-pocket maximums) under the plan or coverage (as
8 of the date of such notification).

9 “(6) In the case such item or service is subject
10 to a medical management technique (including con-
11 current review, prior authorization, and step-therapy
12 or fail-first protocols) for coverage under the plan or
13 coverage, a disclaimer that coverage for such item or
14 service is subject to such medical management tech-
15 nique.

16 “(7) A disclaimer that the information provided
17 in the notification is only an estimate based on the
18 items and services reasonably expected, at the time
19 of scheduling (or requesting) the item or service, to
20 be furnished and is subject to change.

21 “(8) A statement that the individual may seek
22 such an item or service from a provider that is a
23 participating provider or a facility that is a partici-
24 pating facility and a list of participating facilities, or

1 of participating providers, as applicable, who are
2 able to furnish such items and services involved.

3 “(9) Any other information or disclaimer the
4 plan or coverage determines appropriate that is con-
5 sistent with information and disclaimers required
6 under this section.”.

7 **SEC. 112. PATIENT PROTECTIONS THROUGH TRANS-**
8 **PARENCY AND PATIENT-PROVIDER DISPUTE**
9 **RESOLUTION.**

10 Part E of title XXVII of the Public Health Service
11 Act (42 U.S.C. 300gg et seq.), as added by section 104
12 and further amended by the previous provisions of this
13 title, is further amended by adding at the end the fol-
14 lowing new sections:

15 **“SEC. 2799B-6. PROVISION OF INFORMATION UPON RE-**
16 **QUEST AND FOR SCHEDULED APPOINT-**
17 **MENTS.**

18 “Each health care provider and health care facility
19 shall, beginning January 1, 2022, in the case of an indi-
20 vidual who schedules an item or service to be furnished
21 to such individual by such provider or facility at least 3
22 business days before the date such item or service is to
23 be so furnished, not later than 1 business day after the
24 date of such scheduling (or, in the case of such an item
25 or service scheduled at least 10 business days before the

1 date such item or service is to be so furnished (or if re-
2 quested by the individual), not later than 3 business days
3 after the date of such scheduling or such request)—

4 “(1) inquire if such individual is enrolled in a
5 group health plan, group or individual health insur-
6 ance coverage offered by a health insurance issuer,
7 or a Federal health care program (and if is so en-
8 rolled in such plan or coverage, seeking to have a
9 claim for such item or service submitted to such
10 plan or coverage); and

11 “(2) provide a notification (in clear and under-
12 standable language) of the good faith estimate of the
13 expected charges for furnishing such item or service
14 (including any item or service that is reasonably ex-
15 pected to be provided in conjunction with such
16 scheduled item or service) to—

17 “(A) in the case the individual is enrolled
18 in such a plan or such coverage (and is seeking
19 to have a claim for such item or service sub-
20 mitted to such plan or coverage), such plan or
21 issuer of such coverage; and

22 “(B) in the case the individual is not de-
23 scribed in subparagraph (A) and not enrolled in
24 a Federal health care program, the individual.

1 **“SEC. 2799B-7. PATIENT-PROVIDER DISPUTE RESOLUTION.**

2 “(a) IN GENERAL.—Not later than July 1, 2021, the
3 Secretary shall establish a process (in this subsection re-
4 ferred to as the ‘patient-provider dispute resolution proc-
5 ess’) under which an uninsured individual, with respect
6 to an item or service, who received, pursuant to section
7 2799B-6, from a health care provider or health care facil-
8 ity a good-faith estimate of the expected charges for fur-
9 nishing such item or service to such individual and who
10 after being furnished such item or service by such provider
11 or facility is billed by such provider or facility for such
12 item or service for charges that are substantially in excess
13 of such estimate, may seek a determination from a se-
14 lected dispute resolution entity for the charges to be paid
15 by such individual (in lieu of such amount so billed) to
16 such provider or facility for such item or service. For pur-
17 poses of this subsection, the term ‘uninsured individual’
18 means, with respect to an item or service, an individual
19 who does not have benefits for such item or service under
20 a group health plan, group or individual health insurance
21 coverage offered by a health insurance issuer, Federal
22 health care program (as defined in section 1128B(f) of
23 the Social Security Act), or a health benefits plan under
24 chapter 89 of title 5, United States Code (or an individual
25 who has benefits for such item or service under a group
26 health plan or individual or group health insurance cov-

1 erage offered by a health insurance issuer, but who does
2 not seek to have a claim for such item or service submitted
3 to such plan or coverage).

4 “(b) SELECTION OF ENTITIES.—Under the patient-
5 provider dispute resolution process, the Secretary shall,
6 with respect to a determination sought by an individual
7 under subsection (a), with respect to charges to be paid
8 by such individual to a health care provider or health care
9 facility described in such paragraph for an item or service
10 furnished to such individual by such provider or facility,
11 provide for—

12 “(1) a method to select to make such deter-
13 mination an entity certified under subsection (d)
14 that—

15 “(A) is not a party to such determination
16 or an employee or agent of such party;

17 “(B) does not have a material familial, fi-
18 nancial, or professional relationship with such a
19 party; and

20 “(C) does not otherwise have a conflict of
21 interest with such a party (as determined by
22 the Secretary); and

23 “(2) the provision of a notification of such se-
24 lection to the individual and the provider or facility
25 (as applicable) party to such determination.

1 An entity selected pursuant to the previous sentence to
2 make a determination described in such sentence shall be
3 referred to in this subsection as the ‘selected dispute reso-
4 lution entity’ with respect to such determination.

5 “(c) ADMINISTRATIVE FEE.—The Secretary shall es-
6 tablish a fee to participate in the patient-provider dispute
7 resolution process in such a manner as to not create a
8 barrier to an uninsured individual’s access to such process.

9 “(d) CERTIFICATION.—The Secretary shall establish
10 or recognize a process to certify entities under this sub-
11 paragraph. Such process shall ensure that an entity so cer-
12 tified satisfies at least the criteria specified in section
13 2799A–1(c).”.

14 **SEC. 113. ENSURING CONTINUITY OF CARE.**

15 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of
16 the Public Health Service Act (42 U.S.C. 300gg et seq.)
17 is amended, in the part D, as added and amended by sec-
18 tion 102(a) and further amended by the previous provi-
19 sions of this title, by inserting after section 2799A–2 the
20 following new section:

21 **“SEC. 2799A-3. CONTINUITY OF CARE.**

22 “(a) ENSURING CONTINUITY OF CARE WITH RE-
23 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
24 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
25 NETWORK STATUS.—

1 “(1) IN GENERAL.—In the case of an individual
2 with benefits under a group health plan or group or
3 individual health insurance coverage offered by a
4 health insurance issuer and with respect to a health
5 care provider or facility that has a contractual rela-
6 tionship with such plan or such issuer (as applica-
7 ble) for furnishing items and services under such
8 plan or such coverage, if, while such individual is a
9 continuing care patient (as defined in subsection (b))
10 with respect to such provider or facility—

11 “(A) such contractual relationship is termi-
12 nated (as defined in subsection (b));

13 “(B) benefits provided under such plan or
14 such health insurance coverage with respect to
15 such provider or facility are terminated because
16 of a change in the terms of the participation of
17 such provider or facility in such plan or cov-
18 erage; or

19 “(C) a contract between such group health
20 plan and a health insurance issuer offering
21 health insurance coverage in connection with
22 such plan is terminated, resulting in a loss of
23 benefits provided under such plan with respect
24 to such provider or facility;

1 the plan or issuer, respectively, shall meet the re-
2 quirements of paragraph (2) with respect to such in-
3 dividual.

4 “(2) REQUIREMENTS.—The requirements of
5 this paragraph are that the plan or issuer—

6 “(A) notify each individual enrolled under
7 such plan or coverage who is a continuing care
8 patient with respect to a provider or facility at
9 the time of a termination described in para-
10 graph (1) affecting such provider or facility on
11 a timely basis of such termination and such in-
12 dividual’s right to elect continued transitional
13 care from such provider or facility under this
14 section;

15 “(B) provide such individual with an op-
16 portunity to notify the plan or issuer of the in-
17 dividual’s need for transitional care; and

18 “(C) permit the patient to elect to continue
19 to have benefits provided under such plan or
20 such coverage, under the same terms and condi-
21 tions as would have applied and with respect to
22 such items and services as would have been cov-
23 ered under such plan or coverage had such ter-
24 mination not occurred, with respect to the
25 course of treatment furnished by such provider

1 or facility relating to such individual's status as
2 a continuing care patient during the period be-
3 ginning on the date on which the notice under
4 subparagraph (A) is provided and ending on the
5 earlier of—

6 “(i) the 90-day period beginning on
7 such date; or

8 “(ii) the date on which such individual
9 is no longer a continuing care patient with
10 respect to such provider or facility.

11 “(b) DEFINITIONS.—In this section:

12 “(1) CONTINUING CARE PATIENT.—The term
13 ‘continuing care patient’ means an individual who,
14 with respect to a provider or facility—

15 “(A) is undergoing a course of treatment
16 for a serious and complex condition from the
17 provider or facility;

18 “(B) is undergoing a course of institu-
19 tional or inpatient care from the provider or fa-
20 cility;

21 “(C) is scheduled to undergo nonelective
22 surgery from the provider, including receipt of
23 postoperative care from such provider or facility
24 with respect to such a surgery;

1 “(D) is pregnant and undergoing a course
2 of treatment for the pregnancy from the pro-
3 vider or facility; or

4 “(E) is or was determined to be terminally
5 ill (as determined under section 1861(dd)(3)(A)
6 of the Social Security Act) and is receiving
7 treatment for such illness from such provider or
8 facility.

9 “(2) SERIOUS AND COMPLEX CONDITION.—The
10 term ‘serious and complex condition’ means, with re-
11 spect to a participant, beneficiary, or enrollee under
12 a group health plan or group or individual health in-
13 surance coverage—

14 “(A) in the case of an acute illness, a con-
15 dition that is serious enough to require special-
16 ized medical treatment to avoid the reasonable
17 possibility of death or permanent harm; or

18 “(B) in the case of a chronic illness or con-
19 dition, a condition that is—

20 “(i) is life-threatening, degenerative,
21 potentially disabling, or congenital; and

22 “(ii) requires specialized medical care
23 over a prolonged period of time.

24 “(3) TERMINATED.—The term ‘terminated’ in-
25 cludes, with respect to a contract, the expiration or

1 nonrenewal of the contract, but does not include a
2 termination of the contract for failure to meet appli-
3 cable quality standards or for fraud.”.

4 (b) INTERNAL REVENUE CODE.—

5 (1) IN GENERAL.—Subchapter B of chapter
6 100 of the Internal Revenue Code of 1986, as
7 amended by sections 102(c) and 105(a)(3), is fur-
8 ther amended by inserting after section 9817 the fol-
9 lowing new section:

10 **“SEC. 9818. CONTINUITY OF CARE.**

11 “(a) ENSURING CONTINUITY OF CARE WITH RE-
12 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
13 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
14 NETWORK STATUS.—

15 “(1) IN GENERAL.—In the case of an individual
16 with benefits under a group health plan and with re-
17 spect to a health care provider or facility that has
18 a contractual relationship with such plan for fur-
19 nishing items and services under such plan, if, while
20 such individual is a continuing care patient (as de-
21 fined in subsection (b)) with respect to such provider
22 or facility—

23 “(A) such contractual relationship is termi-
24 nated (as defined in paragraph (b));

1 “(B) benefits provided under such plan
2 with respect to such provider or facility are ter-
3 minated because of a change in the terms of the
4 participation of such provider or facility in such
5 plan; or

6 “(C) a contract between such group health
7 plan and a health insurance issuer offering
8 health insurance coverage in connection with
9 such plan is terminated, resulting in a loss of
10 benefits provided under such plan with respect
11 to such provider or facility;

12 the plan shall meet the requirements of paragraph
13 (2) with respect to such individual.

14 “(2) REQUIREMENTS.—The requirements of
15 this paragraph are that the plan—

16 “(A) notify each individual enrolled under
17 such plan who is a continuing care patient with
18 respect to a provider or facility at the time of
19 a termination described in paragraph (1) affect-
20 ing such provider on a timely basis of such ter-
21 mination and such individual’s right to elect
22 continued transitional care from such provider
23 or facility under this section;

1 “(B) provide such individual with an op-
2 portunity to notify the plan of the individual’s
3 need for transitional care; and

4 “(C) permit the patient to elect to continue
5 to have benefits provided under such plan,
6 under the same terms and conditions as would
7 have applied and with respect to such items and
8 services as would have been covered under such
9 plan had such termination not occurred, with
10 respect to the course of treatment furnished by
11 such provider or facility relating to such indi-
12 vidual’s status as a continuing care patient dur-
13 ing the period beginning on the date on which
14 the notice under subparagraph (A) is provided
15 and ending on the earlier of—

16 “(i) the 90-day period beginning on
17 such date; or

18 “(ii) the date on which such individual
19 is no longer a continuing care patient with
20 respect to such provider or facility.

21 “(b) DEFINITIONS.—In this section:

22 “(1) CONTINUING CARE PATIENT.—The term
23 ‘continuing care patient’ means an individual who,
24 with respect to a provider or facility—

1 “(A) is undergoing a course of treatment
2 for a serious and complex condition from the
3 provider or facility;

4 “(B) is undergoing a course of institu-
5 tional or inpatient care from the provider or fa-
6 cility;

7 “(C) is scheduled to undergo nonelective
8 surgery from the provider or facility, including
9 receipt of postoperative care from such provider
10 or facility with respect to such a surgery;

11 “(D) is pregnant and undergoing a course
12 of treatment for the pregnancy from the pro-
13 vider or facility; or

14 “(E) is or was determined to be terminally
15 ill (as determined under section 1861(dd)(3)(A)
16 of the Social Security Act) and is receiving
17 treatment for such illness from such provider or
18 facility.

19 “(2) SERIOUS AND COMPLEX CONDITION.—The
20 term ‘serious and complex condition’ means, with re-
21 spect to a participant, beneficiary, or enrollee under
22 a group health plan—

23 “(A) in the case of an acute illness, a con-
24 dition that is serious enough to require special-

1 ized medical treatment to avoid the reasonable
2 possibility of death or permanent harm; or

3 “(B) in the case of a chronic illness or con-
4 dition, a condition that—

5 “(i) is life-threatening, degenerative,
6 potentially disabling, or congenital; and

7 “(ii) requires specialized medical care
8 over a prolonged period of time.

9 “(3) TERMINATED.—The term ‘terminated’ in-
10 cludes, with respect to a contract, the expiration or
11 nonrenewal of the contract, but does not include a
12 termination of the contract for failure to meet appli-
13 cable quality standards or for fraud.”.

14 (2) CLERICAL AMENDMENT.—The table of sec-
15 tions for such subchapter, as amended by the pre-
16 vious sections, is further amended by inserting after
17 the item relating to section 9817 the following new
18 item:

“Sec. 9818. Continuity of care.”.

19 (c) EMPLOYEE RETIREMENT INCOME SECURITY
20 ACT.—

21 (1) IN GENERAL.—Subpart B of part 7 of sub-
22 title B of title I of the Employee Retirement Income
23 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
24 amended by section 102(c) and further amended by
25 the previous provisions of this title, is further

1 amended by inserting after section 717 the following
2 new section:

3 **“SEC. 718. CONTINUITY OF CARE.**

4 “(a) ENSURING CONTINUITY OF CARE WITH RE-
5 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL
6 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER
7 NETWORK STATUS.—

8 “(1) IN GENERAL.—In the case of an individual
9 with benefits under a group health plan or group
10 health insurance coverage offered by a health insur-
11 ance issuer and with respect to a health care pro-
12 vider or facility that has a contractual relationship
13 with such plan or such issuer (as applicable) for fur-
14 nishing items and services under such plan or such
15 coverage, if, while such individual is a continuing
16 care patient (as defined in subsection (b)) with re-
17 spect to such provider or facility—

18 “(A) such contractual relationship is termi-
19 nated (as defined in paragraph (b));

20 “(B) benefits provided under such plan or
21 such health insurance coverage with respect to
22 such provider or facility are terminated because
23 of a change in the terms of the participation of
24 the provider or facility in such plan or coverage;
25 or

1 “(C) a contract between such group health
2 plan and a health insurance issuer offering
3 health insurance coverage in connection with
4 such plan is terminated, resulting in a loss of
5 benefits provided under such plan with respect
6 to such provider or facility;
7 the plan or issuer, respectively, shall meet the re-
8 quirements of paragraph (2) with respect to such in-
9 dividual.

10 “(2) REQUIREMENTS.—The requirements of
11 this paragraph are that the plan or issuer—

12 “(A) notify each individual enrolled under
13 such plan or coverage who is a continuing care
14 patient with respect to a provider or facility at
15 the time of a termination described in para-
16 graph (1) affecting such provider or facility on
17 a timely basis of such termination and such in-
18 dividual’s right to elect continued transitional
19 care from such provider or facility under this
20 section;

21 “(B) provide such individual with an op-
22 portunity to notify the plan or issuer of the in-
23 dividual’s need for transitional care; and

24 “(C) permit the patient to elect to continue
25 to have benefits provided under such plan or

1 such coverage, under the same terms and condi-
2 tions as would have applied and with respect to
3 such items and services as would have been cov-
4 ered under such plan or coverage had such ter-
5 mination not occurred, with respect to the
6 course of treatment furnished by such provider
7 or facility relating to such individual's status as
8 a continuing care patient during the period be-
9 ginning on the date on which the notice under
10 subparagraph (A) is provided and ending on the
11 earlier of—

12 “(i) the 90-day period beginning on
13 such date; or

14 “(ii) the date on which such individual
15 is no longer a continuing care patient with
16 respect to such provider or facility.

17 “(b) DEFINITIONS.—In this section:

18 “(1) CONTINUING CARE PATIENT.—The term
19 ‘continuing care patient’ means an individual who,
20 with respect to a provider or facility—

21 “(A) is undergoing a course of treatment
22 for a serious and complex condition from the
23 provider or facility;

1 “(B) is undergoing a course of institu-
2 tional or inpatient care from the provider or fa-
3 cility;

4 “(C) is scheduled to undergo nonelective
5 surgery from the provide or facility, including
6 receipt of postoperative care from such provider
7 or facility with respect to such a surgery;

8 “(D) is pregnant and undergoing a course
9 of treatment for the pregnancy from the pro-
10 vider or facility; or

11 “(E) is or was determined to be terminally
12 ill (as determined under section 1861(dd)(3)(A)
13 of the Social Security Act) and is receiving
14 treatment for such illness from such provider or
15 facility.

16 “(2) SERIOUS AND COMPLEX CONDITION.—The
17 term ‘serious and complex condition’ means, with re-
18 spect to a participant, beneficiary, or enrollee under
19 a group health plan or group health insurance cov-
20 erage—

21 “(A) in the case of an acute illness, a con-
22 dition that is serious enough to require special-
23 ized medical treatment to avoid the reasonable
24 possibility of death or permanent harm; or

1 “(B) in the case of a chronic illness or con-
2 dition, a condition that—

3 “(i) is life-threatening, degenerative,
4 potentially disabling, or congenital; and

5 “(ii) requires specialized medical care
6 over a prolonged period of time.

7 “(3) TERMINATED.—The term ‘terminated’ in-
8 cludes, with respect to a contract, the expiration or
9 nonrenewal of the contract, but does not include a
10 termination of the contract for failure to meet appli-
11 cable quality standards or for fraud.”.

12 (2) CLERICAL AMENDMENT.—The table of con-
13 tents in section 1 of the Employee Retirement In-
14 come Security Act of 1974 is amended by inserting
15 after the item relating to section 716 the following
16 new item:

“Sec. 718. Continuity of care.”.

17 (d) PROVIDER REQUIREMENT.—Part E of title
18 XXVII of the Public Health Service Act (42 U.S.C. 300gg
19 et seq.), as added by section 104 and further amended
20 by the previous provisions of this title, is further amended
21 by adding at the end the following new section:

22 **“SEC. 2799B–8. CONTINUITY OF CARE.**

23 “A health care provider or health care facility shall,
24 in the case of an individual furnished items and services
25 by such provider or facility for which coverage is provided

1 under a group health plan or group or individual health
2 insurance coverage pursuant to section 2799A–3, section
3 9818 of the Internal Revenue Code of 1986, or section
4 718 of the Employee Retirement Income Security Act of
5 1974—

6 “(1) accept payment from such plan or such
7 issuer (as applicable) (and cost-sharing from such
8 individual, if applicable, in accordance with sub-
9 section (a)(2)(C) of such section 2799A–3, 9818, or
10 718) for such items and services as payment in full
11 for such items and services; and

12 “(2) continue to adhere to all policies, proce-
13 dures, and quality standards imposed by such plan
14 or issuer with respect to such individual and such
15 items and services in the same manner as if such
16 termination had not occurred.”.

17 (e) EFFECTIVE DATE.—The amendments made by
18 subsections (a), (b), and (c) shall apply with respect to
19 plan years beginning on or after January 1, 2022.

20 **SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL.**

21 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of
22 the Public Health Service Act (42 U.S.C. 300gg et seq.)
23 is amended, in the part D, as added and amended by sec-
24 tion 102 and further amended by the previous provisions

1 of this title, by inserting after section 2799A–3 the fol-
2 lowing new section:

3 **“SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON**
4 **TOOL.**

5 “A group health plan or a health insurance issuer of-
6 fering group or individual health insurance coverage shall
7 offer price comparison guidance by telephone and make
8 available on the Internet website of the plan or issuer a
9 price comparison tool that (to the extent practicable) al-
10 lows an individual enrolled under such plan or coverage,
11 with respect to such plan year and such geographic region,
12 to compare the amount of cost-sharing that the individual
13 would be responsible for paying under such plan or cov-
14 erage with respect to the furnishing of a specific item or
15 service by any such provider.”.

16 (b) INTERNAL REVENUE CODE.—

17 (1) IN GENERAL.—Subchapter B of chapter
18 100 of the Internal Revenue Code of 1986, as
19 amended by sections 102, 105, and 113, is further
20 amended by inserting after section 9818 the fol-
21 lowing new section:

22 **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

23 “A group health plan shall offer price comparison
24 guidance by telephone and make available on the Internet
25 website of the plan or issuer a price comparison tool that

1 (to the extent practicable) allows an individual enrolled
2 under such plan, with respect to such plan year and such
3 geographic region, to compare the amount of cost-sharing
4 that the individual would be responsible for paying under
5 such plan with respect to the furnishing of a specific item
6 or service by any such provider.”.

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for such subchapter, as amended by the pre-
9 vious sections, is further amended by inserting after
10 the item relating to section 9818 the following new
11 item:

“Sec. 9819. Maintenance of price comparison tool.”.

12 (c) EMPLOYEE RETIREMENT INCOME SECURITY
13 ACT.—

14 (1) IN GENERAL.—Subpart B of part 7 of sub-
15 title B of title I of the Employee Retirement Income
16 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
17 amended by sections 102, 105, and 113, is further
18 amended by inserting after section 718 the following
19 new section:

20 **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

21 “A group health plan or a health insurance issuer of-
22 fering group health insurance coverage shall offer price
23 comparison guidance by telephone and make available on
24 the Internet website of the plan or issuer a price compari-
25 son tool that (to the extent practicable) allows an indi-

1 vidual enrolled under such plan or coverage, with respect
2 to such plan year and such geographic region, to compare
3 the amount of cost-sharing that the individual would be
4 responsible for paying under such plan or coverage with
5 respect to the furnishing of a specific item or service by
6 any such provider.”.

7 (2) CLERICAL AMENDMENT.—The table of con-
8 tents in section 1 of the Employee Retirement In-
9 come Security Act of 1974, as amended by the pre-
10 vious provisions of this title, is further amended by
11 inserting after the item relating to section 716 the
12 following new item:

“Sec. 719. Maintenance of price comparison tool.”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this section shall apply with respect to plan years begin-
15 ning on or after January 1, 2022.

16 **SEC. 115. STATE ALL PAYER CLAIMS DATABASES.**

17 (a) GRANTS TO STATES.—Part B of title III of the
18 Public Health Service Act (42 U.S.C. 243 et seq.) is
19 amended by adding at the end the following:

20 **“SEC. 320B. STATE ALL PAYER CLAIMS DATABASES.**

21 “(a) IN GENERAL.—The Secretary shall make one-
22 time grants to eligible States for the purposes described
23 in subsection (b).

24 “(b) USES.—A State may use a grant received under
25 subsection (a) for one of the following purposes:

1 “(1) To establish a State All Payer Claims
2 Database.

3 “(2) To improve an existing State All Payer
4 Claims Databases.

5 “(c) ELIGIBILITY.—To be eligible to receive a grant
6 under subsection (a), a State shall submit to the Secretary
7 an application at such time, in such manner, and con-
8 taining such information as the Secretary specifies, includ-
9 ing, with respect to a State All Payer Claims Database,
10 at least specifics on how the State will ensure uniform
11 data collection and the privacy and security of such data.

12 “(d) GRANT PERIOD AND AMOUNT.—Grants award-
13 ed under this section shall be for a period of 3-years, and
14 in an amount of \$2,500,000, of which \$1,000,000 shall
15 be made available to the State for each of the first 2 years
16 of the grant period, and \$500,000 shall be made available
17 to the State for the third year of the grant period.

18 “(e) AUTHORIZED USERS.—

19 “(1) APPLICATION.—An entity desiring author-
20 ization for access to a State All Payer Claims Data-
21 base that has received a grant under this section
22 shall submit to the State All Payer Claims Database
23 an application for such access, which shall include—

24 “(A) in the case of an entity requesting ac-
25 cess for research purposes—

1 “(i) a description of the uses and
2 methodologies for evaluating health system
3 performance using such data; and

4 “(ii) documentation of approval of the
5 research by an institutional review board,
6 if applicable for a particular plan of re-
7 search; or

8 “(B) in the case of an entity such as an
9 employer, health insurance issuer, third-party
10 administrator, or health care provider, request-
11 ing access for the purpose of quality improve-
12 ment or cost-containment, a description of the
13 intended uses for such data.

14 “(2) REQUIREMENTS.—

15 “(A) ACCESS FOR RESEARCH PURPOSES.—

16 Upon approval of an application for research
17 purposes under paragraph (1)(A), the author-
18 ized user shall enter into a data use and con-
19 fidentiality agreement with the State All Payer
20 Claims Database that has received a grant
21 under this subsection, which shall include a pro-
22 hibition on attempts to reidentify and disclose
23 individually identifiable health information and
24 proprietary financial information.

1 “(B) CUSTOMIZED REPORTS.—Employers
2 and employer organizations may request cus-
3 tomized reports from a State All Payer Claims
4 Database that has received a grant under this
5 section, at cost, subject to the requirements of
6 this section with respect to privacy, security,
7 and proprietary financial information.

8 “(C) NON-CUSTOMIZED REPORTS.—A
9 State All Payer Claims Database that has re-
10 ceived a grant under this section shall make
11 available to all authorized users aggregate data
12 sets available through the State All Payer
13 Claims Database, free of charge.

14 “(3) WAIVERS.—The Secretary may waive the
15 requirements of this subsection of a State All Payer
16 Claims Database to provide access of entities to such
17 database if such State All Payer Claims Database is
18 substantially in compliance with this subsection.

19 “(f) EXPANDED ACCESS.—

20 “(1) MULTI-STATE APPLICATIONS.—The Sec-
21 retary may prioritize applications submitted by a
22 State whose application demonstrates that the State
23 will work with other State All Payer Claims Data-
24 bases to establish a single application for access to
25 data by authorized users across multiple States.

1 “(2) EXPANSION OF DATA SETS.—The Sec-
2 retary may prioritize applications submitted by a
3 State whose application demonstrates that the State
4 will implement the reporting format for self-insured
5 group health plans described in section 735 of the
6 Employee Retirement Income Security Act of 1974.

7 “(g) DEFINITIONS.—In this section—

8 “(1) the term ‘individually identifiable health
9 information’ has the meaning given such term in
10 section 1171(6) of the Social Security Act;

11 “(2) the term ‘proprietary financial informa-
12 tion’ means data that would disclose the terms of a
13 specific contract between an individual health care
14 provider or facility and a specific group health plan,
15 managed care entity (as defined in section
16 1932(a)(1)(B) of the Social Security Act) or other
17 managed care organization, or health insurance
18 issuer offering group or individual health insurance
19 coverage; and

20 “(3) the term ‘State All Payer Claims Data-
21 base’ means, with respect to a State, a database that
22 may include medical claims, pharmacy claims, dental
23 claims, and eligibility and provider files, which are
24 collected from private and public payers.

1 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are appropriated, out of
3 amounts in the Treasury not otherwise appropriated,
4 \$50,000,000 for each of fiscal years 2022 and 2023, and
5 \$25,000,000 for fiscal year 2024, to remain available until
6 expended.”.

7 (b) STANDARDIZED REPORTING FORMAT.—

8 Subpart C of part 7 of subtitle B of title I of
9 the Employee Retirement Income Security Act of
10 1974 (29 U.S.C. 1191 et seq.) is amended by adding
11 at the end the following:

12 **“SEC. 735. STANDARDIZED REPORTING FORMAT.**

13 “(a) IN GENERAL.—Not later than 1 year after the
14 date of enactment of this section, the Secretary shall es-
15 tablish a standardized reporting format for the reporting,
16 by self-insured group health plans to State All Payer
17 Claims Databases, of medical claims, pharmacy claims,
18 dental claims, and eligibility and provider files that are
19 collected from private and public payers, and shall provide
20 guidance to States on the process by which States may
21 collect such data from such plans or coverage in the stand-
22 ardized reporting format.

23 “(b) CONSULTATION.—

24 “(1) ADVISORY COMMITTEE.—Not later than
25 90 days after the date of enactment of this section,

1 the Secretary shall convene an Advisory Committee
2 (referred to in this section as the ‘Committee’), con-
3 sisting of 15 members to advise the Secretary re-
4 garding the format and guidance described in para-
5 graph (1).

6 “(2) MEMBERSHIP.—

7 “(A) APPOINTMENT.—In accordance with
8 subparagraph (B), not later than 90 days after
9 the date of enactment this section, the Sec-
10 retary, in coordination with the Secretary of
11 Health and Human Services, shall appoint
12 under subparagraph (B)(iii), and the Comp-
13 troller General of the United States shall ap-
14 point under subparagraph (B)(iv), members
15 who have distinguished themselves in the fields
16 of health services research, health economics,
17 health informatics, data privacy and security, or
18 the governance of State All Payer Claims Data-
19 bases, or who represent organizations likely to
20 submit data to or use the database, including
21 patients, employers, or employee organizations
22 that sponsor group health plans, health care
23 providers, health insurance issuers, or third-
24 party administrators of group health plans.
25 Such members shall serve 3-year terms on a

1 staggered basis. Vacancies on the Committee
2 shall be filled by appointment consistent with
3 this paragraph not later than 3 months after
4 the vacancy arises.

5 “(B) COMPOSITION.—The Committee shall
6 be comprised of—

7 “(i) the Assistant Secretary of Em-
8 ployee Benefits and Security Administra-
9 tion of the Department of Labor, or a des-
10 ignee of such Assistant Secretary;

11 “(ii) the Assistant Secretary for Plan-
12 ning and Evaluation of the Department of
13 Health and Human Services, or a designee
14 of such Assistant Secretary;

15 “(iii) members appointed by the Sec-
16 retary, in coordination with the Secretary
17 of Health and Human Services, includ-
18 ing—

19 “(I) 1 member to serve as the
20 chair of the Committee;

21 “(II) 1 representative of the Cen-
22 ters for Medicare & Medicaid Services;

23 “(III) 1 representative of the
24 Agency for Healthcare Research and
25 Quality;

1 “(IV) 1 representative of the Of-
2 fice for Civil Rights of the Depart-
3 ment of Health and Human Services
4 with expertise in data privacy and se-
5 curity;

6 “(V) 1 representative of the Na-
7 tional Center for Health Statistics;

8 “(VI) 1 representative of the Of-
9 fice of the National Coordinator for
10 Health Information Technology; and

11 “(VII) 1 representative of a
12 State All-Payer Claims Database;

13 “(iv) members appointed by the
14 Comptroller General of the United States,
15 including—

16 “(I) 1 representative of an em-
17 ployer that sponsors a group health
18 plan;

19 “(II) 1 representative of an em-
20 ployee organization that sponsors a
21 group health plan;

22 “(III) 1 academic researcher with
23 expertise in health economics or
24 health services research;

25 “(IV) 1 consumer advocate; and

1 “(V) 2 additional members.

2 “(3) REPORT.—Not later than 180 days after
3 the date of enactment of this section, the Committee
4 shall report to the Secretary, the Committee on
5 Health, Education, Labor, and Pensions of the Sen-
6 ate, and the Committee on Energy and Commerce
7 and the Committee on Education and Labor of the
8 House of Representatives. Such report shall include
9 recommendations on the establishment of the format
10 and guidance described in subsection (a).

11 “(c) STATE ALL PAYER CLAIMS DATABASE.—In this
12 section, the term ‘State All Payer Claims Database’
13 means, with respect to a State, a database that may in-
14 clude medical claims, pharmacy claims, dental claims, and
15 eligibility and provider files, which are collected from pri-
16 vate and public payers.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there are appropriated, out of
19 amounts in the Treasury not otherwise appropriated,
20 \$5,000,000 for fiscal year 2021, to remain available until
21 expended or until the date described in subsection (e).

22 “(e) SUNSET.—Beginning on the date on which the
23 report is submitted under subsection (b)(3), this section
24 shall have no force or effect.”.

1 **SEC. 116. PROTECTING PATIENTS AND IMPROVING THE AC-**
2 **CURACY OF PROVIDER DIRECTORY INFOR-**
3 **MATION.**

4 (a) PHSA.—Part D of title XXVII of the Public
5 Health Service Act (42 U.S.C. 300gg et seq.), as added
6 and amended by section 102 and further amended by the
7 previous provisions of this title, is further amended by in-
8 serting after section 2799A–4 the following:

9 **“SEC. 2799A–5. PROTECTING PATIENTS AND IMPROVING**
10 **THE ACCURACY OF PROVIDER DIRECTORY**
11 **INFORMATION.**

12 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
13 MENTS.—

14 “(1) IN GENERAL.—For plan years beginning
15 on or after January 1, 2022, each group health plan
16 and health insurance issuer offering group or indi-
17 vidual health insurance coverage shall—

18 “(A) establish the verification process de-
19 scribed in paragraph (2);

20 “(B) establish the response protocol de-
21 scribed in paragraph (3);

22 “(C) establish the database described in
23 paragraph (4); and

24 “(D) include in any directory (other than
25 the database described in subparagraph (C)
26 containing provider directory information with

1 respect to such plan or such coverage the infor-
2 mation described in paragraph (5).

3 “(2) VERIFICATION PROCESS.—The verification
4 process described in this paragraph is, with respect
5 to a group health plan or a health insurance issuer
6 offering group or individual health insurance cov-
7 erage, a process—

8 “(A) under which, not less frequently than
9 once every 90 days, such plan or such issuer (as
10 applicable) verifies and updates the provider di-
11 rectory information included on the database
12 described in paragraph (4) of such plan or
13 issuer of each health care provider and health
14 care facility included in such database;

15 “(B) that establishes a procedure for the
16 removal of such a provider or facility with re-
17 spect to which such plan or issuer has been un-
18 able to verify such information during a period
19 specified by the plan or issuer; and

20 “(C) that provides for the update of such
21 database within 2 business days of such plan or
22 issuer receiving from such a provider or facility
23 information pursuant to section 2799B–9.

24 “(3) RESPONSE PROTOCOL.—The response pro-
25 tocol described in this paragraph is, in the case of

1 an individual enrolled under a group health plan or
2 group or individual health insurance coverage of-
3 fered by a health insurance issuer who requests in-
4 formation through a telephone call or electronic,
5 web-based, or Internet-based means on whether a
6 health care provider or health care facility has a
7 contractual relationship to furnish items and services
8 under such plan or such coverage, a protocol under
9 which such plan or such issuer (as applicable), in the
10 case such request is made through a telephone call—

11 “(A) responds to such individual as soon
12 as practicable and in no case later than 1 busi-
13 ness day after such call is received, through a
14 written electronic or print (as requested by such
15 individual) communication; and

16 “(B) retains such communication in such
17 individual’s file for at least 2 years following
18 such response.

19 “(4) DATABASE.—The database described in
20 this paragraph is, with respect to a group health
21 plan or health insurance issuer offering group or in-
22 dividual health insurance coverage, a database on
23 the public website of such plan or issuer that con-
24 tains—

1 “(A) a list of each health care provider and
2 health care facility with which such plan or
3 such issuer has a direct or indirect contractual
4 relationship for furnishing items and services
5 under such plan or such coverage; and

6 “(B) provider directory information with
7 respect to each such provider and facility.

8 “(5) INFORMATION.—The information de-
9 scribed in this paragraph is, with respect to a print
10 directory containing provider directory information
11 with respect to a group health plan or individual or
12 group health insurance coverage offered by a health
13 insurance issuer, a notification that such informa-
14 tion contained in such directory was accurate as of
15 the date of publication of such directory and that an
16 individual enrolled under such plan or such coverage
17 should consult the database described in paragraph
18 (4) with respect to such plan or such coverage or
19 contact such plan or the issuer of such coverage to
20 obtain the most current provider directory informa-
21 tion with respect to such plan or such coverage.

22 “(6) DEFINITION.—For purposes of this sub-
23 section, the term ‘provider directory information’ in-
24 cludes, with respect to a group health plan and a
25 health insurance issuer offering group or individual

1 health insurance coverage, the name, address, spe-
2 cialty, telephone number, and digital contact infor-
3 mation of each health care provider or health care
4 facility with which such plan or such issuer has a
5 contractual relationship for furnishing items and
6 services under such plan or such coverage.

7 “(7) RULE OF CONSTRUCTION.—Nothing in
8 this section shall be construed to preempt any provi-
9 sion of State law relating to health care provider di-
10 rectories.

11 “(b) COST-SHARING FOR SERVICES PROVIDED
12 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
13 WORK INFORMATION.—

14 “(1) IN GENERAL.—For plan years beginning
15 on or after January 1, 2022, in the case of an item
16 or service furnished to a participant, beneficiary, or
17 enrollee of a group health plan or group or indi-
18 vidual health insurance coverage offered by a health
19 insurance issuer by a nonparticipating provider or a
20 nonparticipating facility, if such item or service
21 would otherwise be covered under such plan or cov-
22 erage if furnished by a participating provider or par-
23 ticipating facility and if either of the criteria de-
24 scribed in paragraph (2) applies with respect to such

1 participant, beneficiary, or enrollee and item or serv-
2 ice, the plan or coverage—

3 “(A) shall not impose on such participant,
4 beneficiary, or enrollee a cost-sharing amount
5 for such item or service so furnished that is
6 greater than the cost-sharing amount that
7 would apply under such plan or coverage had
8 such item or service been furnished by a partici-
9 pating provider; and

10 “(B) shall apply the deductible or out-of-
11 pocket maximum, if any, that would apply if
12 such services were furnished by a participating
13 provider or a participating facility.

14 “(2) CRITERIA DESCRIBED.—For purposes of
15 paragraph (1), the criteria described in this para-
16 graph, with respect to an item or service furnished
17 to a participant, beneficiary, or enrollee of a group
18 health plan or group or individual health insurance
19 coverage offered by a health insurance issuer by a
20 nonparticipating provider or a nonparticipating facil-
21 ity, are the following:

22 “(A) The participant, beneficiary, or en-
23 rollee received through a database, provider di-
24 rectory, or response protocol described in sub-
25 section (a) information with respect to such

1 item and service to be furnished and such infor-
2 mation provided that the provider was a partici-
3 pating provider or facility was a participating
4 facility, with respect to the plan for furnishing
5 such item or service.

6 “(B) The information was not provided, in
7 accordance with subsection (a), to the partici-
8 pant, beneficiary, or enrollee and the partici-
9 pant, beneficiary, or enrollee requested through
10 the response protocol described in subsection
11 (a)(3) of the plan or coverage information on
12 whether the provider was a participating pro-
13 vider or facility was a participating facility with
14 respect to the plan for furnishing such item or
15 service and was informed through such protocol
16 that the provider was such a participating pro-
17 vider or facility was such a participating facil-
18 ity.

19 “(c) DISCLOSURE ON PATIENT PROTECTIONS
20 AGAINST BALANCE BILLING.—For plan years beginning
21 on or after January 1, 2022, each group health plan and
22 health insurance issuer offering group or individual health
23 insurance coverage shall make publicly available, post on
24 a public website of such plan or issuer, and include on
25 each explanation of benefits for an item or service with

1 respect to which the requirements under section 2799A–
2 1 applies—

3 “(1) information in plain language on—

4 “(A) the requirements and prohibitions ap-
5 plied under sections 2799B–1 and 2799B–2
6 (relating to prohibitions on balance billing in
7 certain circumstances);

8 “(B) if provided for under applicable State
9 law, any other requirements on providers and
10 facilities regarding the amounts such providers
11 and facilities may, with respect to an item or
12 service, charge a participant, beneficiary, or en-
13 rollee of such plan or coverage with respect to
14 which such a provider or facility does not have
15 a contractual relationship for furnishing such
16 item or service under the plan or coverage after
17 receiving payment from the plan or coverage for
18 such item or service and any applicable cost
19 sharing payment from such participant, bene-
20 ficiary, or enrollee; and

21 “(C) the requirements applied under sec-
22 tion 2799A-1; and

23 “(2) information on contacting appropriate
24 State and Federal agencies in the case that an indi-
25 vidual believes that such a provider or facility has

1 violated any requirement described in paragraph (1)
2 with respect to such individual.”.

3 (b) ERISA.—Subpart B of part 7 of subtitle B of
4 title I of the Employee Retirement Income Security Act
5 of 1974 (29 U.S.C. 1185 et seq.), as amended by sections
6 102, 105, 113, and 114, is further amended by inserting
7 after section 719 the following:

8 **“SEC. 720. PROTECTING PATIENTS AND IMPROVING THE**
9 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
10 **MATION.**

11 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
12 MENTS.—

13 “(1) IN GENERAL.—For plan years beginning
14 on or after January 1, 2022, each group health plan
15 and health insurance issuer offering group health in-
16 surance coverage shall—

17 “(A) establish the verification process de-
18 scribed in paragraph (2);

19 “(B) establish the response protocol de-
20 scribed in paragraph (3);

21 “(C) establish the database described in
22 paragraph (4); and

23 “(D) include in any directory (other than
24 the database described in subparagraph (C)
25 containing provider directory information with

1 respect to such plan or such coverage the infor-
2 mation described in paragraph (5).

3 “(2) VERIFICATION PROCESS.—The verification
4 process described in this paragraph is, with respect
5 to a group health plan or a health insurance issuer
6 offering group health insurance coverage, a proc-
7 ess—

8 “(A) under which, not less frequently than
9 once every 90 days, such plan or such issuer (as
10 applicable) verifies and updates the provider di-
11 rectory information included on the database
12 described in paragraph (4) of such plan or
13 issuer of each health care provider and health
14 care facility included in such database;

15 “(B) that establishes a procedure for the
16 removal of such a provider or facility with re-
17 spect to which such plan or issuer has been un-
18 able to verify such information during a period
19 specified by the plan or issuer; and

20 “(C) that provides for the update of such
21 database within 2 business days of such plan or
22 issuer receiving from such a provider or facility
23 information pursuant to section 2799B–9.

24 “(3) RESPONSE PROTOCOL.—The response pro-
25 tocol described in this paragraph is, in the case of

1 an individual enrolled under a group health plan or
2 group health insurance coverage offered by a health
3 insurance issuer who requests information through a
4 telephone call or electronic, web-based, or Internet-
5 based means on whether a health care provider or
6 health care facility has a contractual relationship to
7 furnish items and services under such plan or such
8 coverage, a protocol under which such plan or such
9 issuer (as applicable), in the case such request is
10 made through a telephone call—

11 “(A) responds to such individual as soon
12 as practicable and in no case later than 1 busi-
13 ness day after such call is received, through a
14 written electronic or print (as requested by such
15 individual) communication; and

16 “(B) retains such communication in such
17 individual’s file for at least 2 years following
18 such response.

19 “(4) DATABASE.—The database described in
20 this paragraph is, with respect to a group health
21 plan or health insurance issuer offering group health
22 insurance coverage, a database on the public website
23 of such plan or issuer that contains—

24 “(A) a list of each health care provider and
25 health care facility with which such plan or

1 such issuer has a direct or indirect contractual
2 relationship for furnishing items and services
3 under such plan or such coverage; and

4 “(B) provider directory information with
5 respect to each such provider and facility.

6 “(5) INFORMATION.—The information de-
7 scribed in this paragraph is, with respect to a print
8 directory containing provider directory information
9 with respect to a group health plan or group health
10 insurance coverage offered by a health insurance
11 issuer, a notification that such information con-
12 tained in such directory was accurate as of the date
13 of publication of such directory and that an indi-
14 vidual enrolled under such plan or such coverage
15 should consult the database described in paragraph
16 (4) with respect to such plan or such coverage or
17 contact such plan or the issuer of such coverage to
18 obtain the most current provider directory informa-
19 tion with respect to such plan or such coverage.

20 “(6) DEFINITION.—For purposes of this sub-
21 section, the term ‘provider directory information’ in-
22 cludes, with respect to a group health plan and a
23 health insurance issuer offering group health insur-
24 ance coverage, the name, address, specialty, tele-
25 phone number, and digital contact information of

1 each health care provider or health care facility with
2 which such plan or such issuer has a contractual re-
3 lationship for furnishing items and services under
4 such plan or such coverage.

5 “(7) RULE OF CONSTRUCTION.—Nothing in
6 this section shall be construed to preempt any provi-
7 sion of State law relating to health care provider di-
8 rectories, to the extent such State law applies to
9 such plan, coverage, or issuer, subject to section
10 514.

11 “(b) COST-SHARING FOR SERVICES PROVIDED
12 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
13 WORK INFORMATION.—

14 “(1) IN GENERAL.—For plan years beginning
15 on or after January 1, 2022, in the case of an item
16 or service furnished to a participant, beneficiary, or
17 enrollee of a group health plan or group health in-
18 surance coverage offered by a health insurance
19 issuer by a nonparticipating provider or a non-
20 participating facility, if such item or service would
21 otherwise be covered under such plan or coverage if
22 furnished by a participating provider or partici-
23 pating facility and if either of the criteria described
24 in paragraph (2) applies with respect to such partici-

1 pant, beneficiary, or enrollee and item or service, the
2 plan or coverage—

3 “(A) shall not impose on such participant,
4 beneficiary, or enrollee a cost-sharing amount
5 for such item or service so furnished that is
6 greater than the cost-sharing amount that
7 would apply under such plan or coverage had
8 such item or service been furnished by a partici-
9 pating provider; and

10 “(B) shall apply the deductible or out-of-
11 pocket maximum, if any, that would apply if
12 such services were furnished by a participating
13 provider or a participating facility.

14 “(2) CRITERIA DESCRIBED.—For purposes of
15 paragraph (1), the criteria described in this para-
16 graph, with respect to an item or service furnished
17 to a participant, beneficiary, or enrollee of a group
18 health plan or group health insurance coverage of-
19 fered by a health insurance issuer by a nonpartici-
20 pating provider or a nonparticipating facility, are the
21 following:

22 “(A) The participant, beneficiary, or en-
23 rollee received through a database, provider di-
24 rectory, or response protocol described in sub-
25 section (a) information with respect to such

1 item and service to be furnished and such infor-
2 mation provided that the provider was a partici-
3 pating provider or facility was a participating
4 facility, with respect to the plan for furnishing
5 such item or service.

6 “(B) The information was not provided, in
7 accordance with subsection (a), to the partici-
8 pant, beneficiary, or enrollee and the partici-
9 pant, beneficiary, or enrollee requested through
10 the response protocol described in subsection
11 (a)(3) of the plan or coverage information on
12 whether the provider was a participating pro-
13 vider or facility was a participating facility with
14 respect to the plan for furnishing such item or
15 service and was informed through such protocol
16 that the provider was such a participating pro-
17 vider or facility was such a participating facil-
18 ity.

19 “(c) DISCLOSURE ON PATIENT PROTECTIONS
20 AGAINST BALANCE BILLING.—For plan years beginning
21 on or after January 1, 2022, each group health plan and
22 health insurance issuer offering group health insurance
23 coverage shall make publicly available, post on a public
24 website of such plan or issuer, and include on each expla-

1 nation of benefits for an item or service with respect to
2 which the requirements under section 2799A-1 applies—

3 “(1) information in plain language on—

4 “(A) the requirements and prohibitions ap-
5 plied under sections 2799B-1 and 2799B-2
6 (relating to prohibitions on balance billing in
7 certain circumstances);

8 “(B) if provided for under applicable State
9 law, any other requirements on providers and
10 facilities regarding the amounts such providers
11 and facilities may, with respect to an item or
12 service, charge a participant, beneficiary, or en-
13 rollee of such plan or coverage with respect to
14 which such a provider or facility does not have
15 a contractual relationship for furnishing such
16 item or service under the plan or coverage after
17 receiving payment from the plan or coverage for
18 such item or service and any applicable cost
19 sharing payment from such participant, bene-
20 ficiary, or enrollee; and

21 “(C) the requirements applied under sec-
22 tion 2799A-1; and

23 “(2) information on contacting appropriate
24 State and Federal agencies in the case that an indi-
25 vidual believes that such a provider or facility has

1 violated any requirement described in paragraph (1)
2 with respect to such individual.”.

3 (c) IRC.—Subchapter B of chapter 100 of the Inter-
4 nal Revenue Code of 1986, as amended by sections 102,
5 105, 113, and 114, is further amended by inserting after
6 section 9819 the following:

7 **“SEC. 9820. PROTECTING PATIENTS AND IMPROVING THE**
8 **ACCURACY OF PROVIDER DIRECTORY INFOR-**
9 **MATION.**

10 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-
11 MENTS.—

12 “(1) IN GENERAL.—For plan years beginning
13 on or after January 1, 2022, each group health plan
14 shall—

15 “(A) establish the verification process de-
16 scribed in paragraph (2);

17 “(B) establish the response protocol de-
18 scribed in paragraph (3);

19 “(C) establish the database described in
20 paragraph (4); and

21 “(D) include in any directory (other than
22 the database described in subparagraph (C))
23 containing provider directory information with
24 respect to such plan the information described
25 in paragraph (5).

1 “(2) VERIFICATION PROCESS.—The verification
2 process described in this paragraph is, with respect
3 to a group health plan, a process—

4 “(A) under which, not less frequently than
5 once every 90 days, such plan verifies and up-
6 dates the provider directory information in-
7 cluded on the database described in paragraph
8 (4) of such plan or issuer of each health care
9 provider and health care facility included in
10 such database;

11 “(B) that establishes a procedure for the
12 removal of such a provider or facility with re-
13 spect to which such plan or issuer has been un-
14 able to verify such information during a period
15 specified by the plan or issuer; and

16 “(C) that provides for the update of such
17 database within 2 business days of such plan or
18 issuer receiving from such a provider or facility
19 information pursuant to section 2799B–9.

20 “(3) RESPONSE PROTOCOL.—The response pro-
21 tocol described in this paragraph is, in the case of
22 an individual enrolled under a group health plan who
23 requests information through a telephone call or
24 electronic, web-based, or Internet-based means on
25 whether a health care provider or health care facility

1 has a contractual relationship to furnish items and
2 services under such plan, a protocol under which
3 such plan or such issuer (as applicable), in the case
4 such request is made through a telephone call—

5 “(A) responds to such individual as soon
6 as practicable and in no case later than 1 busi-
7 ness day after such call is received, through a
8 written electronic or print (as requested by such
9 individual) communication; and

10 “(B) retains such communication in such
11 individual’s file for at least 2 years following
12 such response.

13 “(4) DATABASE.—The database described in
14 this paragraph is, with respect to a group health
15 plan, a database on the public website of such plan
16 or issuer that contains—

17 “(A) a list of each health care provider and
18 health care facility with which such plan or
19 such issuer has a direct or indirect contractual
20 relationship for furnishing items and services
21 under such plan; and

22 “(B) provider directory information with
23 respect to each such provider and facility.

24 “(5) INFORMATION.—The information de-
25 scribed in this paragraph is, with respect to a print

1 directory containing provider directory information
2 with respect to a group health plan, a notification
3 that such information contained in such directory
4 was accurate as of the date of publication of such
5 directory and that an individual enrolled under such
6 plan should consult the database described in para-
7 graph (4) with respect to such plan or contact such
8 plan to obtain the most current provider directory
9 information with respect to such plan.

10 “(6) DEFINITION.—For purposes of this sub-
11 section, the term ‘provider directory information’ in-
12 cludes, with respect to a group health plan, the
13 name, address, specialty, telephone number, and dig-
14 ital contact information of each health care provider
15 or health care facility with which such plan has a
16 contractual relationship for furnishing items and
17 services under such plan.

18 “(7) RULE OF CONSTRUCTION.—Nothing in
19 this section shall be construed to preempt any provi-
20 sion of State law relating to health care provider di-
21 rectories.

22 “(b) COST-SHARING FOR SERVICES PROVIDED
23 BASED ON RELIANCE ON INCORRECT PROVIDER NET-
24 WORK INFORMATION.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2022, in the case of an item
3 or service furnished to a participant, beneficiary, or
4 enrollee of a group health plan by a nonparticipating
5 provider or a nonparticipating facility, if such item
6 or service would otherwise be covered under such
7 plan if furnished by a participating provider or par-
8 ticipating facility and if either of the criteria de-
9 scribed in paragraph (2) applies with respect to such
10 participant, beneficiary, or enrollee and item or serv-
11 ice, the plan—

12 “(A) shall not impose on such participant,
13 beneficiary, or enrollee a cost-sharing amount
14 for such item or service so furnished that is
15 greater than the cost-sharing amount that
16 would apply under such plan had such item or
17 service been furnished by a participating pro-
18 vider; and

19 “(B) shall apply the deductible or out-of-
20 pocket maximum, if any, that would apply if
21 such services were furnished by a participating
22 provider or a participating facility.

23 “(2) CRITERIA DESCRIBED.—For purposes of
24 paragraph (1), the criteria described in this para-
25 graph, with respect to an item or service furnished

1 to a participant, beneficiary, or enrollee of a group
2 health plan by a nonparticipating provider or a non-
3 participating facility, are the following:

4 “(A) The participant, beneficiary, or en-
5 rollee received through a database, provider di-
6 rectory, or response protocol described in sub-
7 section (a) information with respect to such
8 item and service to be furnished and such infor-
9 mation provided that the provider was a partici-
10 pating provider or facility was a participating
11 facility, with respect to the plan for furnishing
12 such item or service.

13 “(B) The information was not provided, in
14 accordance with subsection (a), to the partici-
15 pant, beneficiary, or enrollee and the partici-
16 pant, beneficiary, or enrollee requested through
17 the response protocol described in subsection
18 (a)(3) of the plan information on whether the
19 provider was a participating provider or facility
20 was a participating facility with respect to the
21 plan for furnishing such item or service and
22 was informed through such protocol that the
23 provider was such a participating provider or
24 facility was such a participating facility.

1 “(c) DISCLOSURE ON PATIENT PROTECTIONS
2 AGAINST BALANCE BILLING.—For plan years beginning
3 on or after January 1, 2022, each group health plan shall
4 make publicly available, post on a public website of such
5 plan or issuer, and include on each explanation of benefits
6 for an item or service with respect to which the require-
7 ments under section 2799A–1 applies—

8 “(1) information in plain language on—

9 “(A) the requirements and prohibitions ap-
10 plied under sections 2799B–1 and 2799B–2
11 (relating to prohibitions on balance billing in
12 certain circumstances);

13 “(B) if provided for under applicable State
14 law, any other requirements on providers and
15 facilities regarding the amounts such providers
16 and facilities may, with respect to an item or
17 service, charge a participant, beneficiary, or en-
18 rollee of such plan with respect to which such
19 a provider or facility does not have a contrac-
20 tual relationship for furnishing such item or
21 service under the plan after receiving payment
22 from the plan for such item or service and any
23 applicable cost sharing payment from such par-
24 ticipant, beneficiary, or enrollee; and

1 “(C) the requirements applied under sec-
2 tion 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.”.

8 (d) CLERICAL AMENDMENTS.—

9 (1) ERISA.—The table of contents in section 1
10 of the Employee Retirement Income Security Act of
11 1974 (29 U.S.C. 1001 et seq.), as amended by the
12 previous provisions of this title, is further amended
13 by inserting after the item relating to section 719
14 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

1 by the previous provisions of this title, is further amended
2 by adding at the end the following:

3 **“SEC. 2799B-9. PROVIDER REQUIREMENTS TO PROTECT PA-**
4 **TIENTS AND IMPROVE THE ACCURACY OF**
5 **PROVIDER DIRECTORY INFORMATION.**

6 “(a) PROVIDER BUSINESS PROCESSES.—Beginning
7 not later than January 1, 2022, each health care provider
8 and each health care facility shall have in place business
9 processes to ensure the timely provision of provider direc-
10 tory information to a group health plan or a health insur-
11 ance issuer offering group or individual health insurance
12 coverage to support compliance by such plans or issuers
13 with section 2799A-5(a)(1). Such providers shall submit
14 provider directory information to a plan or issuers, at a
15 minimum—

16 “(1) when the provider or facility begins a net-
17 work agreement with a plan or with an issuer with
18 respect to certain coverage;

19 “(2) when the provider or facility terminates a
20 network agreement with a plan or with an issuer
21 with respect to certain coverage;

22 “(3) when there are material changes to the
23 content of provider directory information of the pro-
24 vider or facility described in section 2799A-5(a)(1);
25 and

1 “(4) at any other time (including upon the re-
2 quest of such issuer or plan) determined appropriate
3 by the provider, facility, or the Secretary.

4 “(b) REFUNDS TO ENROLLEES.—If a health care
5 provider submits a bill to an enrollee based on cost-sharing
6 for treatment or services provided by the health care pro-
7 vider that is in excess of the normal cost-sharing applied
8 for such treatment or services provided in-network, as pro-
9 hibited under section 2799A–5(b), and the enrollee pays
10 such bill, the provider shall reimburse the enrollee for the
11 full amount paid by the enrollee in excess of the in-net-
12 work cost-sharing amount for the treatment or services
13 involved, plus interest, at an interest rate determined by
14 the Secretary.

15 “(c) LIMITATION.—Nothing in this section shall pro-
16 hibit a provider from requiring in the terms of a contract,
17 or contract termination, with a group health plan or health
18 insurance issuer—

19 “(1) that the plan or issuer remove, at the time
20 of termination of such contract, the provider from a
21 directory of the plan or issuer described in section
22 2799A–5(a); or

23 “(2) that the plan or issuer bear financial re-
24 sponsibility, including under section 2799A–5(b), for

1 providing inaccurate network status information to
2 an enrollee.

3 “(d) DEFINITION.—For purposes of this section, the
4 term ‘provider directory information’ includes the names,
5 addresses, specialty, telephone numbers, and digital con-
6 tact information of individual health care providers, and
7 the names, addresses, telephone numbers, and digital con-
8 tact information of each medical group, clinic, or facility
9 contracted to participate in any of the networks of the
10 group health plan or health insurance coverage involved.

11 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed to preempt any provision of State
13 law relating to health care provider directories.”.

14 **SEC. 117. TIMELY BILLS FOR PATIENTS.**

15 (a) FACILITIES AND PRACTITIONERS REQUIRE-
16 MENTS.—

17 (1) IN GENERAL.—Part E of title XXVII of the
18 Public Health Service Act (42 U.S.C. 300gg et seq.),
19 as added and amended by the previous provisions of
20 this title, is further amended by adding at the end
21 the following:

22 **“SEC. 2799B-10. PROVIDER PROVISION OF TIMELY BILLS**
23 **FOR PATIENTS.**

24 “(a) PROVISION OF LIST OF SERVICES.—Health care
25 facilities, or in the case of practitioners providing services

1 outside of such a facility, practitioners, shall provide to
2 an individual a list of services rendered to such individual
3 during the visit to such facility or practitioner, and, in
4 the case of a facility, the name of the practitioner for each
5 such service, upon discharge or end of the visit or by post-
6 al or electronic communication as soon as practicable and
7 not later than 15 calendar days after the discharge or date
8 of visit.

9 “(b) ADJUDICATION OF BILLS.—In the case of serv-
10 ices provided to an individual covered by a group health
11 plan or group or individual health insurance coverage of-
12 fered by a health insurance issuer, subject to 2799A–6(b),
13 section 721(b) of the Employee Retirement Income Secu-
14 rity Act of 1974, or section 9821(b) of the Internal Rev-
15 enue Code of 1986, as applicable—

16 “(1) the health care facility, or in the case of
17 a practitioner providing services outside of such a
18 facility, the practitioner, shall submit to the group
19 health plan or health insurance issuer the bill with
20 respect to such services not later than 30 calendar
21 days after discharge or date of visit of the indi-
22 vidual; and

23 “(2) the health care facility or practitioner, as
24 applicable under paragraph (1), shall, not later than
25 30 calendar days after transmission of the informa-

1 tion as described in section 2799A–6(a), section
2 721(a) of the Employee Retirement Income Security
3 Act of 1974, or section 9821(a) of the Internal Rev-
4 enue Code of 1986, as applicable, send to the indi-
5 vidual, using such information, the cost-sharing obli-
6 gation applied for such services (which in the case
7 of such services for which a payment is required to
8 be made by the plan or coverage pursuant to sub-
9 section (a)(1) of section 2799A–1, of 716 of the Em-
10 ployee Retirement Income Security Act of 1974, or
11 of section 9816 of the Internal Revenue Code of
12 1986, subsection (b)(1) of such sections, or sub-
13 section (a) of section 2799A–2, of 717 of the Em-
14 ployee Retirement Income Security Act of 1974, or
15 of section 9817 of the Internal Revenue Code of
16 1986, shall be in accordance with such respective
17 subsection).

18 “(c) PAYMENT AFTER BILLING.—No patient may be
19 required to pay a bill for health care services any earlier
20 than 45 days after the postmark date of a bill for such
21 services.

22 “(d) REFUND REQUIREMENT.—

23 “(1) IN GENERAL.—If a facility or practitioner
24 bills a patient after the 90-calendar-day period de-
25 scribed pursuant to subsection (b), in addition to

1 being subject to any penalty under section 2799B–
2 4, such facility or practitioner shall refund the pa-
3 tient for the full amount paid in response to such
4 bill with interest, at a rate determined by the Sec-
5 retary.

6 “(2) EXEMPTIONS.—The Secretary may exempt
7 a practitioner or facility from the penalties under
8 paragraph (1) or extend the periods specified in sub-
9 section (b) for compliance with such subsection if a
10 practitioner or facility—

11 “(A) makes a good-faith attempt to send a
12 bill within the periods specified in subsection
13 (b) but is unable to do so because of an incor-
14 rect address; or

15 “(B) experiences extenuating cir-
16 cumstances (as defined by the Secretary), such
17 as a hurricane or cyberattack, that may reason-
18 ably delay delivery of a timely bill.

19 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
20 tion shall be construed to limit applicability of the appeals
21 process under section 2719 to coverage determinations or
22 claims subject to the requirements of this section. The pe-
23 riods described in subsections (b) and (c) shall be tolled
24 during any period during which a claim is subject to an
25 appeal under section 2719, provided that, in the case of

1 such an appeal by the provider, the patient is informed
2 of such appeal.”.

3 (2) RULEMAKING.—Not later than 1 year after
4 the date of enactment of this Act, the Secretary of
5 Health and Human Services shall promulgate final
6 regulations to implement section 2799B–10 of the
7 Public Health Service Act, as added by paragraph
8 (1). Such regulations shall include—

9 (A) a definition of the term “extenuating
10 circumstance” for purposes of subsection
11 (d)(3)(B) of such section 2799B–10; and

12 (B) a definition of the term “date of serv-
13 ice” for purposes of subsection (b)(1), with re-
14 spect to providers submitting global packages
15 for services provided on multiple visits.

16 (b) GROUP HEALTH PLAN AND HEALTH INSURANCE
17 ISSUER REQUIREMENTS.—

18 (1) PHSA.—Part D of title XXVII of the Pub-
19 lic Health Service Act, as added and amended by
20 section 102 and further amended by the previous
21 provisions of this title, is further amended by insert-
22 ing after section 2799A–5 the following:

23 **“SEC. 2799A–6. TIMELY BILLS FOR PATIENTS.**

24 “(a) IN GENERAL.—Subject to subsection (b), in the
25 case of a group health plan or health insurance issuer of-

1 fering group or individual health insurance coverage that
2 receives a bill as described in section 2799B–10(b)(1)
3 from a facility or practitioner, the group health plan or
4 issuer shall, not later than 30 calendar days after such
5 bill is transmitted by the facility or practitioner, send to
6 the facility or practitioner, as applicable under such sec-
7 tion, the following information:

8 “(1) In the case the bill is with respect to serv-
9 ices for which a payment is required to be made by
10 the plan or coverage pursuant to subsection (a)(1)
11 of section 2799A–1, of 716 of the Employee Retirement
12 Income Security Act of 1974, or of section
13 9816 of the Internal Revenue Code of 1986, sub-
14 section (b)(1) of such sections, or subsection (a) of
15 section 2799A–2, of 717 of the Employee Retirement
16 Income Security Act of 1974, or of section
17 9817 of the Internal Revenue Code of 1986, an ini-
18 tial response to such bill, including the cost-sharing
19 amount applicable with respect to such bill, in ac-
20 cordance with such respective subsection.

21 “(2) In the case the bill is with respect to serv-
22 ices not described in paragraph (1), the completed
23 adjudicated bill by the plan or coverage, including
24 the cost-sharing amount applicable with respect to
25 such bill.

1 “(b) CLARIFICATION.—A provider or a group health
2 plan or health insurance issuer may establish in a contract
3 the timeline for submission by either party to the other
4 party of billing information, adjudication, sending of re-
5 mittance information, or any other coordination required
6 between the provider and the plan or issuer necessary for
7 meeting the deadlines described in subsection (a) and sec-
8 tion 2799B–10(b) as long as such timeline results in the
9 90-calendar day period described in section 2799B–
10 10(d)(1)(B).

11 “(c) RULES OF CONSTRUCTION.—Nothing in this
12 section shall be construed to limit applicability of the ap-
13 peals process under section 2719 to coverage determina-
14 tions or claims subject to the requirements of this section.
15 Any timeline established under subsection (a) or (b) shall
16 be tolled during any period during which a claim is subject
17 to an appeal under section 2719, provided that, in the case
18 of such an appeal by the provider, the patient is informed
19 of such appeal. A group health plan or health insurance
20 issuer that knows or should have known that denials of
21 a claim would lead to noncompliance by providers with sec-
22 tion 2799B–10 may be found to be in violation of this
23 part.”.

24 (2) ERISA.—Subpart B of part 7 of subtitle B
25 of title I of the Employee Retirement Income Secu-

1 rity Act of 1974 (29 U.S.C. 1185 et seq.), as
2 amended by sections 102, 105, 113, 114, and 116,
3 is further amended by inserting after section 720
4 the following:

5 **“SEC. 721. TIMELY BILLS FOR PATIENTS.**

6 “(a) IN GENERAL.—Subject to subsection (b), in the
7 case of a group health plan or health insurance issuer of-
8 fering group health insurance coverage that receives a bill
9 as described in section 2799B–10(b)(1) of the Public
10 Health Service Act from a facility or practitioner, the
11 group health plan or issuer shall, not later than 30 cal-
12 endar days after such bill is transmitted by the facility
13 or practitioner, send to the facility or practitioner, as ap-
14 plicable under such section, the following information:

15 “(1) In the case the bill is with respect to serv-
16 ices for which a payment is required to be made by
17 the plan or coverage pursuant to subsection (a)(1)
18 of section 716, of section 2799A–1 of the Public
19 Health Service Act, or of section 9816 of the Inter-
20 nal Revenue Code of 1986, subsection (b)(1) of such
21 sections, or subsection (a) of section 717, of section
22 2799A–2 of the Public Health Service Act, or of sec-
23 tion 9817 of the Internal Revenue Code of 1986, an
24 initial response to such bill, including the cost-shar-

1 ing amount applicable with respect to such bill, in
2 accordance with such respective subsection.

3 “(2) In the case the bill is with respect to serv-
4 ices not described in paragraph (1), the completed
5 adjudicated bill by the plan or coverage, including
6 the cost-sharing amount applicable with respect to
7 such bill.

8 “(b) CLARIFICATION.—A provider or a group health
9 plan or health insurance issuer may establish in a contract
10 the timeline for submission by either party to the other
11 party of billing information, adjudication, sending of re-
12 mittance information, or any other coordination required
13 between the provider and the plan or issuer necessary for
14 meeting the deadlines described in subsection (a) and sec-
15 tion 2799B–10(b) of the Public Health Service Act as long
16 as such timeline results in the 90-calendar day period de-
17 scribed in section 2799B–10(d)(1)(B) of such Act.

18 “(c) RULES OF CONSTRUCTION.—Nothing in this
19 section shall be construed to limit applicability of the ap-
20 peals process under section 2719 of the Public Health
21 Service Act or section 503 to coverage determinations or
22 claims subject to the requirements of this section. Any
23 timeline established under subsection (a) or (b) shall be
24 tolled during any period during which a claim is subject
25 to an appeal under section 2719 of the Public Health

1 Service Act or section 503, provided that, in the case of
2 such an appeal by the provider, the patient is informed
3 of such appeal. A group health plan or health insurance
4 issuer that knows or should have known that denials of
5 a claim would lead to noncompliance by providers with sec-
6 tion 2799B–10 of the Public Health Service Act may be
7 found to be in violation of this subpart.”.

8 (3) IRC.—Subchapter B of chapter 100 of the
9 Internal Revenue Code of 1986, as amended by the
10 sections 102, 105, 113, 114, and 116, is further
11 amended by inserting after section 9820 the fol-
12 lowing:

13 **“SEC. 9821. TIMELY BILLS FOR PATIENTS.**

14 “(a) IN GENERAL.—Subject to subsection (b), in the
15 case of a group health plan that receives a bill as described
16 in section 2799B–10(b)(1) of the Public Health Service
17 Act from a facility or practitioner, the group health plan
18 shall, not later than 30 calendar days after such bill is
19 transmitted by the facility or practitioner, send to the fa-
20 cility or practitioner, as applicable under such section, the
21 following information:

22 “(1) In the case the bill is with respect to serv-
23 ices for which a payment is required to be made by
24 the plan pursuant to subsection (a)(1) of section
25 716, of section 2799A–1 of the Public Health Serv-

1 ice Act, or of section 9816 of the Internal Revenue
2 Code of 1986, subsection (b)(1) of such sections, or
3 subsection (a) of section 717, of section 2799A–2 of
4 the Public Health Service Act, or of section 9817 of
5 the Internal Revenue Code of 1986, an initial re-
6 sponse to such bill, including the cost-sharing
7 amount applicable with respect to such bill, in ac-
8 cordance with such respective subsection.

9 “(2) In the case the bill is with respect to serv-
10 ices not described in paragraph (1), the completed
11 adjudicated bill by the plan, including the cost-shar-
12 ing amount applicable with respect to such bill.

13 “(b) CLARIFICATION.—A provider or a group health
14 plan may establish in a contract the timeline for submis-
15 sion by either party to the other party of billing informa-
16 tion, adjudication, sending of remittance information, or
17 any other coordination required between the provider and
18 the plan necessary for meeting the deadlines described in
19 subsection (a) and section 2799B–10(b) of the Public
20 Health Service Act as long as such timeline results in the
21 90-calendar day period described in section 2799B–
22 10(d)(1)(B) of such Act.

23 “(c) RULES OF CONSTRUCTION.—Nothing in this
24 section shall be construed to limit applicability of the ap-
25 peals process under section 2719 of the Public Health

1 Service Act to coverage determinations or claims subject
2 to the requirements of this section. Any timeline estab-
3 lished under subsection (a) or (b) shall be tolled during
4 any period during which a claim is subject to an appeal
5 under section 2719 of the Public Health Service Act, pro-
6 vided that, in the case of such an appeal by the provider,
7 the patient is informed of such appeal. A group health
8 plan that knows or should have known that denials of a
9 claim would lead to noncompliance by providers with sec-
10 tion 2799B–10 of the Public Health Service Act may be
11 found to be in violation of this chapter.”.

12 (4) CLERICAL AMENDMENTS.—

13 (A) ERISA.—The table of contents in sec-
14 tion 1 of the Employee Retirement Income Se-
15 curity Act of 1974 (29 U.S.C. 1001 et seq.), as
16 amended by the previous provisions of this title,
17 is further amended by inserting after the item
18 relating to section 720 the following new item:

“721. Timely bills for patients.”.

19 (B) IRC.—The table of sections for sub-
20 chapter B of chapter 100 of the Internal Rev-
21 enue Code of 1986, as amended by the previous
22 provisions of this title, is further amended by
23 inserting after the item relating to section 9820
24 the following new item:

“9821. Timely bills for patients.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 subsections (a) and (b) shall apply beginning 6 months
3 after the date of the enactment of this Act.

4 **SEC. 118. ADVISORY COMMITTEE ON GROUND AMBULANCE**
5 **AND PATIENT BILLING.**

6 (a) IN GENERAL.—Not later than 60 days after the
7 date of enactment of this Act, the Secretary of Labor, Sec-
8 retary of Health and Human Services, and the Secretary
9 of the Treasury (the Secretaries) shall jointly establish an
10 advisory committee for the purpose of reviewing options
11 to improve the disclosure of charges and fees for ground
12 ambulance services, better inform consumers of insurance
13 options for such services, and protect consumers from bal-
14 ance billing.

15 (b) COMPOSITION OF THE ADVISORY COMMITTEE.—
16 The advisory committee shall be composed of the following
17 members:

18 (1) The Secretary of Labor, or the Secretary's
19 designee.

20 (2) The Secretary of Health and Human Serv-
21 ices, or the Secretary's designee.

22 (3) The Secretary of the Treasury, or the Sec-
23 retary's designee.

24 (4) One representative, to be appointed jointly
25 by the Secretaries, for each of the following:

1 (A) Each relevant Federal agency, as de-
2 termined by the Secretaries.

3 (B) State insurance regulators.

4 (C) Health insurance providers.

5 (D) Patient advocacy groups.

6 (E) Consumer advocacy groups.

7 (F) State and local governments.

8 (G) Physician specializing in emergency,
9 trauma, cardiac, or stroke.

10 (5) Three representatives, to be appointed joint-
11 ly by the Secretaries, to represent the various seg-
12 ments of the ground ambulance industry.

13 (6) Up to an additional 2 representatives other-
14 wise not described in paragraphs (1) through (5), as
15 determined necessary and appropriate by the Secre-
16 taries.

17 (c) CONSULTATION.—The advisory committee shall,
18 as appropriate, consult with relevant experts and stake-
19 holders, including those not otherwise included under sub-
20 section (b), while conducting the review described in sub-
21 section (a).

22 (d) RECOMMENDATIONS.—The advisory committee
23 shall make recommendations with respect to disclosure of
24 charges and fees for ground ambulance services and insur-
25 ance coverage, consumer protection and enforcement au-

1 thorities of the Departments of Labor, Health and Human
2 Services, and the Treasury and State authorities, and the
3 prevention of balance billing to consumers. The rec-
4 ommendations shall address, at a minimum—

5 (1) options, best practices, and identified stand-
6 ards to prevent instances of balance billing;

7 (2) steps that can be taken by State legisla-
8 tures, State insurance regulators, State attorneys
9 general, and other State officials as appropriate,
10 consistent with current legal authorities regarding
11 consumer protection; and

12 (3) legislative options for Congress to prevent
13 balance billing.

14 (e) REPORT.—Not later than 180 days after the date
15 of the first meeting of the advisory committee, the advi-
16 sory committee shall submit to the Secretaries, and the
17 Committees on Education and Labor, Energy and Com-
18 merce, and Ways and Means of the House of Representa-
19 tives and the Committees on Finance and Health, Edu-
20 cation, Labor, and Pensions a report containing the rec-
21 ommendations made under subsection (d).