

1 **DIVISION BB—PRIVATE HEALTH**  
 2 **INSURANCE AND PUBLIC**  
 3 **HEALTH PROVISIONS**

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HEALTH PROVISIONS

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1     **TITLE I—NO SURPRISES ACT**2     **SEC. 101. SHORT TITLE.**

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

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

6         (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

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

2 **“SEC. 2799A-1. PREVENTING SURPRISE MEDICAL BILLS.**

3 “(a) COVERAGE OF EMERGENCY SERVICES.—

4 “(1) IN GENERAL.—If a group health plan, or  
5 a health insurance issuer offering group or indi-  
6 vidual health insurance coverage, provides or covers  
7 any benefits with respect to services in an emergency  
8 department of a hospital or with respect to emer-  
9 gency services in an independent freestanding emer-  
10 gency department (as defined in paragraph (3)(D)),  
11 the plan or issuer shall cover emergency services (as  
12 defined in paragraph (3)(C))—

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

15 “(B) whether the health care provider fur-  
16 nishing such services is a participating provider  
17 or a participating emergency facility, as appli-  
18 cable, with respect to such services;

19 “(C) in a manner so that, if such services  
20 are provided to a participant, beneficiary, or en-  
21 rollee by a nonparticipating provider or a non-  
22 participating emergency facility—

23 “(i) such services will be provided  
24 without imposing any requirement under  
25 the plan or coverage for prior authoriza-  
26 tion of services or any limitation on cov-

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1 erage that is more restrictive than the re-  
2 quirements or limitations that apply to  
3 emergency services received from partici-  
4 pating providers and participating emer-  
5 gency facilities with respect to such plan or  
6 coverage, respectively;

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

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

20 “(iv) the group health plan or health  
21 insurance issuer, respectively—

22 “(I) not later than 30 calendar  
23 days after the bill for such services is  
24 transmitted by such provider or facil-  
25 ity, sends to the provider or facility,

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1 as applicable, an initial payment or  
2 notice of denial of payment; and

3 “(II) pays a total plan or cov-  
4 erage payment directly to such pro-  
5 vider or facility, respectively (in ac-  
6 cordance, if applicable, with the tim-  
7 ing requirement described in sub-  
8 section (c)(6)) that is, with applica-  
9 tion of any initial payment under sub-  
10 clause (I), equal to the amount by  
11 which the out-of-network rate (as de-  
12 fined in paragraph (3)(K)) for such  
13 services exceeds the cost-sharing  
14 amount for such services (as deter-  
15 mined in accordance with clauses (ii)  
16 and (iii)) and year; and

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

1 cost-sharing payments were made with re-  
2 spect to emergency services furnished by a  
3 participating provider or a participating  
4 emergency facility; and

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

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

16 “(A) AUDIT PROCESS.—

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

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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

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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 or other infor-  
6                   mation about such plan or coverage,  
7                   respectively, that involves the compli-  
8                   ance of the plan or coverage, respec-  
9                   tively, with either of the requirements  
10                  described in subclauses (I) and (II) of  
11                  such clause.

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

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

22                         “(i) the methodology the group health  
23                         plan or health insurance issuer offering  
24                         group or individual health insurance cov-  
25                         erage shall use to determine the qualifying



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1 payment amount, differentiating by indi-  
2 vidual market, large group market, and  
3 small group market;

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

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

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

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

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

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

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

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

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

5 “(C) EMERGENCY SERVICES.—

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

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

23 “(II) within the capabilities of  
24 the staff and facilities available at the  
25 hospital or the independent free-

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

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

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

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

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

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

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

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

6 “(aa) Such provider or facil-  
7 ity determines such individual is  
8 able to travel using nonmedical  
9 transportation or nonemergency  
10 medical transportation.

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

17 “(cc) Such individual is in a  
18 condition to receive (as deter-  
19 mined in accordance with guide-  
20 lines issued by the Secretary pur-  
21 suant to rulemaking) the infor-  
22 mation described in section  
23 2799B–2 and to provide in-  
24 formed consent under such sec-

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

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

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

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

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

19                  “(E) QUALIFYING PAYMENT AMOUNT.—

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(I) The individual market.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

7 “(i) NONPARTICIPATING PROVIDER.—

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

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

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1 insurance 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 nonparticipating emergency facility  
13 during a year and a group health plan or group  
14 or individual health insurance coverage offered  
15 by a health insurance issuer—

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

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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 nonparticipating  
7           emergency facility; and such an item or  
8           service, the amount that is the qualifying  
9           payment amount (as defined in subpara-  
10          graph (E)) for such year and determined  
11          in accordance with rulemaking described in  
12          paragraph (2)(B)) for such item or service;  
13          or

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

20          “(I) SPECIFIED STATE LAW.—The term  
21          ‘specified State law’ means, with respect to a  
22          State, an item or service furnished by a non-  
23          participating provider or nonparticipating emer-  
24          gency facility during a year and a group health  
25          plan or group or individual health insurance

1 coverage offered by a health insurance issuer, a  
2 State law that provides for a method for deter-  
3 mining the total amount payable under such a  
4 plan, coverage, or issuer, respectively (to the ex-  
5 tent such State law applies to such plan, cov-  
6 erage, or issuer, subject to section 514 of the  
7 Employee Retirement Income Security Act of  
8 1974) in the case of a participant, beneficiary,  
9 or enrollee covered under such plan or coverage  
10 and receiving such item or service from such a  
11 nonparticipating provider or nonparticipating  
12 emergency facility.

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

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

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1 from a nonparticipating provider or nonparticipating emergency facility—

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

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

13 “(I) subject to subclause (II), if  
14 the provider or facility (as applicable)  
15 and such plan or coverage agree on an  
16 amount of payment (including if such  
17 agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 2799A–2(a)(3)(A), as applicable, or is agreed on through open negotiations under

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1 subsection (c)(1)) with respect to such  
2 item or service, such agreed on  
3 amount; or

4 “(II) if such provider or facility  
5 (as applicable) and such plan or cov-  
6 erage enter the independent dispute  
7 resolution process under subsection  
8 (c) and do not so agree before the  
9 date on which a certified IDR entity  
10 (as defined in paragraph (4) of such  
11 subsection) makes a determination  
12 with respect to such item or service  
13 under such subsection, the amount of  
14 such determination; or

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

21 “(L) COST-SHARING.—The term ‘cost-  
22 sharing’ includes copayments, coinsurance, and  
23 deductibles.

1       “(b) COVERAGE OF NON-EMERGENCY SERVICES  
2 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-  
3 TAIN PARTICIPATING FACILITIES.—

4           “(1) IN GENERAL.—In the case of items or  
5 services (other than emergency services to which  
6 subsection (a) applies) for which any benefits are  
7 provided or covered by a group health plan or health  
8 insurance issuer offering group or individual health  
9 insurance coverage furnished to a participant, bene-  
10 ficiary, or enrollee of such plan or coverage by a  
11 nonparticipating provider (as defined in subsection  
12 (a)(3)(G)(i)) (and who, with respect to such items  
13 and services, has not satisfied the notice and consent  
14 criteria of section 2799B–2(d)) with respect to a  
15 visit (as defined by the Secretary in accordance with  
16 paragraph (2)(B)) at a participating health care fa-  
17 cility (as defined in paragraph (2)(A)), with respect  
18 to such plan or coverage, respectively, the plan or  
19 coverage, respectively—

20           “(A) shall not impose on such participant,  
21 beneficiary, or enrollee a cost-sharing require-  
22 ment for such items and services so furnished  
23 that is greater than the cost-sharing require-  
24 ment that would apply under such plan or cov-  
25 erage, respectively, had such items or services



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1           been furnished by a participating provider (as  
2           defined in subsection (a)(3)(G)(ii));

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

10          “(C) not later than 30 calendar days after  
11          the bill for such services is transmitted by such  
12          provider, shall send to the provider an initial  
13          payment or notice of denial of payment;

14          “(D) shall pay a total plan or coverage  
15          payment directly, in accordance, if applica-  
16          ble, with the timing requirement described in  
17          subsection (e)(6), to such provider furnishing  
18          such items and services to such participant,  
19          beneficiary, or enrollee that is, with application  
20          of any initial payment under subparagraph (C),  
21          equal to the amount by which the out-of-net-  
22          work rate (as defined in subsection (a)(3)(K))  
23          for such items and services involved exceeds the  
24          cost-sharing amount imposed under the plan or  
25          coverage, respectively, for such items and serv-

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1           ices (as determined in accordance with subpara-  
2           graphs (A) and (B)) and year; and

3           “(E) shall count toward any in-network de-  
4           ductible and in-network out-of-pocket maxi-  
5           mums (as applicable) applied under the plan or  
6           coverage, respectively, any cost-sharing pay-  
7           ments made by the participant, beneficiary, or  
8           enrollee (and such in-network deductible and  
9           out-of-pocket maximums shall be applied) with  
10          respect to such items and services so furnished  
11          in the same manner as if such cost-sharing pay-  
12          ments were with respect to items and services  
13          furnished by a participating provider.

14          “(2) DEFINITIONS.—In this section:

15                 “(A) PARTICIPATING HEALTH CARE FACIL-  
16                 ITY.—

17                         “(i) IN GENERAL.—The term ‘partici-  
18                         pating health care facility’ means, with re-  
19                         spect to an item or service and a group  
20                         health plan or health insurance issuer of-  
21                         fering group or individual health insurance  
22                         coverage, a health care facility described in  
23                         clause (ii) that has a direct or indirect con-  
24                         tractual relationship with the plan or  
25                         issuer, respectively, with respect to the fur-

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1 nishing of such an item or service at the  
2 facility.

3 “(ii) HEALTH CARE FACILITY DE-  
4 SCRIBED.—A health care facility described  
5 in this clause, with respect to a group  
6 health plan or group or individual health  
7 insurance coverage, is each of the fol-  
8 lowing:

9 “(I) A hospital (as defined in  
10 1861(e) of the Social Security Act).

11 “(II) A hospital outpatient de-  
12 partment.

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

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

19 “(V) Any other facility, specified  
20 by the Secretary, that provides items  
21 or services for which coverage is pro-  
22 vided under the plan or coverage, re-  
23 spectively.

24 “(B) VISIT.—The term ‘visit’ shall, with  
25 respect to items and services furnished to an in-

1           dividual at a health care facility, include equip-  
2           ment and devices, telemedicine services, imag-  
3           ing services, laboratory services, preoperative  
4           and postoperative services, and such other items  
5           and services as the Secretary may specify, re-  
6           gardless of whether or not the provider fur-  
7           nishing such items or services is at the facility.

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

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

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

23           “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If  
24 a group health plan, or a health insurance issuer offering  
25 group or individual health insurance coverage, requires or

1 provides for designation by a participant, beneficiary, or  
2 enrollee of a participating primary care provider, then the  
3 plan or issuer shall permit each participant, beneficiary,  
4 and enrollee to designate any participating primary care  
5 provider who is available to accept such individual.

6 “(b) ACCESS TO PEDIATRIC CARE.—

7 “(1) PEDIATRIC CARE.—In the case of a person  
8 who has a child who is a participant, beneficiary, or  
9 enrollee under a group health plan, or group or indi-  
10 vidual health insurance coverage offered by a health  
11 insurance issuer, if the plan or issuer requires or  
12 provides for the designation of a participating pri-  
13 mary care provider for the child, the plan or issuer  
14 shall permit such person to designate a physician  
15 (allopathic or osteopathic) who specializes in pediat-  
16 rics as the child’s primary care provider if such pro-  
17 vider participates in the network of the plan or  
18 issuer.

19 “(2) CONSTRUCTION.—Nothing in paragraph  
20 (1) shall be construed to waive any exclusions of cov-  
21 erage under the terms and conditions of the plan or  
22 health insurance coverage with respect to coverage  
23 of pediatric care.

24 “(c) PATIENT ACCESS TO OBSTETRICAL AND GYNE-  
25 COLOGICAL CARE.—

1           “(1) GENERAL RIGHTS.—

2                   “(A) DIRECT ACCESS.—A group health  
3 plan, or health insurance issuer offering group  
4 or individual health insurance coverage, de-  
5 scribed in paragraph (2) may not require au-  
6 thorization or referral by the plan, issuer, or  
7 any person (including a primary care provider  
8 described in paragraph (2)(B)) in the case of a  
9 female participant, beneficiary, or enrollee who  
10 seeks coverage for obstetrical or gynecological  
11 care provided by a participating health care  
12 professional who specializes in obstetrics or  
13 gynecology. Such professional shall agree to  
14 otherwise adhere to such plan’s or issuer’s poli-  
15 cies and procedures, including procedures re-  
16 garding referrals and obtaining prior authoriza-  
17 tion and providing services pursuant to a treat-  
18 ment plan (if any) approved by the plan or  
19 issuer.

20                   “(B) OBSTETRICAL AND GYNECOLOGICAL  
21 CARE.—A group health plan or health insur-  
22 ance issuer described in paragraph (2) shall  
23 treat the provision of obstetrical and gynecolo-  
24 gical care, and the ordering of related obstet-  
25 rical and gynecological items and services, pur-

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

6           “(2) APPLICATION OF PARAGRAPH.—A group  
7           health plan, or health insurance issuer offering  
8           group or individual health insurance coverage, de-  
9           scribed in this paragraph is a group health plan or  
10          health insurance coverage that—

11                   “(A) provides coverage for obstetric or  
12                   gynecologic care; and

13                   “(B) requires the designation by a partici-  
14                   pant, beneficiary, or enrollee of a participating  
15                   primary care provider.

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

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

22                   “(B) preclude the group health plan or  
23                   health insurance issuer involved from requiring  
24                   that the obstetrical or gynecological provider

1 notify the primary care health care professional  
2 or the plan or issuer of treatment decisions.”.

3 (3) CONFORMING AMENDMENTS.—

4 (A) Section 2719A of the Public Health  
5 Service Act (42 U.S.C. 300gg–19a) is amended  
6 by adding at the end the following new sub-  
7 section:

8 “(e) APPLICATION.—The provisions of this section  
9 shall not apply with respect to a group health plan, health  
10 insurance issuers, or group or individual health insurance  
11 coverage with respect to plan years beginning on or on  
12 January 1, 2022.”.

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

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

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

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

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

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



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

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

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

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

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

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

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

17 (D) Section 2724 of the Public Health  
18 Service Act (42 U.S.C. 300gg–23) is amend-  
19 ed—

20 (i) in subsection (a)(1)—

21 (I) by striking “this part and  
22 part C insofar as it relates to this  
23 part” and inserting “this part, part  
24 D, and part C insofar as it relates to  
25 this part or part D”; and

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1 (II) by inserting “or part D”  
2 after “requirement of this part”;  
3 (ii) in subsection (a)(2), by inserting  
4 “or part D” after “this part”; and  
5 (iii) in subsection (c), by inserting “or  
6 part D” after “this part (other than sec-  
7 tion 2704)”.

8 (b) ERISA AMENDMENTS.—

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

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

14 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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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 cating 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 or coverage, respec-  
18 tively;

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

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

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

7 “(iv) the group health plan or health  
8 insurance issuer, respectively—

9 “(I) not later than 30 calendar  
10 days after the bill for such services is  
11 transmitted by such provider or facil-  
12 ity, sends to the provider or facility,  
13 as applicable, an initial payment or  
14 notice of denial of payment; and

15 “(II) pays a total plan or cov-  
16 erage payment directly to such pro-  
17 vider or facility, respectively (in ac-  
18 cordance, if applicable, with the tim-  
19 ing requirement described in sub-  
20 section (c)(6)) that is, with applica-  
21 tion of any initial payment under sub-  
22 clause (I), equal to the amount by  
23 which the out-of-network rate (as de-  
24 fined in paragraph (3)(K)) for such  
25 services exceeds the cost-sharing

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1 amount for such services (as deter-  
2 mined in accordance with clauses (ii)  
3 and (iii)) and year; and

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

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

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

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

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

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

22           “(D) a process to receive complaints of vio-  
23 lations of the requirements described in sub-  
24 clauses (I) and (II) of subparagraph (A)(i) by  
25 group health plans and health insurance issuers

1 offering health insurance coverage in the group  
2 market.

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

19 “(3) DEFINITIONS.—In this subpart:

20 “(A) EMERGENCY DEPARTMENT OF A HOS-  
21 PITAL.—The term ‘emergency department of a  
22 hospital’ includes a hospital outpatient depart-  
23 ment that provides emergency services (as de-  
24 fined in subparagraph (C)(i)).

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1 “(B) EMERGENCY MEDICAL CONDITION.—

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

12 “(C) EMERGENCY SERVICES.—

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

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



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1 applicable, including ancillary services  
2 routinely available to the emergency  
3 department to evaluate such emer-  
4 gency medical condition; and

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

19 “(ii) INCLUSION OF ADDITIONAL  
20 SERVICES.—

21 “(I) IN GENERAL.—For purposes  
22 of this subsection and section 2799B-  
23 1 of the Public Health Service Act, in  
24 the case of a participant or bene-  
25 ficiary who is enrolled in a group

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

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

16 “(bb) that are furnished by  
17 a nonparticipating provider or  
18 nonparticipating emergency facil-  
19 ity (regardless of the department  
20 of the hospital in which such  
21 items or services are furnished)  
22 after the participant or bene-  
23 ficiary is stabilized and as part of  
24 outpatient observation or an in-  
25 patient or outpatient stay with

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1 respect to the visit in which the  
2 services described in clause (i)  
3 are furnished.

4 “(II) CONDITIONS.—For pur-  
5 poses of subclause (I), the conditions  
6 described in this subclause, with re-  
7 spect to a participant or beneficiary  
8 who is stabilized and furnished addi-  
9 tional items and services described in  
10 subclause (I) after such stabilization  
11 by a provider or facility described in  
12 subclause (I), are the following;

13 “(aa) Such provider or facil-  
14 ity determines such individual is  
15 able to travel using nonmedical  
16 transportation or nonemergency  
17 medical transportation.

18 “(bb) Such provider fur-  
19 nishing such additional items and  
20 services satisfies the notice and  
21 consent criteria of section  
22 2799B–2(d) with respect to such  
23 items and services.

24 “(cc) Such individual is in a  
25 condition to receive (as deter-

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1 mined in accordance with guide-  
2 lines issued by the Secretary pur-  
3 suant to rulemaking) the infor-  
4 mation described in section  
5 2799B-2 and to provide in-  
6 formed consent under such sec-  
7 tion, in accordance with applica-  
8 ble State law.

9 “(dd) Such other conditions,  
10 as specified by the Secretary,  
11 such as conditions relating to co-  
12 ordinating care transitions to  
13 participating providers and facili-  
14 ties.

15 “(D) INDEPENDENT FREESTANDING  
16 EMERGENCY DEPARTMENT.—The term ‘inde-  
17 pendent freestanding emergency department’  
18 means a health care facility that—

19 “(i) is geographically separate and  
20 distinct and licensed separately from a hos-  
21 pital under applicable State law; and

22 “(ii) provides any of the emergency  
23 services (as defined in subparagraph  
24 (C)(i)).

25 “(E) QUALIFYING PAYMENT AMOUNT.—

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

7                   “(I) for an item or service fur-  
8                   nished during 2022, the median of the  
9                   contracted rates recognized by the  
10                  plan or issuer, respectively (deter-  
11                  mined with respect to all such plans  
12                  of such sponsor or all such coverage  
13                  offered by such issuer that are offered  
14                  within the same insurance market  
15                  (specified in subclause (I), (II), or  
16                  (III) of clause (iv)) as the plan or cov-  
17                  erage) as the total maximum payment  
18                  (including the cost-sharing amount  
19                  imposed for such item or service and  
20                  the amount to be paid by the plan or  
21                  issuer, respectively) under such plans  
22                  or coverage, respectively, on January  
23                  31, 2019, for the same or a similar  
24                  item or service that is provided by a  
25                  provider in the same or similar spe-

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1 cialty and provided in the geographic  
2 region in which the item or service is  
3 furnished, consistent with the method-  
4 ology established by the Secretary  
5 under paragraph (2), increased by the  
6 percentage increase in the consumer  
7 price index for all urban consumers  
8 (United States city average) over  
9 2019, such percentage increase over  
10 2020, and such percentage increase  
11 over 2021; and

12 “(II) for an item or service fur-  
13 nished during 2023 or a subsequent  
14 year, the qualifying payment amount  
15 determined under this clause for such  
16 an item or service 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 “(ii) NEW PLANS AND COVERAGE.—  
23 The term ‘qualifying payment amount’  
24 means, with respect to a sponsor of a  
25 group health plan or health insurance

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1 issuer offering group health insurance cov-  
2 erage in a geographic region in which such  
3 sponsor or issuer, respectively, did not  
4 offer any group health plan or health in-  
5 surance coverage during 2019—

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

15 “(II) for each subsequent year  
16 such group health plan or health in-  
17 surance coverage, respectively, is of-  
18 fered in such region, the qualifying  
19 payment amount determined under  
20 this clause for such items and services  
21 furnished in the previous year, in-  
22 creased by the percentage increase in  
23 the consumer price index for all urban  
24 consumers (United States city aver-  
25 age) over such previous year.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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 health insurance coverage of-  
13                  fered by a health insurance issuer—

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

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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 health insur-  
18 ance issuer offering group health in-  
19 surance coverage, an item or service  
20 for which coverage was not offered in  
21 2019 under such plan or coverage, but  
22 is offered under such plan or coverage  
23 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 health insurance coverage offered  
9                   by a health insurance issuer, an emergency  
10                  department of a hospital, or an inde-  
11                  pendent freestanding emergency depart-  
12                  ment, that does not have a contractual re-  
13                  lationship directly or indirectly with the  
14                  plan or issuer, respectively, for furnishing  
15                  such item or service under the plan or cov-  
16                  erage, 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 health insurance coverage offered by  
22                  a health insurance issuer, an emergency  
23                  department of a hospital, or an inde-  
24                  pendent freestanding emergency depart-  
25                  ment, that has a contractual relationship

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

20 “(ii) PARTICIPATING PROVIDER.—The  
21 term ‘participating provider’ means, with  
22 respect to an item or service and a group  
23 health plan or group health insurance cov-  
24 erage offered by a health insurance issuer,  
25 a physician or other health care provider

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

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

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, coverage, or  
19                 issuer, respectively; such a nonparticipating  
20                 provider or nonparticipating emergency  
21                 facility; and such an item or service,  
22                 the 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



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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 nonparticipating  
5 emergency facility; and such an item or  
6 service, the amount that is the qualifying  
7 payment amount (as defined in subpara-  
8 graph (E)) for such year and determined  
9 in accordance with rulemaking described in  
10 paragraph (2)) 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 nonparticipating emer-  
21 gency facility during a year and a group health  
22 plan or group health insurance coverage offered  
23 by a health insurance issuer, a State law that  
24 provides 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) in the case of a partici-  
4 pant or beneficiary covered under such plan or  
5 coverage and receiving such item or service  
6 from such a nonparticipating provider or non-  
7 participating emergency facility.

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

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

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

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1 issuer, respectively; such a nonpartici-  
2 pating provider or nonparticipating emer-  
3 gency facility; and such an item or service,  
4 the amount determined in accordance with  
5 such law;

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

10 “(I) subject to subclause (II), if  
11 the provider or facility (as applicable)  
12 and such plan or coverage agree on an  
13 amount of payment (including if such  
14 agreed on amount is the initial pay-  
15 ment sent by the plan under sub-  
16 section (a)(1)(C)(iv)(I), subsection  
17 (b)(1)(C), or section 717(a)(3)(A), as  
18 applicable, or is agreed on through  
19 open negotiations under subsection  
20 (c)(1)) with respect to such item or  
21 service, such agreed on amount; or

22 “(II) if such provider or facility  
23 (as applicable) and such plan or cov-  
24 erage enter the independent dispute  
25 resolution process under subsection

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1 (c) and do not so agree before the  
2 date on which a certified IDR entity  
3 (as defined in paragraph (4) of such  
4 subsection) makes a determination  
5 with respect to such item or service  
6 under such subsection, the amount of  
7 such determination; or

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

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

17 “(b) COVERAGE OF NON-EMERGENCY SERVICES  
18 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-  
19 TAIN PARTICIPATING FACILITIES.—

20 “(1) IN GENERAL.—In the case of items or  
21 services (other than emergency services to which  
22 subsection (a) applies) for which any benefits are  
23 provided or covered by a group health plan or health  
24 insurance issuer offering group health insurance cov-  
25 erage furnished to a participant or beneficiary of

1 such plan or coverage by a nonparticipating provider  
2 (as defined in subsection (a)(3)(G)(i)) (and who,  
3 with respect to such items and services, has not sat-  
4 isfied the notice and consent criteria of section  
5 2799B–2(d) of the Public Health Service Act) with  
6 respect to a visit (as defined by the Secretary in ac-  
7 cordance with paragraph (2)(B)) at a participating  
8 health care facility (as defined in paragraph (2)(A)),  
9 with respect to such plan or coverage, respectively,  
10 the plan or coverage, respectively—

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

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

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1           “(C) not later than 30 calendar days after  
2           the bill for such items or services is transmitted  
3           by such provider, shall send to the provider an  
4           initial payment or notice of denial of payment;

5           “(D) shall pay a total plan or coverage  
6           payment directly, in accordance, if applicable,  
7           with the timing requirement described in sub-  
8           section (c)(6), to such provider furnishing such  
9           items and services to such participant or bene-  
10          ficiary that is, with application of any initial  
11          payment under subparagraph (C), equal to the  
12          amount by which the out-of-network rate (as  
13          defined in subsection (a)(3)(K)) for such items  
14          and services exceeds the cost-sharing amount  
15          imposed under the plan or coverage, respec-  
16          tively, for such items and services (as deter-  
17          mined in accordance with subparagraphs (A)  
18          and (B)) and year; and

19          “(E) shall count toward any in-network de-  
20          ductible and in-network out-of-pocket maxi-  
21          mums (as applicable) applied under the plan or  
22          coverage, respectively, any cost-sharing pay-  
23          ments made by the participant or beneficiary  
24          (and such in-network deductible and out-of-  
25          pocket maximums shall be applied) with respect

1 to such items and services so furnished in the  
2 same manner as if such cost-sharing payments  
3 were with respect to items and services fur-  
4 nished by a participating provider.

5 “(2) DEFINITIONS.—In this section:

6 “(A) PARTICIPATING HEALTH CARE FACIL-  
7 ITY.—

8 “(i) IN GENERAL.—The term ‘partici-  
9 pating health care facility’ means, with re-  
10 spect to an item or service and a group  
11 health plan or health insurance issuer of-  
12 fering group health insurance coverage, a  
13 health care facility described in clause (ii)  
14 that has a direct or indirect contractual re-  
15 lationship with the plan or issuer, respec-  
16 tively, with respect to the furnishing of  
17 such an item or service at the facility.

18 “(ii) HEALTH CARE FACILITY DE-  
19 SCRIBED.—A health care facility described  
20 in this clause, with respect to a group  
21 health plan or group health insurance cov-  
22 erage, is each of the following:

23 “(I) A hospital (as defined in  
24 1861(e) of the Social Security Act).

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1                   “(II) A hospital outpatient de-  
2                   partment.

3                   “(III) A critical access hospital  
4                   (as defined in section 1861(mm)(1) of  
5                   such Act).

6                   “(IV) An ambulatory surgical  
7                   center described in section  
8                   1833(i)(1)(A) of such Act.

9                   “(V) Any other facility, specified  
10                  by the Secretary, that provides items  
11                  or services for which coverage is pro-  
12                  vided under the plan or coverage, re-  
13                  spectively.

14                  “(B) VISIT.—The term ‘visit’ shall, with  
15                  respect to items and services furnished to an in-  
16                  dividual at a health care facility, include equip-  
17                  ment and devices, telemedicine services, imag-  
18                  ing services, laboratory services, preoperative  
19                  and postoperative services, and such other items  
20                  and services as the Secretary may specify, re-  
21                  gardless of whether or not the provider fur-  
22                  nishing such items or services is at the facility.

23                  “(c) CERTAIN ACCESS FEES TO CERTAIN DATA-  
24                  BASES.—In the case of a sponsor of a group health plan  
25                  or health insurance issuer offering group health insurance



1 coverage that, pursuant to subsection (a)(3)(E)(iii), uses  
2 a database described in such subsection to determine a  
3 rate to apply under such subsection for an item or service  
4 by reason of having insufficient information described in  
5 such subsection with respect to such item or service, such  
6 sponsor or issuer shall cover the cost for access to such  
7 database.”.

8 (2) TRANSFER AMENDMENT.—Subpart B of  
9 part 7 of title I of the Employee Retirement Income  
10 Security Act of 1974 (29 U.S.C. 1185 et seq.), as  
11 amended by paragraph (1), is further amended by  
12 adding at the end the following:

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

14 “(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If  
15 a group health plan, or a health insurance issuer offering  
16 group health insurance coverage, requires or provides for  
17 designation by a participant or beneficiary of a partici-  
18 pating primary care provider, then the plan or issuer shall  
19 permit each participant and beneficiary to designate any  
20 participating primary care provider who is available to ac-  
21 cept such individual.

22 “(b) ACCESS TO PEDIATRIC CARE.—

23 “(1) PEDIATRIC CARE.—In the case of a person  
24 who has a child who is a participant or beneficiary  
25 under a group health plan, or group health insur-

1           ance coverage offered by a health insurance issuer,  
2           if the plan or issuer requires or provides for the des-  
3           ignation of a participating primary care provider for  
4           the child, the plan or issuer shall permit such person  
5           to designate a physician (allopathic or osteopathic)  
6           who specializes in pediatrics as the child’s primary  
7           care provider if such provider participates in the net-  
8           work of the plan or issuer.

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

14          “(c) PATIENT ACCESS TO OBSTETRICAL AND GYNE-  
15          COLOGICAL CARE.—

16                 “(1) GENERAL RIGHTS.—

17                         “(A) DIRECT ACCESS.—A group health  
18                         plan, or health insurance issuer offering group  
19                         health insurance coverage, described in para-  
20                         graph (2) may not require authorization or re-  
21                         ferral by the plan, issuer, or any person (includ-  
22                         ing a primary care provider described in para-  
23                         graph (2)(B)) in the case of a female partici-  
24                         pant or beneficiary who seeks coverage for ob-  
25                         stetrical or gynecological care provided by a

1 participating health care professional who spe-  
2 cializes in obstetrics or gynecology. Such profes-  
3 sional shall agree to otherwise adhere to such  
4 plan's or issuer's policies and procedures, in-  
5 cluding procedures regarding referrals and ob-  
6 taining prior authorization and providing serv-  
7 ices pursuant to a treatment plan (if any) ap-  
8 proved by the plan or issuer.

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

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

24 “(A) provides coverage for obstetric or  
25 gynecologic care; and

1 “(B) requires the designation by a partici-  
2 pant or beneficiary of a participating primary  
3 care provider.

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

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

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

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

“Sec. 715. Additional market reforms.

“Sec. 716. Preventing surprise medical bills.

“Sec. 722. Other patient protections.”.

19 (c) IRC AMENDMENTS.—

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

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

24 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

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1 participating emergency facilities with re-  
2 spect to such plan;

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, and  
15 year;

16 “(iv) the group health plan—

17 “(I) not later than 30 calendar  
18 days after the bill for such services is  
19 transmitted by such provider or facil-  
20 ity, sends to the provider or facility,  
21 as applicable, an initial payment or  
22 notice of denial of payment; and

23 “(II) pays a total plan payment  
24 directly to such provider or facility,  
25 respectively (in accordance, if applica-

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1 ble, with the timing requirement de-  
2 scribed in subsection (c)(6)) that is,  
3 with application of any initial pay-  
4 ment under subclause (I), equal to the  
5 amount by which the out-of-network  
6 rate (as defined in paragraph (3)(K))  
7 for such services exceeds the cost-  
8 sharing amount for such services (as  
9 determined in accordance with clauses  
10 (ii) and (iii)) and year; and

11 “(iv) any cost-sharing payments made  
12 by the participant or beneficiary with re-  
13 spect to such emergency services so fur-  
14 nished shall be counted toward any in-net-  
15 work deductible or out-of-pocket maxi-  
16 mums applied under the plan (and such in-  
17 network deductible and out-of-pocket maxi-  
18 mums shall be applied) in the same man-  
19 ner as if such cost-sharing payments were  
20 made with respect to emergency services  
21 furnished by a participating provider or a  
22 participating emergency facility; and

23 “(D) without regard to any other term or  
24 condition of such coverage (other than exclusion  
25 or coordination of benefits, or an affiliation or

1           waiting period, permitted under section 2704 of  
2           the Public Health Service Act, including as in-  
3           corporated pursuant to section 715 of the Em-  
4           ployee Retirement Income Security Act of 1974  
5           and section 9815 of this Act, and other than  
6           applicable cost-sharing).

7           “(2) AUDIT PROCESS AND REGULATIONS FOR  
8           QUALIFYING PAYMENT AMOUNTS.—

9                   “(A) AUDIT PROCESS.—

10                           “(i) IN GENERAL.—Not later than Oc-  
11                           tober 1, 2021, the Secretary, in consulta-  
12                           tion with the Secretary of Health and  
13                           Human Services and the Secretary of  
14                           Labor, shall establish through rulemaking  
15                           a process, in accordance with clause (ii),  
16                           under which group health plans are au-  
17                           dited by the Secretary or applicable State  
18                           authority to ensure that—

19                                   “(I) such plans are in compliance  
20                                   with the requirement of applying a  
21                                   qualifying payment amount under this  
22                                   section; and

23   “(II) such qualifying payment  
24   amount so applied satisfies the defini-  
25   tion under paragraph (3)(E) with re-



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1                   spect to the year involved, including  
2                   with respect to a group health plan  
3                   described in clause (ii) of such para-  
4                   graph (3)(E).

5                   “(ii) AUDIT SAMPLES.—Under the  
6                   process established pursuant to clause (i),  
7                   the Secretary—

8                   “(I) shall conduct audits de-  
9                   scribed in such clause, with respect to  
10                  a year (beginning with 2022), of a  
11                  sample with respect to such year of  
12                  claims data from not more than 25  
13                  group health plans; and

14                  “(II) may audit any group health  
15                  plan if the Secretary has received any  
16                  complaint or other information about  
17                  such plan or coverage, respectively,  
18                  that involves the compliance of the  
19                  plan with either of the requirements  
20                  described in subclauses (I) and (II) of  
21                  such clause.

22                  “(iii) REPORTS.—Beginning for 2022,  
23                  the Secretary shall annually submit to  
24                  Congress a report on the number of plans  
25                  and issuers with respect to which audits

1           were conducted during such year pursuant  
2           to this subparagraph.

3           “(B) RULEMAKING.—Not later than July  
4           1, 2021, the Secretary, in consultation with the  
5           Secretary of Labor and the Secretary of Health  
6           and Human Services, shall establish through  
7           rulemaking—

8                   “(i) the methodology the group health  
9                   plan shall use to determine the qualifying  
10                  payment amount, differentiating by large  
11                  group market and small group market;

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

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

24                   “(iv) a process to receive complaints  
25                   of violations of the requirements described

1                   in subclauses (I) and (II) of subparagraph  
2                   (A)(i) by group health plans.

3                   Such rulemaking shall take into account pay-  
4                   ments that are made by such plan that are not  
5                   on a fee-for-service basis. Such methodology  
6                   may account for relevant payment adjustments  
7                   that take into account quality or facility type  
8                   (including higher acuity settings and the case-  
9                   mix of various facility types) that are otherwise  
10                  taken into account for purposes of determining  
11                  payment amounts with respect to participating  
12                  facilities. In carrying out clause (iii), the Sec-  
13                  retary shall consult with the National Associa-  
14                  tion of Insurance Commissioners to establish  
15                  the geographic regions under such clause and  
16                  shall periodically update such regions, as appro-  
17                  priate, taking into account the findings of the  
18                  report submitted under section 109(a) of the  
19                  No Surprises Act.

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

21                         “(A) EMERGENCY DEPARTMENT OF A HOS-  
22                         PITAL.—The term ‘emergency department of a  
23                         hospital’ includes a hospital outpatient depart-  
24                         ment that provides emergency services (as de-  
25                         fined in subparagraph (C)(i)).

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

12          “(C) EMERGENCY SERVICES.—

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

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

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1 applicable, including ancillary services  
2 routinely available to the emergency  
3 department to evaluate such emer-  
4 gency medical condition; and

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

19 “(ii) INCLUSION OF ADDITIONAL  
20 SERVICES.—

21 “(I) IN GENERAL.—For purposes  
22 of this subsection and section 2799B-  
23 1 of the Public Health Service Act, in  
24 the case of a participant or bene-  
25 ficiary who is enrolled in a group

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1 health plan and who is furnished serv-  
2 ices described in clause (i) with re-  
3 spect to an emergency medical condi-  
4 tion, the term ‘emergency services’  
5 shall include, unless each of the condi-  
6 tions described in subclause (II) are  
7 met, in addition to the items and serv-  
8 ices described in clause (i), items and  
9 services—

10 “(aa) for which benefits are  
11 provided or covered under the  
12 plan; and

13 “(bb) that are furnished by  
14 a nonparticipating provider or  
15 nonparticipating emergency facil-  
16 ity (regardless of the department  
17 of the hospital in which such  
18 items or services are furnished)  
19 after the participant or bene-  
20 ficiary is stabilized and as part of  
21 outpatient observation or an in-  
22 patient or outpatient stay with  
23 respect to the visit in which the  
24 services described in clause (i)  
25 are furnished.

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1                   “(II) CONDITIONS.—For pur-  
2                   poses of subclause (I), the conditions  
3                   described in this subclause, with re-  
4                   spect to a participant or beneficiary  
5                   who is stabilized and furnished addi-  
6                   tional items and services described in  
7                   subclause (I) after such stabilization  
8                   by a provider or facility described in  
9                   subclause (I), are the following;

10                   “(aa) Such provider or facil-  
11                   ity determines such individual is  
12                   able to travel using nonmedical  
13                   transportation or nonemergency  
14                   medical transportation.

15                   “(bb) Such provider fur-  
16                   nishing such additional items and  
17                   services satisfies the notice and  
18                   consent criteria of section  
19                   2799B–2(d) with respect to such  
20                   items and services.

21                   “(cc) Such individual is in a  
22                   condition to receive (as deter-  
23                   mined in accordance with guide-  
24                   lines issued by the Secretary pur-  
25                   suant to rulemaking) the infor-

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1 mation described in section  
2 2799B-2 and to provide in-  
3 formed consent under such sec-  
4 tion, in accordance with applica-  
5 ble State law.

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

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

16 “(i) is geographically separate and  
17 distinct and licensed separately from a hos-  
18 pital under applicable State law; and

19 “(ii) provides any of the emergency  
20 services (as defined in subparagraph  
21 (C)(i)).

22 “(E) QUALIFYING PAYMENT AMOUNT.—

23 “(i) IN GENERAL.—The term ‘quali-  
24 fying payment amount’ means, subject to



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1 clauses (ii) and (iii), with respect to a  
2 sponsor of a group health plan—

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

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1 consumers (United States city average)  
2 over 2019, such percentage increase  
3 over 2020, and such percentage in-  
4 crease over 2021; and

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

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

22 “(I) for the first year in which  
23 such group health plan is offered in  
24 such region, a rate (determined in ac-  
25 cordance with a methodology estab-

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1 lished by the Secretary) for items and  
2 services that are covered by such plan  
3 and furnished during such first year;  
4 and

5 “(II) for each subsequent year  
6 such group health plan is offered in  
7 such region, the qualifying payment  
8 amount determined under this clause  
9 for such items and services furnished  
10 in the previous year, increased by the  
11 percentage increase in the consumer  
12 price index for all urban consumers  
13 (United States city average) over such  
14 previous year.

15 “(iii) INSUFFICIENT INFORMATION;  
16 NEWLY COVERED ITEMS AND SERVICES.—  
17 In the case of a sponsor of a group health  
18 plan that does not have sufficient informa-  
19 tion to calculate the median of the con-  
20 tracted rates described in clause (i)(I) in  
21 2019 (or, in the case of a newly covered  
22 item or service (as defined in clause  
23 (v)(III)), in the first coverage year (as de-  
24 fined in clause (v)(I)) for such item or  
25 service with respect to such plan) for an

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1 item or service (including with respect to  
2 provider type, or amount, of claims for  
3 items or services (as determined by the  
4 Secretary) provided in a particular geo-  
5 graphic region (other than in a case with  
6 respect to which clause (ii) applies)) the  
7 term ‘qualifying payment amount’—

8 “(I) for an item or service fur-  
9 nished during 2022 (or, in the case of  
10 a newly covered item or service, dur-  
11 ing the first coverage year for such  
12 item or service with respect to such  
13 plan), means such rate for such item  
14 or service determined by the sponsor  
15 through use of any database that is  
16 determined, in accordance with rule-  
17 making described in paragraph  
18 (2)(B), to not have any conflicts of in-  
19 terest and to have sufficient informa-  
20 tion reflecting allowed amounts paid  
21 to a health care provider or facility for  
22 relevant services furnished in the ap-  
23 plicable geographic region (such as a  
24 State all-payer claims database);

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1           “(II) for an item or service fur-  
2           nished in a subsequent year (before  
3           the first sufficient information year  
4           (as defined in clause (v)(II)) for such  
5           item or service with respect to such  
6           plan), means the rate determined  
7           under subclause (I) or this subclause,  
8           as applicable, for such item or service  
9           for the year previous to such subse-  
10          quent year, increased by the percent-  
11          age increase in the consumer price  
12          index for all urban consumers (United  
13          States city average) over such pre-  
14          vious year;

15           “(III) for an item or service fur-  
16          nished in the first sufficient informa-  
17          tion year for such item or service with  
18          respect to such plan, has the meaning  
19          given the term qualifying payment  
20          amount in clause (i)(I), except that in  
21          applying such clause to such item or  
22          service, the reference to ‘furnished  
23          during 2022’ shall be treated as a ref-  
24          erence to furnished during such first  
25          sufficient information year, the ref-

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1                   erence to ‘on January 31, 2019’ shall  
2                   be treated as a reference to in such  
3                   sufficient information year, and the  
4                   increase described in such clause shall  
5                   not be applied; and

6                   “(IV) for an item or service fur-  
7                   nished in any year subsequent to the  
8                   first sufficient information year for  
9                   such item or service with respect to  
10                  such plan, has the meaning given such  
11                  term in clause (i)(II), except that in  
12                  applying such clause to such item or  
13                  service, the reference to ‘furnished  
14                  during 2023 or a subsequent year’  
15                  shall be treated as a reference to fur-  
16                  nished during the year after such first  
17                  sufficient information year or a subse-  
18                  quent year.

19                  “(iv) INSURANCE MARKET.—For pur-  
20                  poses of clause (i)(I), a health insurance  
21                  market specified in this clause is one of the  
22                  following:

23                  “(I) The large group market  
24                  (other than plans described in sub-  
25                  clause (III)).

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1                   “(II) The small group market  
2                   (other than plans described in sub-  
3                   clause (III)).

4                   “(III) In the case of a self-in-  
5                   sured group health plan, other self-in-  
6                   sured group health plans.

7                   “(v) DEFINITIONS.—For purposes of  
8                   this subparagraph:

9                   “(I) FIRST COVERAGE YEAR.—  
10                  The term ‘first coverage year’ means,  
11                  with respect to a group health plan  
12                  and an item or service for which cov-  
13                  erage is not offered in 2019 under  
14                  such plan or coverage, the first year  
15                  after 2019 for which coverage for  
16                  such item or service is offered under  
17                  such plan.

18                  “(II) FIRST SUFFICIENT INFOR-  
19                  MATION YEAR.—The term ‘first suffi-  
20                  cient information year’ means, with  
21                  respect to a group health plan—

22                               “(aa) in the case of an item  
23                               or service for which the plan does  
24                               not have sufficient information to  
25                               calculate the median of the con-

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1           tracted rates described in clause  
2           (i)(I) in 2019, the first year sub-  
3           sequent to 2022 for which such  
4           sponsor has such sufficient infor-  
5           mation to calculate the median of  
6           such contracted rates in the year  
7           previous to such first subsequent  
8           year; and

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

20                   “(III) NEWLY COVERED ITEM OR  
21           SERVICE.—The term ‘newly covered  
22           item or service’ means, with respect to  
23           a group health plan, an item or serv-  
24           ice for which coverage was not offered  
25           in 2019 under such plan or coverage,



1 but is offered under such plan or cov-  
2 erage in a year after 2019.

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

6 “(i) NONPARTICIPATING EMERGENCY  
7 FACILITY.—The term ‘nonparticipating  
8 emergency facility’ means, with respect to  
9 an item or service and a group health plan,  
10 an emergency department of a hospital, or  
11 an independent freestanding emergency de-  
12 partment, that does not have a contractual  
13 relationship directly or indirectly with the  
14 plan for furnishing such item or service  
15 under the plan.

16 “(ii) PARTICIPATING EMERGENCY FA-  
17 CILITY.—The term ‘participating emer-  
18 gency facility’ means, with respect to an  
19 item or service and a group health plan, an  
20 emergency department of a hospital, or an  
21 independent freestanding emergency de-  
22 partment, that has a contractual relation-  
23 ship directly or indirectly with the plan,  
24 with respect to the furnishing of such an  
25 item or service at such facility.

1                   “(G) NONPARTICIPATING PROVIDERS; PAR-  
2                   TICIPATING PROVIDERS.—

3                   “(i) NONPARTICIPATING PROVIDER.—

4                   The term ‘nonparticipating provider’  
5                   means, with respect to an item or service  
6                   and a group health plan, a physician or  
7                   other health care provider who is acting  
8                   within the scope of practice of that pro-  
9                   vider’s license or certification under appli-  
10                  cable State law and who does not have a  
11                  contractual relationship with the plan or  
12                  issuer, respectively, for furnishing such  
13                  item or service under the plan.

14                  “(ii) PARTICIPATING PROVIDER.—The  
15                  term ‘participating provider’ means, with  
16                  respect to an item or service and a group  
17                  health plan, a physician or other health  
18                  care provider who is acting within the  
19                  scope of practice of that provider’s license  
20                  or certification under applicable State law  
21                  and who has a contractual relationship  
22                  with the plan for furnishing such item or  
23                  service under the plan.

24                  “(H) RECOGNIZED AMOUNT.—The term  
25                  ‘recognized amount’ means, with respect to an

1 item or service furnished by a nonparticipating  
2 provider or nonparticipating emergency facility  
3 during a year and a group health plan—

4 “(i) subject to clause (iii), in the case  
5 of such item or service furnished in a State  
6 that has in effect a specified State law  
7 with respect to such plan; such a non-  
8 participating provider or nonparticipating  
9 emergency facility; and such an item or  
10 service, the amount determined in accord-  
11 ance with such law;

12 “(ii) subject to clause (iii), in the case  
13 of such item or service furnished in a State  
14 that does not have in effect a specified  
15 State law, with respect to such plan; such  
16 a nonparticipating provider or nonpartici-  
17 pating emergency facility; and such an  
18 item or service, the amount that is the  
19 qualifying payment amount (as defined in  
20 subparagraph (E)) for such year and de-  
21 termined in accordance with rulemaking  
22 described in paragraph (2)(B)) for such  
23 item or service; or

24 “(iii) in the case of such item or serv-  
25 ice furnished in a State with an All-Payer

1 Model Agreement under section 1115A of  
2 the Social Security Act, the amount that  
3 the State approves under such system for  
4 such item or service so furnished.

5 “(I) SPECIFIED STATE LAW.—The term  
6 ‘specified State law’ means, with respect to a  
7 State, an item or service furnished by a non-  
8 participating provider or nonparticipating emer-  
9 gency facility during a year and a group health  
10 plan, a State law that provides for a method for  
11 determining the total amount payable under  
12 such a plan (to the extent such State law ap-  
13 plies to such plan, subject to section 514) in the  
14 case of a participant or beneficiary covered  
15 under such plan and receiving such item or  
16 service from such a nonparticipating provider or  
17 nonparticipating emergency facility.

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

23 “(K) OUT-OF-NETWORK RATE.—The term  
24 ‘out-of-network rate’ means, with respect to an  
25 item or service furnished in a State during a

1 year to a participant or beneficiary of a group  
2 health plan receiving such item or service from  
3 a nonparticipating provider or nonparticipating  
4 emergency facility—

5 “(i) subject to clause (iii), in the case  
6 of such item or service furnished in a State  
7 that has in effect a specified State law  
8 with respect to such plan; such a non-  
9 participating provider or nonparticipating  
10 emergency facility; and such an item or  
11 service, the amount determined in accord-  
12 ance with such law;

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

17 “(I) subject to subclause (II), if  
18 the provider or facility (as applicable)  
19 and such plan or coverage agree on an  
20 amount of payment (including if such  
21 agreed on amount is the initial pay-  
22 ment sent by the plan under sub-  
23 section (a)(1)(C)(iv)(I), subsection  
24 (b)(1)(C), or section 9817(a)(3)(A),  
25 as applicable, or is agreed on through

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1 open negotiations under subsection  
2 (c)(1)) with respect to such item or  
3 service, such agreed on amount; or

4 “(II) if such provider or facility  
5 (as applicable) and such plan or cov-  
6 erage enter the independent dispute  
7 resolution process under subsection  
8 (c) and do not so agree before the  
9 date on which a certified IDR entity  
10 (as defined in paragraph (4) of such  
11 subsection) makes a determination  
12 with respect to such item or service  
13 under such subsection, the amount of  
14 such determination; or

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

21 “(L) COST-SHARING.—The term ‘cost-  
22 sharing’ includes copayments, coinsurance, and  
23 deductibles.

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1       “(b) COVERAGE OF NON-EMERGENCY SERVICES  
2 PERFORMED BY NONPARTICIPATING PROVIDERS AT CER-  
3 TAIN PARTICIPATING FACILITIES.—

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

18           “(A) shall not impose on such participant  
19 or beneficiary a cost-sharing requirement for  
20 such items and services so furnished that is  
21 greater than the cost-sharing requirement that  
22 would apply under such plan had such items or  
23 services been furnished by a participating pro-  
24 vider (as defined in subsection (a)(3)(G)(ii));

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

8           “(C) not later than 30 calendar days after  
9           the bill for such items or services is transmitted  
10          by such provider, shall send to the provider an  
11          initial payment or notice of denial of payment;

12          “(D) shall pay a total plan payment di-  
13          rectly, in accordance, if applicable, with the  
14          timing requirement described in subsection  
15          (c)(6), to such provider furnishing such items  
16          and services to such participant or beneficiary  
17          that is, with application of any initial payment  
18          under subparagraph (C), equal to the amount  
19          by which the out-of-network rate (as defined in  
20          subsection (a)(3)(K)) for such items and serv-  
21          ices exceeds the cost-sharing amount imposed  
22          under the plan for such items and services (as  
23          determined in accordance with subparagraphs  
24          (A) and (B)) and year; and



1           “(E) shall count toward any in-network de-  
2 ductible 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

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

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

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

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

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

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

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

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

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

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

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

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

22            “(b) ACCESS TO PEDIATRIC CARE.—

23            “(1) PEDIATRIC CARE.—In the case of a person  
24 who has a child who is a participant or beneficiary  
25 under a group health plan if the plan requires or

1 provides for the designation of a participating pri-  
2 mary care provider for the child, the plan shall per-  
3 mit such person to designate a physician (allopathic  
4 or osteopathic) who specializes in pediatrics as the  
5 child's primary care provider if such provider par-  
6 ticipates in the network of the plan.

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

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

13 “(1) GENERAL RIGHTS.—

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

1 ferrals and obtaining prior authorization and  
2 providing services pursuant to a treatment plan  
3 (if any) approved by the plan.

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

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

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

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

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

24 “(A) waive any exclusions of coverage  
25 under the terms and conditions of the plan with

1           respect to coverage of obstetrical or gynecological care; or

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

7  
8           (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  
9  
10          the end the following new item:  
11

“Sec. 9815. Additional market reforms.

“Sec. 9816. Preventing surprise medical bills.

“Sec. 9822. Other patient protections.”.

12          (4) CONFORMING AMENDMENTS.—

13           (A) IN GENERAL.—Section 223(c) of the  
14          Internal Revenue Code of 1986 is amended—

15           (i) in paragraph (1), by adding at the  
16          end the following:

17           “(D) SPECIAL RULE FOR INDIVIDUALS RECEIVING BENEFITS SUBJECT TO SURPRISE BILLING STATUTES.—An individual shall not  
18          fail to be treated as an eligible individual for  
19          any period merely because the individual receives benefits for medical care subject to and  
20          in accordance with section 9816 or 9817, section 2799A–1 or 2799A–2 of the Public Health  
21  
22  
23  
24

1 Service Act, or section 716 or 717 of the Em-  
2 ployee Retirement Income Security Act of 1974,  
3 or any State law providing similar protections  
4 to such individual.”; and

5 (ii) in paragraph (2), by adding at the  
6 end the following:

7 “(F) SPECIAL RULE FOR SURPRISE BILL-  
8 ING.—A plan shall not fail to be treated as a  
9 high deductible health plan by reason of pro-  
10 viding benefits for medical care in accordance  
11 with section 9816 or 9817, section 2799A–1 or  
12 2799A–2 of the Public Health Service Act, or  
13 section 716 or 717 of the Employee Retirement  
14 Income Security Act of 1974, or any State law  
15 providing similar protections to individuals,  
16 prior to the satisfaction of the deductible under  
17 paragraph (2)(A)(i).”.

18 (B) EFFECTIVE DATE.—The amendments  
19 made by subparagraph (A) shall apply for plan  
20 years beginning on or after January 1, 2022.

21 (d) ADDITIONAL APPLICATION PROVISIONS.—

22 (1) APPLICATION TO FEHB.—Section 8902 of  
23 title 5, United States Code, is amended by adding  
24 at the end the following new subsection:

1           “(p) Each contract under this chapter shall require  
2 the carrier to comply with requirements described in the  
3 provisions of sections 2799A–1, 2799A–2, and 2799A–7  
4 of the Public Health Service Act, sections 716, 717, and  
5 722 of the Employee Retirement Income Security Act of  
6 1974, and sections 9816, 9817, and 9822 of the Internal  
7 Revenue Code of 1986 (as applicable) in the same manner  
8 as such provisions apply to a group health plan or health  
9 insurance issuer offering group or individual health insur-  
10 ance coverage, as described in such sections. The provi-  
11 sions of sections 2799B–1, 2799B–2, 2799B–3, and  
12 2799B–5 of the Public Health Service Act shall apply to  
13 a health care provider and facility and an air ambulance  
14 provider described in such respective sections with respect  
15 to an enrollee in a health benefits plan under this chapter  
16 in the same manner as such provisions apply to such a  
17 provider and facility with respect to an enrollee in a group  
18 health plan or group or individual health insurance cov-  
19 erage offered by a health insurance issuer, as described  
20 in such sections.”.

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



1           “(5) APPLICATION OF ADDITIONAL PROVI-  
2           SIONS.—Sections 2799A–1, 2799A–2, and 2799A–7  
3           of the Public Health Service Act shall apply to  
4           grandfathered health plans for plan years beginning  
5           on or after January 1, 2022.”.

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

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

18                   (B) the requirements under section  
19                   1866(a)(1)(U) of the Social Security Act (42  
20                   U.S.C. 1395cc(a)(1)(U)).

21           (e) EFFECTIVE DATE.—The amendments made by  
22           this section shall apply with respect to plan years (or, in  
23           the case of the amendment made by subsection (d)(1),  
24           with respect to contracts entered into or renewed for con-  
25           tract years) beginning on or after January 1, 2022.

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

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

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

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

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

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

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

1 the 30-day period beginning on the day the pro-  
2 vider or facility receives an initial payment or  
3 a notice of denial of payment from the plan or  
4 coverage regarding a claim for payment for  
5 such item or service, initiate open negotiations  
6 under this paragraph between such provider or  
7 facility and plan or coverage for purposes of de-  
8 termining, during the open negotiation period,  
9 an amount agreed on by such provider or facil-  
10 ity, respectively, and such plan or coverage for  
11 payment (including any cost-sharing) for such  
12 item or service. For purposes of this subsection,  
13 the open negotiation period, with respect to an  
14 item or service, is the 30-day period beginning  
15 on the date of initiation of the negotiations with  
16 respect to such item or service.

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 4-  
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

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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 IDR process.  
5 Such items and services may be so considered  
6 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 group health plan or health insurance  
13 issuer;

14 “(iii) such items and services are re-  
15 lated to the treatment of a similar condi-  
16 tion; and

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

1 procedural efficiency and minimize health  
2 plan and provider administrative costs.

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

11 “(4) CERTIFICATION AND SELECTION OF IDR  
12 ENTITIES.—

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

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

24 “(ii) is not—



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1           “(I) a group health plan or  
2 health insurance issuer offering group  
3 or individual health insurance cov-  
4 erage, provider, or facility;

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

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

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

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

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

24           “(vi) does not under the IDR process  
25 carry out any determination with respect

1 to which the entity would not pursuant to  
2 subclause (I), (II), or (III) of subpara-  
3 graph (F)(i) be eligible for selection; and

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

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

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

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

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

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

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

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

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

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

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

17                  “(I) select such an entity that  
18                  satisfies subclauses (I) through (III)  
19                  of clause (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 determination for  
9 a qualified IDR item or service, the certified  
10 IDR entity shall—

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

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

24 “(B) SUBMISSION OF OFFERS.—Not later  
25 than 10 days after the date of selection of the

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1 certified IDR entity with respect to a deter-  
2 mination for a qualified IDR item or service,  
3 the provider or facility and the group health  
4 plan or health insurance issuer offering group  
5 or individual health insurance coverage party to  
6 such determination—

7 “(i) shall each submit to the certified  
8 IDR entity with respect to such determina-  
9 tion—

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

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

17 “(ii) may each submit to the certified  
18 IDR entity with respect to such determina-  
19 tion any information relating to such offer  
20 submitted by either party, including infor-  
21 mation relating to any circumstance de-  
22 scribed in subparagraph (C)(ii).

23 “(C) CONSIDERATIONS IN DETERMINA-  
24 TION.—

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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 item or service  
6           shall consider—

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

17                      “(II) subject to subparagraph  
18                      (D), information on any circumstance  
19                      described in clause (ii), such informa-  
20                      tion as requested in subparagraph  
21                      (B)(i)(II), and any additional infor-  
22                      mation provided in subparagraph  
23                      (B)(ii).

24                      “(ii) ADDITIONAL CIRCUMSTANCES.—  
25           For purposes of clause (i)(II), the cir-

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1 cumstances described in this clause are,  
2 with respect to a qualified IDR item or  
3 service of a nonparticipating provider, non-  
4 participating emergency facility, group  
5 health plan, or health insurance issuer of  
6 group or individual health insurance cov-  
7 erage the following:

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

15 “(II) The market share held by  
16 the nonparticipating provider or facil-  
17 ity or that of the plan or issuer in the  
18 geographic region in which the item or  
19 service was provided.

20 “(III) The acuity of the indi-  
21 vidual receiving such item or service  
22 or the complexity of furnishing such  
23 item or service to such individual.

24 “(IV) The teaching status, case  
25 mix, and scope of services of the non-



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1 participating facility that furnished  
2 such item or service.

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

13 “(D) PROHIBITION ON CONSIDERATION OF  
14 CERTAIN FACTORS.—In determining which offer  
15 is the payment to be applied with respect to  
16 qualified IDR items and services furnished by a  
17 provider or facility, the certified IDR entity  
18 with respect to a determination shall not con-  
19 sider usual and customary charges, the amount  
20 that would have been billed by such provider or  
21 facility with respect to such items and services  
22 had the provisions of section 2799B–1 or  
23 2799B–2 (as applicable) not applied, or the  
24 payment or reimbursement rate for such items  
25 and services furnished by such provider or facil-

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1           ity payable by a public payor, including under  
2           the Medicare program under title XVIII of the  
3           Social Security Act, under the Medicaid pro-  
4           gram under title XIX of such Act, under the  
5           Children’s Health Insurance Program under  
6           title XXI of such Act, under the TRICARE  
7           program under chapter 55 of title 10, United  
8           States Code, or under chapter 17 of title 38,  
9           United States Code.

10                   “(E) EFFECTS OF DETERMINATION.—

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

14                                   “(I) shall be binding upon the  
15                                   parties involved, in the absence of a  
16                                   fraudulent claim or evidence of mis-  
17                                   representation of facts presented to  
18                                   the IDR entity involved regarding  
19                                   such claim; 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-

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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           4-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) REPORTS.—The Secretary, joint-  
10          ly with the Secretary of Labor and the  
11          Secretary of the Treasury, shall examine  
12          the impact of the application of clause (ii)  
13          and whether the application of such clause  
14          delays payment determinations or impacts  
15          early, alternative resolution of claims (such  
16          as through open negotiations), and shall  
17          submit to Congress, not later than 2 years  
18          after the date of implementation of such  
19          clause an interim report (and not later  
20          than 4 years after such date of implemen-  
21          tation, a final report) on whether any  
22          group health plans or health insurance  
23          issuers offering group or individual health  
24          insurance coverage or types of such plans  
25          or coverage have a pattern or practice of

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1 routine denial, low payment, or down-cod-  
2 ing of claims, or otherwise abuse the 90-  
3 day period described in such clause, includ-  
4 ing recommendations on ways to discour-  
5 age such a pattern or practice.

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

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

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

1           “(6) TIMING OF PAYMENT.—The total plan or  
2 coverage payment required pursuant to subsection  
3 (a)(1) or (b)(1), with respect to a qualified IDR  
4 item or service for which a determination is made  
5 under paragraph (5)(A) or with respect to an item  
6 or service for which a payment amount is deter-  
7 mined under open negotiations under paragraph (1),  
8 shall be made directly to the nonparticipating pro-  
9 vider or facility not later than 30 days after the date  
10 on which such determination is made.

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

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

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

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

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

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

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

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

17          “(vii) the total amount of fees paid  
18          under paragraph (8) during such calendar  
19          quarter; and

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

24          “(B) INFORMATION.—For purposes of sub-  
25          paragraph (A), the information described in

1           this subparagraph is, with respect to a notifica-  
2           tion under paragraph (1)(B) by a nonpartici-  
3           pating provider, nonparticipating emergency fa-  
4           cility, group health plan, or health insurance  
5           issuer offering group or individual health insur-  
6           ance coverage—

7                   “(i) a description of each item and  
8                   service included with respect to such notifi-  
9                   cation;

10                   “(ii) the geography in which the items  
11                   and services with respect to such notifica-  
12                   tion were provided;

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

21                   “(iv) whether the offer selected by the  
22                   certified IDR entity under paragraph (5)  
23                   to be the payment applied was the offer  
24                   submitted by such plan or issuer (as appli-  
25                   cable) or by such provider or facility (as



1 applicable) and the amount of such offer  
2 so selected expressed as a percentage of  
3 the qualifying payment amount;

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

8 “(vi) the identity of the health plan or  
9 health insurance issuer, provider, or facil-  
10 ity, with respect to the notification;

11 “(vii) the length of time in making  
12 each determination;

13 “(viii) the compensation paid to the  
14 certified IDR entity with respect to the  
15 settlement or determination; and

16 “(ix) any other information specified  
17 by the Secretary.

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

24 “(D) CLARIFICATION.—The Secretary  
25 shall ensure the public reporting under this

1 paragraph does not contain information that  
2 would disclose privileged or confidential infor-  
3 mation of a group health plan or health insur-  
4 ance issuer offering group or individual health  
5 insurance coverage or of a provider or facility.

6 “(8) ADMINISTRATIVE FEE.—

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

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

23 “(9) WAIVER AUTHORITY.—The Secretary may  
24 modify any deadline or other timing requirement  
25 specified under this subsection (other than the es-

1        establishment date for the IDR process under para-  
2        graph (2)(A) and other than under paragraph (6))  
3        in cases of extenuating circumstances, as specified  
4        by the Secretary, or to ensure that all claims that  
5        occur during a 90-day period described in paragraph  
6        (5)(E)(ii), but with respect to which a notification is  
7        not permitted by reason of such paragraph to be  
8        submitted under paragraph (1)(B) during such pe-  
9        riod, are eligible for the IDR process.”.

10        (b) ERISA.—Section 716 of the Employee Retire-  
11        ment Income Security Act of 1974, as added by section  
12        102, is amended—

13                (1) by redesignating subsection (c) as sub-  
14        section (d); and

15                (2) by inserting after subsection (b) the fol-  
16        lowing new subsection:

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

20                “(1) DETERMINATION THROUGH OPEN NEGO-  
21        TIATION.—

22                “(A) IN GENERAL.—With respect to an  
23        item or service furnished in a year by a non-  
24        participating provider or a nonparticipating fa-  
25        cility, with respect to a group health plan or

1 health insurance issuer offering group health  
2 insurance coverage, in a State described in sub-  
3 section (a)(3)(K)(ii) with respect to such plan  
4 or coverage and provider or facility, and for  
5 which a payment is required to be made by the  
6 plan or coverage pursuant to subsection (a)(1)  
7 or (b)(1), the provider or facility (as applicable)  
8 or plan or coverage may, during the 30-day pe-  
9 riod beginning on the day the provider or facil-  
10 ity receives an initial payment or a notice of de-  
11 nial of payment from the plan or coverage re-  
12 garding a claim for payment for such item or  
13 service, initiate open negotiations under this  
14 paragraph between such provider or facility and  
15 plan or coverage for purposes of determining,  
16 during the open negotiation period, an amount  
17 agreed on by such provider or facility, respec-  
18 tively, and such plan or coverage for payment  
19 (including any cost-sharing) for such item or  
20 service. For purposes of this subsection, the  
21 open negotiation period, with respect to an item  
22 or service, is the 30-day period beginning on  
23 the date of initiation of the negotiations with  
24 respect to such item or service.

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 an item or service, that do not result in a deter-  
6 mination of an amount of payment for such  
7 item or service by the last day of the open nego-  
8 tiation period described in such subparagraph  
9 with respect to such item or service, the pro-  
10 vider or facility (as applicable) or group health  
11 plan or health insurance issuer offering group  
12 health insurance coverage that was party to  
13 such negotiations may, during the 4-day period  
14 beginning on the day after such open negotia-  
15 tion period, initiate the independent dispute res-  
16 olution process under paragraph (2) with re-  
17 spect to such item or service. The independent  
18 dispute resolution process shall be initiated by  
19 a party pursuant to the previous sentence by  
20 submission to the other party and to the Sec-  
21 retary of a notification (containing such infor-  
22 mation as specified by the Secretary) and for  
23 purposes of this subsection, the date of initi-  
24 ation of such process shall be the date of such  
25 submission or such other date specified by the

1 Secretary pursuant to regulations that is not  
2 later than the date of receipt of such notifica-  
3 tion by both the other 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 Health and Human Services and the  
11 Secretary of the Treasury, shall establish by  
12 regulation one independent dispute resolution  
13 process (referred to in this subsection as the  
14 ‘IDR process’) under which, in the case of an  
15 item or service with respect to which a provider  
16 or facility (as applicable) or group health plan  
17 or health insurance issuer offering group health  
18 insurance coverage submits a notification under  
19 paragraph (1)(B) (in this subsection referred to  
20 as a ‘qualified IDR item or service’), a certified  
21 IDR entity under paragraph (4) determines,  
22 subject to subparagraph (B) and in accordance  
23 with the succeeding provisions of this sub-  
24 section, the amount of payment under the plan

1 or coverage for such item or service furnished  
2 by such provider or facility.

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

22 “(C) CLARIFICATION.—A nonparticipating  
23 provider may not, with respect to an item or  
24 service furnished by such provider, submit a no-  
25 tification under paragraph (1)(B) if such pro-

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1           vider is exempt from the requirement under  
2           subsection (a) of section 2799B–2 of the Public  
3           Health Service Act with respect to such item or  
4           service pursuant to subsection (b) of such sec-  
5           tion.

6           “(3) TREATMENT OF BATCHING OF ITEMS AND  
7           SERVICES.—

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

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

20                           “(ii) payment for such items and serv-  
21                           ices is required to be made by the same  
22                           group health plan or health insurance  
23                           issuer;



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1           “(iii) such items and services are re-  
2           lated to the treatment of a similar condi-  
3           tion; and

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

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

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

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1           “(A) IN GENERAL.—The Secretary, jointly  
2           with the Secretary of Health and Human Serv-  
3           ices and Secretary of the Treasury, shall estab-  
4           lish a process to certify (including to recertify)  
5           entities under this paragraph. Such process  
6           shall ensure that an entity so certified—

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

12                  “(ii) is not—

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

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

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

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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

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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—

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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

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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 clause (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 determination for  
19 a qualified IDR item or service, the certified  
20 IDR entity shall—

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

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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 or health insurance  
5 issuer offering group health insurance cov-  
6 erage party to such determination of the  
7 offer selected under clause (i).

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

16 “(i) shall each submit to the certified  
17 IDR entity with respect to such determina-  
18 tion—

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

23 “(II) such information as re-  
24 quested by the certified IDR entity re-  
25 lating to such offer; and

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1           “(ii) may each submit to the certified  
2           IDR entity with respect to such determina-  
3           tion any information relating to such offer  
4           submitted by either party, including infor-  
5           mation relating to any circumstance de-  
6           scribed in subparagraph (C)(ii).

7           “(C) CONSIDERATIONS IN DETERMINA-  
8           TION.—

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

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



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1                   “(II) subject to subparagraph  
2                   (D), information on any circumstance  
3                   described in clause (ii), such informa-  
4                   tion as requested in subparagraph  
5                   (B)(i)(II), and any additional infor-  
6                   mation provided in subparagraph  
7                   (B)(ii).

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

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

24                         “(II) The market share held by  
25                         the nonparticipating provider or facil-

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1                   ity or that of the plan or issuer in the  
2                   geographic region in which the item or  
3                   service was provided.

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

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

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

22                  “(D) PROHIBITION ON CONSIDERATION OF  
23                  CERTAIN FACTORS.—In determining which offer  
24                  is the payment to be applied with respect to  
25                  qualified IDR items and services furnished by a

1 provider or facility, the certified IDR entity  
2 with respect to a determination shall not con-  
3 sider usual and customary charges, the amount  
4 that would have been billed by such provider or  
5 facility with respect to such items and services  
6 had the provisions of section 2799B–1 of the  
7 Public Health Service Act or 2799B–2 of such  
8 Act (as applicable) not applied, or the payment  
9 or reimbursement rate for such items and serv-  
10 ices furnished by such provider or facility pay-  
11 able by a public payor, including under the  
12 Medicare program under title XVIII of the So-  
13 cial Security Act, under the Medicaid program  
14 under title XIX of such Act, under the Chil-  
15 dren’s Health Insurance Program under title  
16 XXI of such Act, under the TRICARE program  
17 under chapter 55 of title 10, United States  
18 Code, or under chapter 17 of title 38, United  
19 States Code.

20 “(E) EFFECTS OF DETERMINATION.—

21 “(i) IN GENERAL.—A determination  
22 of a certified IDR entity under subpara-  
23 graph (A)—

24 “(I) shall be binding upon the  
25 parties involved, in the absence of a

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1 fraudulent claim or evidence of mis-  
2 representation of facts presented to  
3 the IDR entity involved regarding  
4 such claim; and

5 “(II) shall not be subject to judi-  
6 cial review, except in a case described  
7 in any of paragraphs (1) through (4)  
8 of section 10(a) of title 9, United  
9 States Code.

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

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1           “(iii) SUBSEQUENT SUBMISSION OF  
2           REQUESTS PERMITTED.—In the case of a  
3           notification that pursuant to clause (ii) is  
4           not permitted to be submitted under para-  
5           graph (1)(B) during a 90-day period speci-  
6           fied in such clause, if the end of the open  
7           negotiation period specified in paragraph  
8           (1)(A), that but for this clause would oth-  
9           erwise apply with respect to such notifica-  
10          tion, occurs during such 90-day period,  
11          such paragraph (1)(B) shall be applied as  
12          if the reference in such paragraph to the  
13          4-day period beginning on the day after  
14          such open negotiation period were instead  
15          a reference to the 30-day period beginning  
16          on the day after the last day of such 90-  
17          day period.

18          “(iv) REPORTS.—The Secretary, joint-  
19          ly with the Secretary of Health and  
20          Human Services and the Secretary of the  
21          Treasury, shall examine the impact of the  
22          application of clause (ii) and whether the  
23          application of such clause delays payment  
24          determinations or impacts early, alter-  
25          native resolution of claims (such as

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1 through open negotiations), and shall sub-  
2 mit to Congress, not later than 2 years  
3 after the date of implementation of such  
4 clause an interim report (and not later  
5 than 4 years after such date of implemen-  
6 tation, a final report) on whether any  
7 group health plans or health insurance  
8 issuers offering group or individual health  
9 insurance coverage or types of such plans  
10 or coverage have a pattern or practice of  
11 routine denial, low payment, or down-cod-  
12 ing of claims, or otherwise abuse the 90-  
13 day period described in such clause, includ-  
14 ing recommendations on ways to discour-  
15 age such a pattern or practice.

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

24 “(i) if such entity makes a determina-  
25 tion with respect to such notification under

1           subparagraph (A), the party whose offer is  
2           not chosen under such subparagraph shall  
3           be responsible for paying all fees charged  
4           by such entity; and

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

10           “(6) TIMING OF PAYMENT.—The total plan or  
11           coverage payment required pursuant to subsection  
12           (a)(1) or (b)(1), with respect to a qualified IDR  
13           item or service for which a determination is made  
14           under paragraph (5)(A) or with respect to an item  
15           or service for which a payment amount is deter-  
16           mined under open negotiations under paragraph (1),  
17           shall be made directly to the nonparticipating pro-  
18           vider or facility not later than 30 days after the date  
19           on which such determination is made.

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

22                   “(A) PUBLICATION OF INFORMATION.—  
23           For each calendar quarter in 2022 and each  
24           calendar quarter in a subsequent year, the Sec-

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1           retary shall make available on the public  
2           website of the Department of Labor—

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

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

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

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

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

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



1           “(vii) the total amount of fees paid  
2           under paragraph (8) 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, group health plan, or health insurance  
14          issuer offering group health insurance cov-  
15          erage—

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

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

22           “(iii) the amount of the offer sub-  
23           mitted under paragraph (5)(B) by the  
24           group health plan or health insurance  
25           issuer (as applicable) and by the non-

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1 participating provider or nonparticipating  
2 emergency facility (as applicable) expressed  
3 as a percentage of the qualifying payment  
4 amount;

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

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

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

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

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

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1                   “(ix) any other information specified  
2                   by the Secretary.

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

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

16                  “(8) ADMINISTRATIVE FEE.—

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

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

9           “(9) WAIVER AUTHORITY.—The Secretary may  
10          modify any deadline or other timing requirement  
11          specified under this subsection (other than the es-  
12          tablishment date for the IDR process under para-  
13          graph (2)(A) and other than under paragraph (6))  
14          in cases of extenuating circumstances, as specified  
15          by the Secretary, or to ensure that all claims that  
16          occur during a 90-day period described in paragraph  
17          (5)(E)(ii), but with respect to which a notification is  
18          not permitted by reason of such paragraph to be  
19          submitted under paragraph (1)(B) during such pe-  
20          riod, are eligible for the IDR process.”.

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

23                 (1) by redesignating subsection (c) as sub-  
24                 section (d); and

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

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

6           “(1) DETERMINATION THROUGH OPEN NEGO-  
7 TIATION.—

8           “(A) IN GENERAL.—With respect to an  
9           item or service furnished in a year by a non-  
10           participating provider or a nonparticipating fa-  
11           cility, with respect to a group health plan, in a  
12           State described in subsection (a)(3)(K)(ii) with  
13           respect to such plan and provider or facility,  
14           and for which a payment is required to be made  
15           by the plan pursuant to subsection (a)(1) or  
16           (b)(1), the provider or facility (as applicable) or  
17           plan may, during the 30-day period beginning  
18           on the day the provider or facility receives an  
19           initial payment or a notice of denial of payment  
20           from the plan regarding a claim for payment  
21           for such item or service, initiate open negotia-  
22           tions under this paragraph between such pro-  
23           vider or facility and plan for purposes of deter-  
24           mining, during the open negotiation period, an  
25           amount agreed on by such provider or facility,

1           respectively, and such plan for payment (includ-  
2           ing any cost-sharing) for such item or service.  
3           For purposes of this subsection, the open nego-  
4           tiation period, with respect to an item or serv-  
5           ice, is the 30-day period beginning on the date  
6           of initiation of the negotiations with respect to  
7           such item or service.

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          an item or service, that do not result in a deter-  
13          mination of an amount of payment for such  
14          item or service by the last day of the open nego-  
15          tiation period described in such subparagraph  
16          with respect to such item or service, the pro-  
17          vider or facility (as applicable) or group health  
18          plan that was party to such negotiations may,  
19          during the 4-day period beginning on the day  
20          after such open negotiation period, initiate the  
21          independent dispute resolution process under  
22          paragraph (2) with respect to such item or  
23          service. The independent dispute resolution  
24          process shall be initiated by a party pursuant to  
25          the previous sentence by submission to the

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

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

13 “(A) ESTABLISHMENT.—Not later than 1  
14 year after the date of the enactment of this  
15 subsection, the Secretary, jointly with the Sec-  
16 retary of Health and Human Services and the  
17 Secretary of Labor, shall establish by regulation  
18 one independent dispute resolution process (re-  
19 ferred to in this subsection as the ‘IDR proc-  
20 ess’) under which, in the case of an item or  
21 service with respect to which a provider or facil-  
22 ity (as applicable) or group health plan submits  
23 a notification under paragraph (1)(B) (in this  
24 subsection referred to as a ‘qualified IDR item  
25 or service’), a certified IDR entity under para-

1 graph (4) determines, subject to subparagraph  
2 (B) and in accordance with the succeeding pro-  
3 visions of this subsection, the amount of pay-  
4 ment under the plan for such item or service  
5 furnished by such provider 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 of the Public  
7 Health Service Act with respect to such item or  
8 service pursuant to subsection (b) of such sec-  
9 tion.

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

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

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

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

1 group health plan or health insurance  
2 issuer;

3 “(iii) such items and services are re-  
4 lated to the treatment of a similar condi-  
5 tion; 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 the Secretary, for  
12 use in limited situations, such as by the  
13 consent 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, jointly  
4 with the Secretary of Health and Human Serv-  
5 ices and the Secretary of Labor, shall establish  
6 a process to certify (including to recertify) enti-  
7 ties under this paragraph. Such process shall  
8 ensure that 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

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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—

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1                   “(I) select such an entity that  
2                   satisfies subclauses (I) through (III)  
3                   of clause (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 determination for  
17                   a qualified IDR item or service, the certified  
18                   IDR entity shall—

19                   “(i) taking into account the consider-  
20                   ations specified in subparagraph (C), select  
21                   one of the offers submitted under subpara-  
22                   graph (B) to be the amount of payment for  
23                   such item or service determined under this  
24                   subsection for purposes of subsection  
25                   (a)(1) or (b)(1), as applicable; and

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

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

11                  “(i) shall each submit to the certified  
12                  IDR entity with respect to such determina-  
13                  tion—

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

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

21                  “(ii) may each submit to the certified  
22                  IDR entity with respect to such determina-  
23                  tion any information relating to such offer  
24                  submitted by either party, including infor-



1                   mation relating to any circumstance de-  
2                   scribed in subparagraph (C)(ii).

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

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

11                  “(I) 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                  “(II) subject to subparagraph  
22                  (D), information on any circumstance  
23                  described in clause (ii), such informa-  
24                  tion as requested in subparagraph  
25                  (B)(i)(II), and any additional infor-

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1 mation provided in subparagraph  
2 (B)(ii).

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

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

17 “(II) The market share held by  
18 the nonparticipating provider or facil-  
19 ity or that of the plan or issuer in the  
20 geographic region in which the item or  
21 service was provided.

22 “(III) The acuity of the indi-  
23 vidual receiving such item or service  
24 or the complexity of furnishing such  
25 item or service to such individual.

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1                   “(IV) The teaching status, case  
2                   mix, and scope of services of the non-  
3                   participating facility that furnished  
4                   such item or service.

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

15                  “(D) PROHIBITION ON CONSIDERATION OF  
16                  CERTAIN FACTORS.—In determining which offer  
17                  is the payment to be applied with respect to  
18                  qualified IDR items and services furnished by a  
19                  provider or facility, the certified IDR entity  
20                  with respect to a determination shall not con-  
21                  sider usual and customary charges, the amount  
22                  that would have been billed by such provider or  
23                  facility with respect to such items and services  
24                  had the provisions of section 2799B–1 of the  
25                  Public Health Service Act or 2799B–2 of such

1 Act (as applicable) not applied, or the payment  
2 or reimbursement rate for such items and serv-  
3 ices furnished by such provider or facility pay-  
4 able by a public payor, including under the  
5 Medicare program under title XVIII of the So-  
6 cial Security Act, under the Medicaid program  
7 under title XIX of such Act, under the Chil-  
8 dren’s Health Insurance Program under title  
9 XXI of such Act, under the TRICARE program  
10 under chapter 55 of title 10, United States  
11 Code, or under chapter 17 of title 38, United  
12 States Code.

13 “(E) EFFECTS OF DETERMINATION.—

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

17 “(I) shall be binding upon the  
18 parties involved, in the absence of a  
19 fraudulent claim or evidence of mis-  
20 representation of facts presented to  
21 the IDR entity involved regarding  
22 such claim; and

23 “(II) shall not be subject to judi-  
24 cial review, except in a case described  
25 in any of paragraphs (1) through (4)

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1 of section 10(a) of title 9, United  
2 States Code.

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

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

1 (1)(A), that but for this clause would oth-  
2 erwise apply with respect to such notifica-  
3 tion, occurs during such 90-day period,  
4 such paragraph (1)(B) shall be applied as  
5 if the reference in such paragraph to the  
6 4-day period beginning on the day after  
7 such open negotiation period were instead  
8 a reference to the 30-day period beginning  
9 on the day after the last day of such 90-  
10 day period.

11 “(iv) REPORTS.—The Secretary, joint-  
12 ly with the Secretary of Labor and the  
13 Secretary of the Health and Human Serv-  
14 ices, shall examine the impact of the appli-  
15 cation of clause (ii) and whether the appli-  
16 cation of such clause delays payment deter-  
17 minations or impacts early, alternative res-  
18 olution of claims (such as through open ne-  
19 gotiations), and shall submit to Congress,  
20 not later than 2 years after the date of im-  
21 plementation of such clause an interim re-  
22 port (and not later than 4 years after such  
23 date of implementation, a final report) on  
24 whether any group health plans or health  
25 insurance issuers offering group or indi-

1           vidual health insurance coverage or types  
2           of such plans or coverage have a pattern or  
3           practice of routine denial, low payment, or  
4           down-coding of claims, or otherwise abuse  
5           the 90-day period described in such clause,  
6           including recommendations on ways to dis-  
7           courage such a pattern or practice.

8           “(F) COSTS OF INDEPENDENT DISPUTE  
9           RESOLUTION PROCESS.—In the case of a notifi-  
10          cation under paragraph (1)(B) submitted by a  
11          nonparticipating provider, nonparticipating  
12          emergency facility, or group health plan and  
13          submitted to a certified IDR entity—

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

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

1           “(6) TIMING OF PAYMENT.—The total plan  
2           payment required pursuant to subsection (a)(1) or  
3           (b)(1), with respect to a qualified IDR item or serv-  
4           ice for which a determination is made under para-  
5           graph (5)(A) or with respect to an item or service  
6           for which a payment amount is determined under  
7           open negotiations under paragraph (1), shall be  
8           made directly to the nonparticipating provider or fa-  
9           cility not later than 30 days after the date on which  
10          such determination is made.

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

13                 “(A) PUBLICATION OF INFORMATION.—  
14                 For each calendar quarter in 2022 and each  
15                 calendar quarter in a subsequent year, the Sec-  
16                 retary shall make available on the public  
17                 website of the Department of the Treasury—

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

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



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

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

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

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

17          “(vii) the total amount of fees paid  
18          under paragraph (8) during such calendar  
19          quarter; and

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

24          “(B) INFORMATION.—For purposes of sub-  
25          paragraph (A), the information described in

1           this subparagraph is, with respect to a notifica-  
2           tion under paragraph (1)(B) by a nonpartici-  
3           pating provider, nonparticipating emergency fa-  
4           cility, or group health plan—

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

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

11                  “(iii) the amount of the offer sub-  
12                  mitted under paragraph (5)(B) by the  
13                  group health plan and by the nonpartici-  
14                  pating provider or nonparticipating emer-  
15                  gency facility (as applicable) expressed as  
16                  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 by such provider  
22                  or facility (as applicable) and the amount  
23                  of such offer so selected expressed as a  
24                  percentage of the qualifying payment  
25                  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 group health  
6           plan, provider, or facility, with respect to  
7           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 requirement  
22          specified under this subsection (other than the es-  
23          tablishment date for the IDR process under para-  
24          graph (2)(A) and other than under paragraph (6))  
25          in cases of extenuating circumstances, as specified

1 by the Secretary, or to ensure that all claims that  
2 occur during a 90-day period described in paragraph  
3 (5)(E)(ii), but with respect to which a notification is  
4 not permitted by reason of such paragraph to be  
5 submitted under paragraph (1)(B) during such pe-  
6 riod, are eligible for the IDR process.”.

7 **SEC. 104. HEALTH CARE PROVIDER REQUIREMENTS RE-**  
8 **GARDING SURPRISE MEDICAL BILLING.**

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

13 **“PART E—HEALTH CARE PROVIDER**  
14 **REQUIREMENTS**  
15 **“SEC. 2799B-1. BALANCE BILLING IN CASES OF EMERGENCY**  
16 **SERVICES.**

17 “(a) IN GENERAL.—In the case of a participant, ben-  
18 efiary, or enrollee with benefits under a group health  
19 plan or group or individual health insurance coverage of-  
20 fered by a health insurance issuer and who is furnished  
21 during a plan year beginning on or after January 1, 2022,  
22 emergency services (for which benefits are provided under  
23 the plan or coverage) with respect to an emergency med-  
24 ical condition with respect to a visit at an emergency de-

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

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

17          “(2) in the case that such services are furnished  
18          by a nonparticipating provider, the health care pro-  
19          vider shall not bill, and shall not hold liable, such  
20          participant, beneficiary, or enrollee for a payment  
21          amount for an emergency service furnished to such  
22          individual by such provider with respect to such  
23          emergency medical condition and visit for which the  
24          individual receives emergency services at the hospital  
25          or emergency department that is more than the cost-

1 sharing requirement for such services furnished by  
2 the provider (as determined in accordance with  
3 clauses (ii) and (iii) of section 2799A–1(a)(1)(C), of  
4 section 9816(a)(1)(C) of the Internal Revenue Code  
5 of 1986, and of section 716(a)(1)(C) of the Em-  
6 ployee Retirement Income Security Act of 1974, as  
7 applicable).

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

11 **“SEC. 2799B–2. BALANCE BILLING IN CASES OF NON-EMER-**  
12 **GENCY SERVICES PERFORMED BY NON-**  
13 **PARTICIPATING PROVIDERS AT CERTAIN**  
14 **PARTICIPATING FACILITIES.**

15 “(a) IN GENERAL.—Subject to subsection (b), in the  
16 case of a participant, beneficiary, or enrollee with benefits  
17 under a group health plan or group or individual health  
18 insurance coverage offered by a health insurance issuer  
19 and who is furnished during a plan year beginning on or  
20 after January 1, 2022, items or services (other than emer-  
21 gency services to which section 2799B–1 applies) for  
22 which benefits are provided under the plan or coverage  
23 at a participating health care facility by a nonparticipating  
24 provider, such provider shall not bill, and shall not hold  
25 liable, such participant, beneficiary, or enrollee for a pay-

1 ment amount for such an item or service furnished by such  
2 provider with respect to a visit at such facility that is more  
3 than the cost-sharing requirement for such item or service  
4 (as determined in accordance with subparagraphs (A) and  
5 (B) of section 2799A–1(b)(1) of section 9816(b)(1) of the  
6 Internal Revenue Code of 1986, and of section 716(b)(1)  
7 of the Employee Retirement Income Security Act of 1974,  
8 as applicable).

9 “(b) EXCEPTION.—

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

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

23 “(A) subject to paragraph (3), items and  
24 services related to emergency medicine, anesthe-  
25 siology, pathology, radiology, and neonatology,



1           whether or not provided by a physician or non-  
2           physician practitioner, and items and services  
3           provided by assistant surgeons, hospitalists, and  
4           intensivists;

5           “(B) subject to paragraph (3), diagnostic  
6           services (including radiology and laboratory  
7           services);

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

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

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

21          “(e) CLARIFICATION.—In the case of a nonpartici-  
22          pating provider that satisfies the notice and consent cri-  
23          teria of subsection (d) with respect to an item or service  
24          (referred to in this subsection as a ‘covered item or serv-  
25          ice’), such notice and consent criteria may not be con-

1 strued as applying with respect to any item or service that  
2 is furnished as a result of unforeseen, urgent medical  
3 needs that arise at the time such covered item or service  
4 is furnished. For purposes of the previous sentence, a cov-  
5 ered item or service shall not include an ancillary service  
6 described in subsection (b)(2).

7 “(d) NOTICE AND CONSENT TO BE TREATED BY A  
8 NONPARTICIPATING PROVIDER OR NONPARTICIPATING  
9 FACILITY.—

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

20 “(A) in the case that the participant, bene-  
21 ficiary, or enrollee makes an appointment to be  
22 furnished such items or services at least 72  
23 hours prior to the date on which the individual  
24 is to be furnished such items or services, pro-  
25 vides to the participant, beneficiary, or enrollee

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

19 “(i) contains the information required  
20 under paragraph (2);

21 “(ii) clearly states that consent to re-  
22 ceive such items and services from such  
23 nonparticipating provider or nonpartici-  
24 pating facility is optional and that the par-  
25 ticipant, beneficiary, or enrollee may in-

1           stead seek care from a participating pro-  
2           vider or at a participating facility, with re-  
3           spect to such plan or coverage, as applica-  
4           ble, in which case the cost-sharing respon-  
5           sibility of the participant, beneficiary, or  
6           enrollee would not exceed such responsi-  
7           bility that would apply with respect to such  
8           an item or service that is furnished by a  
9           participating provider or participating fa-  
10          cility, as applicable with respect to such  
11          plan; and

12                   “(iii) is available in the 15 most com-  
13                   mon languages in the geographic region of  
14                   the applicable facility;

15                   “(B) obtains from the participant, bene-  
16                   ficiary, or enrollee (or from such an authorized  
17                   representative) the consent described in para-  
18                   graph (3) to be treated by a nonparticipating  
19                   provider or nonparticipating facility; and

20                   “(C) provides a signed copy of such con-  
21                   sent to the participant, beneficiary, or enrollee  
22                   through mail or email (as selected by the par-  
23                   ticipant, beneficiary, or enrollee).

24                   “(2) INFORMATION REQUIRED UNDER WRITTEN  
25                   NOTICE.—For purposes of paragraph (1)(A)(i), the

1 information described in this paragraph, with re-  
2 spect to a nonparticipating provider or nonpartici-  
3 pating facility and a participant, beneficiary, or en-  
4 rollee of a group health plan or group or individual  
5 health insurance coverage offered by a health insur-  
6 ance issuer, is each of the following:

7 “(A) Notification, as applicable, that the  
8 health care provider is a nonparticipating pro-  
9 vider with respect to the health plan or the  
10 health care facility is a nonparticipating facility  
11 with respect to the health plan.

12 “(B) Notification of the good faith esti-  
13 mated amount that such provider or facility  
14 may charge the participant, beneficiary, or en-  
15 rollee for such items and services involved, in-  
16 cluding a notification that the provision of such  
17 estimate or consent to be treated under para-  
18 graph (3) does not constitute a contract with  
19 respect to the charges estimated for such items  
20 and services.

21 “(C) In the case of a participating facility  
22 and a nonparticipating provider, a list of any  
23 participating providers at the facility who are  
24 able to furnish such items and services involved  
25 and notification that the participant, bene-

1           ficiary, or enrollee may be referred, at their op-  
2           tion, to such a participating provider.

3           “(D) Information about whether prior au-  
4           thorization or other care management limita-  
5           tions may be required in advance of receiving  
6           such items or services at the facility.

7           “(3) CONSENT DESCRIBED TO BE TREATED BY  
8           A NONPARTICIPATING PROVIDER OR NONPARTICI-  
9           PATING FACILITY.—For purposes of paragraph  
10          (1)(B), the consent described in this paragraph, with  
11          respect to a participant, beneficiary, or enrollee of a  
12          group health plan or group or individual health in-  
13          surance coverage offered by a health insurance  
14          issuer who is to be furnished items or services by a  
15          nonparticipating provider or nonparticipating facil-  
16          ity, is a document specified by the Secretary, in con-  
17          sultation with the Secretary of Labor, through guid-  
18          ance that shall be signed by the participant, bene-  
19          ficiary, or enrollee before such items or services are  
20          furnished and that —

21                 “(A) acknowledges (in clear and under-  
22                 standable language) that the participant, bene-  
23                 ficiary, or enrollee has been—

24                         “(i) provided with the written notice  
25                         under paragraph (1)(A);

1                   “(ii) informed that the payment of  
2                   such charge by the participant, beneficiary,  
3                   or enrollee may not accrue toward meeting  
4                   any limitation that the plan or coverage  
5                   places on cost-sharing, including an expla-  
6                   nation that such payment may not apply to  
7                   an in-network deductible applied under the  
8                   plan or coverage; and

9                   “(iii) provided the opportunity to re-  
10                  ceive the written notice under paragraph  
11                  (1)(A) in the form selected by the partici-  
12                  pant, beneficiary or enrollee; and

13                  “(B) documents the date on which the par-  
14                  ticipant, beneficiary, or enrollee received the  
15                  written notice under paragraph (1)(A) and the  
16                  date on which the individual signed such con-  
17                  sent to be furnished such items or services by  
18                  such provider or facility.

19                  “(4) RULE OF CONSTRUCTION.—The consent  
20                  described in paragraph (3), with respect to a partici-  
21                  pant, beneficiary, or enrollee of a group health plan  
22                  or group or individual health insurance coverage of-  
23                  fered by a health insurance issuer, shall constitute  
24                  only consent to the receipt of the information pro-  
25                  vided pursuant to this subsection and shall not con-

1       stitute a contractual agreement of the participant,  
2       beneficiary, or enrollee to any estimated charge or  
3       amount included in such information.

4       “(e) RETENTION OF CERTAIN DOCUMENTS.—A non-  
5       participating facility (with respect to such facility or any  
6       nonparticipating provider at such facility) or a partici-  
7       pating facility (with respect to nonparticipating providers  
8       at such facility) that obtains from a participant, bene-  
9       ficiary, or enrollee of a group health plan or group or indi-  
10      vidual health insurance coverage offered by a health insur-  
11      ance issuer (or an authorized representative of such par-  
12      ticipant, beneficiary, or enrollee) a written notice in ac-  
13      cordance with subsection (d)(1)(B), with respect to fur-  
14      nishing an item or service to such participant, beneficiary,  
15      or enrollee, shall retain such notice for at least a 7-year  
16      period after the date on which such item or service is so  
17      furnished.

18      “(f) DEFINITIONS.—In this section:

19           “(1) The terms ‘nonparticipating provider’ and  
20           ‘participating provider’ have the meanings given  
21           such terms, respectively, in subsection (a)(3) of sec-  
22           tion 2799A–1.

23           “(2) The term ‘participating health care facil-  
24           ity’ has the meaning given such term in subsection  
25           (b)(2) of section 2799A–1.



1           “(3) The term ‘nonparticipating facility’  
2 means—

3           “(A) with respect to emergency services (as  
4 defined in section 2799A–1(a)(3)(C)(i)) and a  
5 group health plan or group or individual health  
6 insurance coverage offered by a health insur-  
7 ance issuer, an emergency department of a hos-  
8 pital, or an independent freestanding emergency  
9 department, that does not have a contractual  
10 relationship with the plan or issuer, respec-  
11 tively, with respect to the furnishing of such  
12 services under the plan or coverage, respec-  
13 tively; and

14           “(B) with respect to services described in  
15 section 2799A–1(a)(3)(C)(ii) and a group  
16 health plan or group or individual health insur-  
17 ance coverage offered by a health insurance  
18 issuer, a hospital or an independent free-  
19 standing emergency department, that does not  
20 have a contractual relationship with the plan or  
21 issuer, respectively, with respect to the fur-  
22 nishing of such services under the plan or cov-  
23 erage, respectively.

24           “(4) The term ‘participating facility’ means—

1           “(A) with respect to emergency services (as  
2 defined in clause (i) of section 2799A–  
3 1(a)(3)(C)) that are not described in clause(ii)  
4 of such section and a group health plan or  
5 group or individual health insurance coverage  
6 offered by a health insurance issuer, an emer-  
7 gency department of a hospital, or an inde-  
8 pendent freestanding emergency department,  
9 that has a direct or indirect contractual rela-  
10 tionship with the plan or issuer, respectively,  
11 with respect to the furnishing of such services  
12 under the plan or coverage, respectively; and

13           “(B) with respect to services that pursuant  
14 to clause (ii) of section 2799A–1(a)(3)(C), of  
15 section 9816(a)(3) of the Internal Revenue  
16 Code of 1986, and of section 716(a)(3) of the  
17 Employee Retirement Income Security Act of  
18 1974, as applicable are included as emergency  
19 services (as defined in clause (i) of such section  
20 and a group health plan or group or individual  
21 health insurance coverage offered by a health  
22 insurance issuer, a hospital or an independent  
23 freestanding emergency department, that has a  
24 contractual relationship with the plan or cov-  
25 erage, respectively, with respect to the fur-

1 nishing of such services under the plan or cov-  
2 erage, respectively.

3 **“SEC. 2799B-3. PROVIDER REQUIREMENTS WITH RESPECT**  
4 **TO DISCLOSURE ON PATIENT PROTECTIONS**  
5 **AGAINST BALANCE BILLING.**

6 “Beginning not later than January 1, 2022, each  
7 health care provider and health care facility shall make  
8 publicly available, and (if applicable) post on a public  
9 website of such provider or facility and provide to individ-  
10 uals who are participants, beneficiaries, or enrollees of a  
11 group health plan or group or individual health insurance  
12 coverage offered by a health insurance issuer a one-page  
13 notice (either postal or electronic mail, as specified by the  
14 participant, beneficiary, or enrollee) in clear and under-  
15 standable language containing information on—

16 “(1) the requirements and prohibitions of such  
17 provider or facility under sections 2799B-1 and  
18 2799B-2 (relating to prohibitions on balance billing  
19 in certain circumstances);

20 “(2) any other applicable State law require-  
21 ments on such provider or facility regarding the  
22 amounts such provider or facility may, with respect  
23 to an item or service, charge a participant, bene-  
24 ficiary, or enrollee of a group health plan or group  
25 or individual health insurance coverage offered by a

1 health insurance issuer with respect to which such  
2 provider or facility does not have a contractual rela-  
3 tionship for furnishing such item or service under  
4 the plan or coverage, respectively, after receiving  
5 payment from the plan or coverage, respectively, for  
6 such item or service and any applicable cost-sharing  
7 payment from such participant, beneficiary, or en-  
8 rollee; and

9 “(3) information on contacting appropriate  
10 State and Federal agencies in the case that an indi-  
11 vidual believes that such provider or facility has vio-  
12 lated any requirement described in paragraph (1) or  
13 (2) with respect to such individual.

14 **“SEC. 2799B-4. ENFORCEMENT.**

15 “(a) STATE ENFORCEMENT.—

16 “(1) STATE AUTHORITY.—Each State may re-  
17 quire a provider or health care facility (including a  
18 provider of air ambulance services) subject to the re-  
19 quirements of this part to satisfy such requirements  
20 applicable to the provider or facility.

21 “(2) FAILURE TO IMPLEMENT REQUIRE-  
22 MENTS.—In the case of a determination by the Sec-  
23 retary that a State has failed to substantially en-  
24 force the requirements to which paragraph (1) ap-  
25 plies with respect to applicable providers and facili-

1       ties in the State, the Secretary shall enforce such re-  
2       quirements under subsection (b) insofar as they re-  
3       late to violations of such requirements occurring in  
4       such State.

5           “(3) NOTIFICATION OF APPLICABLE SEC-  
6       RETARY.—A State may notify the Secretary of  
7       Labor, Secretary of Health and Human Services, or  
8       the Secretary of the Treasury, as applicable, of in-  
9       stances of violations of sections 2799B–1, 2799B–2,  
10      or 2799B–5 with respect to participants, bene-  
11      ficiaries, or enrollees under a group health plan or  
12      group or individual health insurance coverage, as ap-  
13      plicable offered by a health insurance issuer and any  
14      enforcement actions taken against providers or fa-  
15      cilities as a result of such violations, including the  
16      disposition of any such enforcement actions.

17      “(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

18           “(1) IN GENERAL.—If a provider or facility is  
19      found by the Secretary to be in violation of a re-  
20      quirement to which subsection (a)(1) applies, the  
21      Secretary may apply a civil monetary penalty with  
22      respect to such provider or facility (including, as ap-  
23      plicable, a provider of air ambulance services) in an  
24      amount not to exceed \$10,000 per violation. The  
25      provisions of subsections (c) (with the exception of

1 the first sentence of paragraph (1) of such sub-  
2 section), (d), (e), (g), (h), (k), and (l) of section  
3 1128A of the Social Security Act shall apply to a  
4 civil monetary penalty or assessment under this sub-  
5 section in the same manner as such provisions apply  
6 to a penalty, assessment, or proceeding under sub-  
7 section (a) of such section.

8 “(2) LIMITATION.—The provisions of para-  
9 graph (1) shall apply to enforcement of a provision  
10 (or provisions) specified in subsection (a)(1) only as  
11 provided under subsection (a)(2).

12 “(3) COMPLAINT PROCESS.—The Secretary  
13 shall, through rulemaking, establish a process to re-  
14 ceive consumer complaints of violations of such pro-  
15 visions and provide a response to such complaints  
16 within 60 days of receipt of such complaints.

17 “(4) EXCEPTION.—The Secretary shall waive  
18 the penalties described under paragraph (1) with re-  
19 spect to a facility or provider (including a provider  
20 of air ambulance services) who does not knowingly  
21 violate, and should not have reasonably known it vio-  
22 lated, section 2799B–1 or 2799B–2 (or, in the case  
23 of a provider of air ambulance services, section  
24 2799B–5) with respect to a participant, beneficiary,  
25 or enrollee, if such facility or provider, within 30

1 days of the violation, withdraws the bill that was in  
2 violation of such provision and reimburses the health  
3 plan or enrollee, as applicable, in an amount equal  
4 to the difference between the amount billed and the  
5 amount allowed to be billed under the provision, plus  
6 interest, at an interest rate determined by the Sec-  
7 retary.

8 “(5) HARDSHIP EXEMPTION.—The Secretary  
9 may establish a hardship exemption to the penalties  
10 under this subsection.

11 “(c) CONTINUED APPLICABILITY OF STATE LAW.—  
12 The sections specified in subsection (a)(1) shall not be  
13 construed to supersede any provision of State law which  
14 establishes, implements, or continues in effect any require-  
15 ment or prohibition except to the extent that such require-  
16 ment or prohibition prevents the application of a require-  
17 ment or prohibition of such a section.”.

18 (b) SECRETARY OF LABOR ENFORCEMENT.—

19 (1) IN GENERAL.—Part 5 of subtitle B of title  
20 I of the Employee Retirement Income Security Act  
21 of 1974 (29 U.S.C. 1131 et seq.) is amended by  
22 adding at the end the following new section:

1 **“SEC. 522. COORDINATION OF ENFORCEMENT REGARDING**  
2 **VIOLATIONS OF CERTAIN HEALTH CARE PRO-**  
3 **VIDER REQUIREMENTS; COMPLAINT PROC-**  
4 **ESS.**

5 “(a) INVESTIGATING VIOLATIONS.—Upon receiving a  
6 notice from a State or the Secretary of Health and Human  
7 Services of violations of sections 2799B–1, 2799B–2, or  
8 2799B–5 of the Public Health Service Act, the Secretary  
9 of Labor shall identify patterns of such violations with re-  
10 spect to participants or beneficiaries under a group health  
11 plan or group health insurance coverage offered by a  
12 health insurance issuer and conduct an investigation pur-  
13 suant to section 504 where appropriate, as determined by  
14 the Secretary. The Secretary shall coordinate with States  
15 and the Secretary of Health and Human Services, in ac-  
16 cordance with section 506 and with section 104 of Health  
17 Insurance Portability and Accountability Act of 1996,  
18 where appropriate, as determined by the Secretary, to en-  
19 sure that appropriate measures have been taken to correct  
20 such violations retrospectively and prospectively with re-  
21 spect to participants or beneficiaries under a group health  
22 plan or group health insurance coverage offered by a  
23 health insurance issuer.

24 “(b) COMPLAINT PROCESS.— Not later than January  
25 1, 2022, the Secretary shall ensure a process under which  
26 the Secretary—



1           “(1) may receive complaints from participants  
2           and beneficiaries of group health plans or group  
3           health insurance coverage offered by a health insur-  
4           ance issuer relating to alleged violations of the sec-  
5           tions specified in subsection (a); and

6           “(2) transmits such complaints to States or the  
7           Secretary of Health and Human Services (as deter-  
8           mined appropriate by the Secretary) for potential  
9           enforcement actions.”.

10           (2) TECHNICAL AMENDMENT.—The table of  
11           contents in section 1 of the Employee Retirement  
12           Income Security Act of 1974 (29 U.S.C. 1001 et  
13           seq.) is amended by inserting after the item relating  
14           to section 521 the following new item:

          “Sec. 522. Coordination of enforcement regarding violations of certain health  
          care provider requirements; complaint process.”.

15   **SEC. 105. ENDING SURPRISE AIR AMBULANCE BILLS.**

16           (a) GROUP HEALTH PLANS AND INDIVIDUAL AND  
17   GROUP HEALTH INSURANCE COVERAGE.—

18           (1) PHSA AMENDMENTS.—Part D of title  
19           XXVII of the Public Health Service Act, as added  
20           and amended by section 102 and further amended  
21           by the previous provisions of this title, is further  
22           amended by inserting after section 2799A–1 the fol-  
23           lowing:

1 **“SEC. 2799A-2. ENDING SURPRISE AIR AMBULANCE BILLS.**

2       “(a) IN GENERAL.—In the case of a participant, ben-  
3 eficiary, or enrollee who is in a group health plan or group  
4 or individual health insurance coverage offered by a health  
5 insurance issuer and who receives air ambulance services  
6 from a nonparticipating provider (as defined in section  
7 2799A-1(a)(3)(G)) with respect to such plan or coverage,  
8 if such services would be covered if provided by a partici-  
9 pating provider (as defined in such section) with respect  
10 to such plan or coverage—

11               “(1) the cost-sharing requirement with respect  
12 to such services shall be the same requirement that  
13 would apply if such services were provided by such  
14 a participating provider, and any coinsurance or de-  
15 ductible shall be based on rates that would apply for  
16 such services if they were furnished by such a par-  
17 ticipating provider;

18               “(2) such cost-sharing amounts shall be count-  
19 ed towards the in-network deductible and in-network  
20 out-of-pocket maximum amount under the plan or  
21 coverage for the plan year (and such in-network de-  
22 ductible shall be applied) with respect to such items  
23 and services so furnished in the same manner as if  
24 such cost-sharing payments were with respect to  
25 items and services furnished by a participating pro-  
26 vider; and

1           “(3) the group health plan or health insurance  
2 issuer, respectively, shall—

3           “(A) not later than 30 calendar days after  
4 the bill for such services is transmitted by such  
5 provider, send to the provider, an initial pay-  
6 ment or notice of denial of payment; and

7           “(B) pay a total plan or coverage payment,  
8 in accordance with, if applicable, subsection  
9 (b)(6), directly to such provider furnishing such  
10 services to such participant, beneficiary, or en-  
11 rollee that is, with application of any initial  
12 payment under subparagraph (A), equal to the  
13 amount by which the out-of-network rate (as  
14 defined in section 2799A–1(a)(3)(K)) for such  
15 services and year involved exceeds the cost-shar-  
16 ing amount imposed under the plan or cov-  
17 erage, respectively, for such services (as deter-  
18 mined in accordance with paragraphs (1) and  
19 (2)).

20           “(b) DETERMINATION OF OUT-OF-NETWORK RATES  
21 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE  
22 RESOLUTION PROCESS.—

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

1           “(A) IN GENERAL.—With respect to air  
2 ambulance services furnished in a year by a  
3 nonparticipating provider, with respect to a  
4 group health plan or health insurance issuer of-  
5 fering group or individual health insurance cov-  
6 erage, and for which a payment is required to  
7 be made by the plan or coverage pursuant to  
8 subsection (a)(3), the provider or plan or cov-  
9 erage may, during the 30-day period beginning  
10 on the day the provider receives an initial pay-  
11 ment or a notice of denial of payment from the  
12 plan or coverage regarding a claim for payment  
13 for such service, initiate open negotiations  
14 under this paragraph between such provider  
15 and plan or coverage for purposes of deter-  
16 mining, during the open negotiation period, an  
17 amount agreed on by such provider, and such  
18 plan or coverage for payment (including any  
19 cost-sharing) for such service. For purposes of  
20 this subsection, the open negotiation period,  
21 with respect to air ambulance services, is the  
22 30-day period beginning on the date of initi-  
23 ation of the negotiations with respect to such  
24 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 4-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 a determination for  
11          qualified IDR ambulance services, the certified  
12          IDR entity shall—

13                 “(i) taking into account the consider-  
14          ations specified in subparagraph (C), select  
15          one of the offers submitted under subpara-  
16          graph (B) to be the amount of payment for  
17          such services determined under this sub-  
18          section for purposes of subsection (a)(3);  
19          and

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

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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 qualified IDR air ambulance serv-  
5 ices, the provider and the group health plan or  
6 health insurance issuer offering group or indi-  
7 vidual health insurance coverage party to such  
8 determination—

9           “(i) shall each submit to the certified  
10 IDR entity with respect to such determina-  
11 tion—

12           “(I) an offer for a payment  
13 amount for such services furnished by  
14 such provider; and

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

18           “(ii) may each submit to the certified  
19 IDR entity with respect to such determina-  
20 tion any information relating to such offer  
21 submitted by either party, including infor-  
22 mation relating to any circumstance de-  
23 scribed in subparagraph (C)(ii).

24           “(C) CONSIDERATIONS IN DETERMINA-  
25 TION.—

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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 qualifying payment  
8                       amounts (as defined in section  
9                       2799A–1(a)(3)(E)) for the applicable  
10                      year for items or services that are  
11                      comparable to the qualified IDR air  
12                      ambulance service and that are fur-  
13                      nished in the same geographic region  
14                      (as defined by the Secretary for pur-  
15                      poses of such subsection) as such  
16                      qualified IDR air ambulance service;  
17                      and

18                      “(II) subject to clause (iii), infor-  
19                      mation on any circumstance described  
20                      in clause (ii), such information as re-  
21                      quested in subparagraph (B)(i)(II),  
22                      and any additional information pro-  
23                      vided in subparagraph (B)(ii).

24                      “(ii) ADDITIONAL CIRCUMSTANCES.—  
25                      For purposes of clause (i)(II), the cir-

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1           cumstances described in this clause are,  
2           with respect to air ambulance services in-  
3           cluded in the notification submitted under  
4           paragraph (1)(B) of a nonparticipating  
5           provider, group health plan, or health in-  
6           surance issuer the following:

7                   “(I) The quality and outcomes  
8                   measurements of the provider that  
9                   furnished such services.

10                   “(II) The acuity of the individual  
11                   receiving such services or the com-  
12                   plexity of furnishing such services to  
13                   such individual.

14                   “(III) The training, experience,  
15                   and quality of the medical personnel  
16                   that furnished such services.

17                   “(IV) Ambulance vehicle type, in-  
18                   cluding the clinical capability level of  
19                   such vehicle.

20                   “(V) Population density of the  
21                   pick up location (such as urban, sub-  
22                   urban, rural, or frontier).

23                   “(VI) Demonstrations of good  
24                   faith efforts (or lack of good faith ef-  
25                   forts) made by the nonparticipating

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1 provider or nonparticipating facility or  
2 the plan or issuer to enter into net-  
3 work agreements and, if applicable,  
4 contracted rates between the provider  
5 and the plan or issuer, as applicable,  
6 during the previous 4 plan years.

7 “(iii) PROHIBITION ON CONSIDER-  
8 ATION OF CERTAIN FACTORS.—In deter-  
9 mining which offer is the payment amount  
10 to be applied with respect to qualified IDR  
11 air ambulance services furnished by a pro-  
12 vider, the certified IDR entity with respect  
13 to such determination shall not consider  
14 usual and customary charges, the amount  
15 that would have been billed by such pro-  
16 vider with respect to such services had the  
17 provisions of section 2799B–5 not applied,  
18 or the payment or reimbursement rate for  
19 such services furnished by such provider  
20 payable by a public payor, including under  
21 the Medicare program under title XVIII of  
22 the Social Security Act, under the Med-  
23 icaid program under title XIX of such Act,  
24 under the Children’s Health Insurance  
25 Program under title XXI of such Act,

1 under the TRICARE program under chap-  
2 ter 55 of title 10, United States Code, or  
3 under chapter 17 of title 38, United States  
4 Code.

5 “(D) EFFECTS OF DETERMINATION.—The  
6 provisions of section 2799A–1(c)(5)(E)) shall  
7 apply with respect to a determination of a cer-  
8 tified IDR entity under subparagraph (A), the  
9 notification submitted with respect to such de-  
10 termination, the services with respect to such  
11 notification, and the parties to such notification  
12 in the same manner as such provisions apply  
13 with respect to a determination of a certified  
14 IDR entity under section 2799A–1(c)(5)(E),  
15 the notification submitted with respect to such  
16 determination, the items and services with re-  
17 spect to such notification, and the parties to  
18 such notification.

19 “(E) COSTS OF INDEPENDENT DISPUTE  
20 RESOLUTION PROCESS.—The provisions of sec-  
21 tion 2799A–1(c)(5)(F) shall apply to a notifica-  
22 tion made under this subsection, the parties to  
23 such notification, and a determination under  
24 subparagraph (A) in the same manner and to  
25 the same extent such provisions apply to a noti-

1           fication under section 2799A–1(c), the parties  
2           to such notification and a determination made  
3           under section 2799A–1(c)(5)(A).

4           “(6) TIMING OF PAYMENT.—The total plan or  
5           coverage payment required pursuant to subsection  
6           (a)(3), with respect to qualified IDR air ambulance  
7           services for which a determination is made under  
8           paragraph (5)(A) or with respect to an air ambu-  
9           lance service for which a payment amount is deter-  
10          mined under open negotiations under paragraph (1),  
11          shall be made directly to the nonparticipating pro-  
12          vider not later than 30 days after the date on which  
13          such determination is made.

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

16                 “(A) IN GENERAL.—For each calendar  
17                 quarter in 2022 and each calendar quarter in a  
18                 subsequent year, the Secretary shall publish on  
19                 the public website of the Department of Health  
20                 and Human Services—

21                         “(i) the number of notifications sub-  
22                         mitted under the IDR process during such  
23                         calendar quarter;

1           “(ii) the number of such notifications  
2           with respect to which a final determination  
3           was made under paragraph (5)(A);

4           “(iii) the information described in  
5           subparagraph (B) with respect to each no-  
6           tification with respect to which such a de-  
7           termination was so made.

8           “(iv) the number of times the pay-  
9           ment amount determined (or agreed to)  
10          under this subsection exceeds the quali-  
11          fying payment amount;

12          “(v) the amount of expenditures made  
13          by the Secretary during such calendar  
14          quarter to carry out the IDR process;

15          “(vi) the total amount of fees paid  
16          under paragraph (8) during such calendar  
17          quarter; and

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

22          “(B) INFORMATION WITH RESPECT TO RE-  
23          QUESTS.—For purposes of subparagraph (A),  
24          the information described in this subparagraph  
25          is, with respect to a notification under the IDR



1 process of a nonparticipating provider, group  
2 health plan, or health insurance issuer offering  
3 group or individual health insurance coverage—

4 “(i) a description of each air ambu-  
5 lance service included in such notification;

6 “(ii) the geography in which the serv-  
7 ices included in such notification were pro-  
8 vided;

9 “(iii) the amount of the offer sub-  
10 mitted under paragraph (2) by the group  
11 health plan or health insurance issuer (as  
12 applicable) and by the nonparticipating  
13 provider expressed as a percentage of the  
14 qualifying payment amount;

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

23 “(v) ambulance vehicle type, including  
24 the clinical capability level of such vehicle;

1           “(vi) the identity of the group health  
2           plan or health insurance issuer or air am-  
3           bulance provider with respect to such noti-  
4           fication;

5           “(vii) the length of time in making  
6           each determination;

7           “(viii) the compensation paid to the  
8           certified IDR entity with respect to the  
9           settlement or determination; and

10           “(ix) any other information specified  
11           by the Secretary.

12           “(C) IDR ENTITY REQUIREMENTS.—For  
13           2022 and each subsequent year, an IDR entity,  
14           as a condition of certification as an IDR entity,  
15           shall submit to the Secretary such information  
16           as the Secretary determines necessary for the  
17           Secretary to carry out the provisions of this  
18           paragraph.

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

1           “(8) ADMINISTRATIVE FEE.—

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

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

18                   “(9) WAIVER AUTHORITY.—The Secretary may  
19           modify any deadline or other timing requirement  
20           specified under this subsection (other than the es-  
21           tablishment date for the IDR process under para-  
22           graph (2)(A) and other than under paragraph (6))  
23           in cases of extenuating circumstances, as specified  
24           by the Secretary, or to ensure that all claims that  
25           occur during a 90-day period applied through para-

1 graph (5)(D), but with respect to which a notifica-  
2 tion is not permitted by reason of such paragraph to  
3 be submitted under paragraph (1)(B) during such  
4 period, are eligible for the IDR process.

5 “(c) DEFINITIONS.—For purposes of this section:

6 “(1) AIR AMBULANCE SERVICE.—The term ‘air  
7 ambulance service’ means medical transport by heli-  
8 copter or airplane for patients.

9 “(2) QUALIFYING PAYMENT AMOUNT.—The  
10 term ‘qualifying payment amount’ has the meaning  
11 given such term in section 2799A–1(a)(3).

12 “(3) NONPARTICIPATING PROVIDER.—The term  
13 ‘nonparticipating provider’ has the meaning given  
14 such term in section 2799A–1(a)(3).”.

15 (2) ERISA AMENDMENT.—

16 (A) IN GENERAL.—Subpart B of part 7 of  
17 title I of the Employee Retirement Income Se-  
18 curity Act of 1974 (29 U.S.C. 1185 et seq.), as  
19 amended by section 102(b) and further amend-  
20 ed by the previous provisions of this title, is fur-  
21 ther amended by inserting after section 716 the  
22 following:

23 **“SEC. 717. ENDING SURPRISE AIR AMBULANCE BILLS.**

24 “(a) IN GENERAL.—In the case of a participant or  
25 beneficiary who is in a group health plan or group health

1 insurance coverage offered by a health insurance issuer  
2 and who receives air ambulance services from a nonpartici-  
3 pating provider (as defined in section 716(a)(3)(G)) with  
4 respect to such plan or coverage, if such services would  
5 be covered if provided by a participating provider (as de-  
6 fined in such section) with respect to such plan or cov-  
7 erage—

8           “(1) the cost-sharing requirement with respect  
9           to such services shall be the same requirement that  
10           would apply if such services were provided by such  
11           a participating provider, and any coinsurance or de-  
12           ductible shall be based on rates that would apply for  
13           such services if they were furnished by such a par-  
14           ticipating provider;

15           “(2) such cost-sharing amounts shall be count-  
16           ed towards the in-network deductible and in-network  
17           out-of-pocket maximum amount under the plan or  
18           coverage for the plan year (and such in-network de-  
19           ductible shall be applied) with respect to such items  
20           and services so furnished in the same manner as if  
21           such cost-sharing payments were with respect to  
22           items and services furnished by a participating pro-  
23           vider; and

24           “(3) the group health plan or health insurance  
25           issuer, respectively, shall—

1           “(A) not later than 30 calendar days after  
2           the bill for such services is transmitted by such  
3           provider, send to the provider, an initial pay-  
4           ment or notice of denial of payment; and

5           “(B) pay a total plan or coverage payment,  
6           in accordance with, if applicable, subsection  
7           (b)(6), directly to such provider furnishing such  
8           services to such participant, beneficiary, or en-  
9           rollee that is, with application of any initial  
10          payment under subparagraph (A), equal to the  
11          amount by which the out-of-network rate (as  
12          defined in section 716(a)(3)(K)) for such serv-  
13          ices and year involved exceeds the cost-sharing  
14          amount imposed under the plan or coverage, re-  
15          spectively, for such services (as determined in  
16          accordance with paragraphs (1) and (2)).

17          “(b) DETERMINATION OF OUT-OF-NETWORK RATES  
18          TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE  
19          RESOLUTION PROCESS.—

20                 “(1) DETERMINATION THROUGH OPEN NEGO-  
21          TIATION.—

22                 “(A) IN GENERAL.—With respect to air  
23          ambulance services furnished in a year by a  
24          nonparticipating provider, with respect to a  
25          group health plan or health insurance issuer of-

1           fering group health insurance coverage, and for  
2           which a payment is required to be made by the  
3           plan or coverage pursuant to subsection (a)(3),  
4           the provider or plan or coverage may, during  
5           the 30-day period beginning on the day the pro-  
6           vider receives a payment or a statement of de-  
7           nial of payment from the plan or coverage re-  
8           garding a claim for payment for such service,  
9           initiate open negotiations under this paragraph  
10          between such provider and plan or coverage for  
11          purposes of determining, during the open nego-  
12          tiation period, an amount agreed on by such  
13          provider, and such plan or coverage for pay-  
14          ment (including any cost-sharing) for such serv-  
15          ice. For purposes of this subsection, the open  
16          negotiation period, with respect to air ambu-  
17          lance services, is the 30-day period beginning  
18          on the date of initiation of the negotiations with  
19          respect to such services.

20               “(B) ACCESSING INDEPENDENT DISPUTE  
21               RESOLUTION PROCESS IN CASE OF FAILED NE-  
22               GOTIATIONS.—In the case of open negotiations  
23               pursuant to subparagraph (A), with respect to  
24               air ambulance services, that do not result in a  
25               determination of an amount of payment for

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

23               “(2) INDEPENDENT DISPUTE RESOLUTION  
24          PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-  
25          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 a determination for  
4 qualified IDR ambulance services, the certified  
5 IDR entity shall—

6           “(i) taking into account the consider-  
7 ations specified in subparagraph (C), select  
8 one of the offers submitted under subpara-  
9 graph (B) to be the amount of payment for  
10 such services determined under this sub-  
11 section for purposes of subsection (a)(3);  
12 and

13           “(ii) notify the provider or facility and  
14 the group health plan or health insurance  
15 issuer offering group health insurance cov-  
16 erage party to such determination of the  
17 offer selected under clause (i).

18           “(B) SUBMISSION OF OFFERS.—Not later  
19 than 10 days after the date of selection of the  
20 certified IDR entity with respect to a deter-  
21 mination for qualified IDR air ambulance serv-  
22 ices, the provider and the group health plan or  
23 health insurance issuer offering group health  
24 insurance coverage party to such determina-  
25 tion—

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1           “(i) shall each submit to the certified  
2           IDR entity with respect to such determina-  
3           tion—

4                   “(I) an offer for a payment  
5                   amount for such services furnished by  
6                   such provider; and

7                   “(II) such information as re-  
8                   quested by the certified IDR entity re-  
9                   lating to such offer; and

10           “(ii) may each submit to the certified  
11           IDR entity with respect to such determina-  
12           tion any information relating to such offer  
13           submitted by either party, including infor-  
14           mation relating to any circumstance de-  
15           scribed in subparagraph (C)(ii).

16           “(C) CONSIDERATIONS IN DETERMINA-  
17           TION.—

18                   “(i) IN GENERAL.—In determining  
19                   which offer is the payment to be applied  
20                   pursuant to this paragraph, the certified  
21                   IDR entity, with respect to the determina-  
22                   tion for a qualified IDR air ambulance  
23                   service shall consider—

24                           “(I) the qualifying payment  
25                           amounts (as defined in section

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1 716(a)(3)(E)) for the applicable year  
2 for items and services that are com-  
3 parable to the qualified IDR air am-  
4 bulance service and that are furnished  
5 in the same geographic region (as de-  
6 fined by the Secretary for purposes of  
7 such subsection) as such qualified  
8 IDR air ambulance service; and

9 “(II) subject to clause (iii), infor-  
10 mation on any circumstance described  
11 in clause (ii), such information as re-  
12 quested in subparagraph (B)(i)(II),  
13 and any additional information pro-  
14 vided in subparagraph (B)(ii).

15 “(ii) ADDITIONAL CIRCUMSTANCES.—  
16 For purposes of clause (i)(II), the cir-  
17 cumstances described in this clause are,  
18 with respect to air ambulance services in-  
19 cluded in the notification submitted under  
20 paragraph (1)(B) of a nonparticipating  
21 provider, group health plan, or health in-  
22 surance issuer the following:

23 “(I) The quality and outcomes  
24 measurements of the provider that  
25 furnished such services.

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1           “(II) The acuity of the individual  
2           receiving such services or the com-  
3           plexity of furnishing such services to  
4           such individual.

5           “(III) The training, experience,  
6           and quality of the medical personnel  
7           that furnished such services.

8           “(IV) Ambulance vehicle type, in-  
9           cluding the clinical capability level of  
10          such vehicle.

11          “(V) Population density of the  
12          pick up location (such as urban, sub-  
13          urban, rural, or frontier).

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

23          “(iii) PROHIBITION ON CONSIDER-  
24          ATION OF CERTAIN FACTORS.—In deter-  
25          mining which offer is the payment amount

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1 to be applied with respect to qualified IDR  
2 air ambulance services furnished by a pro-  
3 vider, the certified IDR entity with respect  
4 to such determination shall not consider  
5 usual and customary charges, the amount  
6 that would have been billed by such pro-  
7 vider with respect to such services had the  
8 provisions of section 2799B-5 of the Pub-  
9 lic Health Service Act not applied, or the  
10 payment or reimbursement rate for such  
11 services furnished by such provider payable  
12 by a public payor, including under the  
13 Medicare program under title XVIII of the  
14 Social Security Act, under the Medicaid  
15 program under title XIX of such Act,  
16 under the Children’s Health Insurance  
17 Program under title XXI of such Act,  
18 under the TRICARE program under chap-  
19 ter 55 of title 10, United States Code, or  
20 under chapter 17 of title 38, United States  
21 Code.

22 “(D) EFFECTS OF DETERMINATION.—The  
23 provisions of section 716(c)(5)(E)) shall apply  
24 with respect to a determination of a certified  
25 IDR entity under subparagraph (A), the notifi-



1 cation submitted with respect to such deter-  
2 mination, the services with respect to such noti-  
3 fication, and the parties to such notification in  
4 the same manner as such provisions apply with  
5 respect to a determination of a certified IDR  
6 entity under section 716(c)(5)(E), the notifica-  
7 tion submitted with respect to such determina-  
8 tion, the items and services with respect to such  
9 notification, and the parties to such notifica-  
10 tion.

11 “(E) COSTS OF INDEPENDENT DISPUTE  
12 RESOLUTION PROCESS.—The provisions of sec-  
13 tion 716(c)(5)(F) shall apply to a notification  
14 made under this subsection, the parties to such  
15 notification, and a determination under sub-  
16 paragraph (A) in the same manner and to the  
17 same extent such provisions apply to a notifica-  
18 tion under section 716(c), the parties to such  
19 notification and a determination made under  
20 section 716(c)(5)(A).

21 “(6) TIMING OF PAYMENT.—The total plan or  
22 coverage payment required pursuant to subsection  
23 (a)(3), with respect to qualified IDR air ambulance  
24 services for which a determination is made under  
25 paragraph (5)(A) or with respect to air ambulance

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1 services for which a payment amount is determined  
2 under open negotiations under paragraph (1), shall  
3 be made directly to the nonparticipating provider not  
4 later than 30 days after the date on which such de-  
5 termination is made.

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

8 “(A) IN GENERAL.—For each calendar  
9 quarter in 2022 and each calendar quarter in a  
10 subsequent year, the Secretary shall publish on  
11 the public website of the Department of  
12 Labor—

13 “(i) the number of notifications sub-  
14 mitted under the IDR process during such  
15 calendar quarter;

16 “(ii) the number of such notifications  
17 with respect to which a final determination  
18 was made under paragraph (5)(A);

19 “(iii) the information described in  
20 subparagraph (B) with respect to each no-  
21 tification with respect to which such a de-  
22 termination was so made.

23 “(iv) the number of times the pay-  
24 ment amount determined (or agreed to)

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1 under this subsection exceeds the quali-  
2 fying payment amount;

3 “(v) the amount of expenditures made  
4 by the Secretary during such calendar  
5 quarter to carry out the IDR process;

6 “(vi) the total amount of fees paid  
7 under paragraph (8) during such calendar  
8 quarter; and

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

13 “(B) INFORMATION WITH RESPECT TO RE-  
14 QUESTS.—For purposes of subparagraph (A),  
15 the information described in this subparagraph  
16 is, with respect to a notification under the IDR  
17 process of a nonparticipating provider, group  
18 health plan, or health insurance issuer offering  
19 group health insurance coverage—

20 “(i) a description of each air ambu-  
21 lance service included in such notification;

22 “(ii) the geography in which the serv-  
23 ices included in such notification were pro-  
24 vided;

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1 “(iii) the amount of the offer sub-  
2 mitted under paragraph (2) by the group  
3 health plan or health insurance issuer (as  
4 applicable) and by the nonparticipating  
5 provider expressed as a percentage of the  
6 qualifying payment 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 and the amount  
12 of such offer so selected expressed as a  
13 percentage of the qualifying payment  
14 amount;

15 “(v) ambulance vehicle type, including  
16 the clinical capability level of such vehicle;

17 “(vi) the identity of the group health  
18 plan or health insurance issuer or air am-  
19 bulance provider with respect to such noti-  
20 fication;

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

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

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1                   “(ix) any other information specified  
2                   by the Secretary.

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

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

17                  “(8) ADMINISTRATIVE FEE.—

18                  “(A) IN GENERAL.—Each party to a deter-  
19                  mination under paragraph (5) to which an enti-  
20                  ty is selected under paragraph (4) in a year  
21                  shall pay to the Secretary, at such time and in  
22                  such manner as specified by the Secretary, a  
23                  fee for participating in the IDR process with re-  
24                  spect to such determination in an amount de-  
25                  scribed in subparagraph (B) for such year.

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

9           “(9) WAIVER AUTHORITY.—The Secretary may  
10          modify any deadline or other timing requirement  
11          specified under this subsection (other than the es-  
12          tablishment date for the IDR process under para-  
13          graph (2)(A) and other than under paragraph (6))  
14          in cases of extenuating circumstances, as specified  
15          by the Secretary, or to ensure that all claims that  
16          occur during a 90-day period applied through para-  
17          graph (5)(D), but with respect to which a notifica-  
18          tion is not permitted by reason of such paragraph to  
19          be submitted under paragraph (1)(B) during such  
20          period, are eligible for the IDR process.

21          “(c) DEFINITION.—For purposes of this section:

22               “(1) AIR AMBULANCE SERVICES.—The term  
23               ‘air ambulance service’ means medical transport by  
24               helicopter or airplane for patients.

1           “(2) QUALIFYING PAYMENT AMOUNT.—The  
2 term ‘qualifying payment amount’ has the meaning  
3 given such term in section 716(a)(3).

4           “(3) NONPARTICIPATING PROVIDER.—The term  
5 ‘nonparticipating provider’ has the meaning given  
6 such term in section 716(a)(3).”.

7           (3) IRC AMENDMENTS.—

8           (A) IN GENERAL.—Subchapter B of chap-  
9 ter 100 of the Internal Revenue Code of 1986,  
10 as amended by section 102(c) and further  
11 amended by the previous provisions of this title,  
12 is further amended by inserting after section  
13 9816 the following:

14 **“SEC. 9817. ENDING SURPRISE AIR AMBULANCE BILLS.**

15           “(a) IN GENERAL.—In the case of a participant or  
16 beneficiary in a group health plan who receives air ambu-  
17 lance services from a nonparticipating provider (as defined  
18 in section 9816(a)(3)(G)) with respect to such plan, if  
19 such services would be covered if provided by a partici-  
20 pating provider (as defined in such section) with respect  
21 to such plan—

22           “(1) the cost-sharing requirement with respect  
23 to such services shall be the same requirement that  
24 would apply if such services were provided by such  
25 a participating provider, and any coinsurance or de-

1 ductible shall be based on rates that would apply for  
2 such services if they were furnished by such a par-  
3 ticipating provider;

4 “(2) such cost-sharing amounts shall be count-  
5 ed towards the in-network deductible and in-network  
6 out-of-pocket maximum amount under the plan for  
7 the plan year (and such in-network deductible shall  
8 be applied) with respect to such items and services  
9 so furnished in the same manner as if such cost-  
10 sharing payments were with respect to items and  
11 services furnished by a participating provider; and

12 “(3) the group health plan shall—

13 “(A) not later than 30 calendar days after  
14 the bill for such services is transmitted by such  
15 provider, send to the provider, an initial pay-  
16 ment or notice of denial of payment; and

17 “(B) pay a total plan payment, in accord-  
18 ance with, if applicable, subsection (b)(6), di-  
19 rectly to such provider furnishing such services  
20 to such participant, beneficiary, or enrollee that  
21 is, with application of any initial payment under  
22 subparagraph (A), equal to the amount by  
23 which the out-of-network rate (as defined in  
24 section 9816(a)(3)(K)) for such services and  
25 year involved exceeds the cost-sharing amount



1           imposed under the plan for such services (as de-  
2           termined in accordance with paragraphs (1)  
3           and (2)).

4           “(b) DETERMINATION OF OUT-OF-NETWORK RATES  
5 TO BE PAID BY HEALTH PLANS; INDEPENDENT DISPUTE  
6 RESOLUTION PROCESS.—

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

9           “(A) IN GENERAL.—With respect to air  
10 ambulance services furnished in a year by a  
11 nonparticipating provider, with respect to a  
12 group health plan, and for which a payment is  
13 required to be made by the plan pursuant to  
14 subsection (a)(3), the provider or plan may,  
15 during the 30-day period beginning on the day  
16 the provider receives a payment or a statement  
17 of denial of payment from the plan regarding a  
18 claim for payment for such service, initiate open  
19 negotiations under this paragraph between such  
20 provider and plan for purposes of determining,  
21 during the open negotiation period, an amount  
22 agreed on by such provider, and such plan for  
23 payment (including any cost-sharing) for such  
24 service. For purposes of this subsection, the  
25 open negotiation period, with respect to air am-

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1 balance services, is the 30-day period beginning  
2 on the date of initiation of the negotiations with  
3 respect to such services.

4 “(B) ACCESSING INDEPENDENT DISPUTE  
5 RESOLUTION PROCESS IN CASE OF FAILED NE-  
6 GOTIATIONS.—In the case of open negotiations  
7 pursuant to subparagraph (A), with respect to  
8 air ambulance services, that do not result in a  
9 determination of an amount of payment for  
10 such services by the last day of the open nego-  
11 tiation period described in such subparagraph  
12 with respect to such services, the provider or  
13 group health plan that was party to such nego-  
14 tiations may, during the 4-day period beginning  
15 on the day after such open negotiation period,  
16 initiate the independent dispute resolution proc-  
17 ess under paragraph (2) with respect to such  
18 services. The independent dispute resolution  
19 process shall be initiated by a party pursuant to  
20 the previous sentence by submission to the  
21 other party and to the Secretary of a notifica-  
22 tion (containing such information as specified  
23 by the Secretary) and for purposes of this sub-  
24 section, the date of initiation of such process  
25 shall be the date of such submission or such

1 other date specified by the Secretary pursuant  
2 to regulations that is not later than the date of  
3 receipt of such notification by both the other  
4 party and the Secretary.

5 “(2) INDEPENDENT DISPUTE RESOLUTION  
6 PROCESS AVAILABLE IN CASE OF FAILED OPEN NE-  
7 GOTIATIONS.—

8 “(A) ESTABLISHMENT.—Not later than 1  
9 year after the date of the enactment of this  
10 subsection, the Secretary, jointly with the Sec-  
11 retary of Health and Human Services and the  
12 Secretary of Labor, shall establish by regulation  
13 one independent dispute resolution process (re-  
14 ferred to in this subsection as the ‘IDR proc-  
15 ess’) under which, in the case of air ambulance  
16 services with respect to which a provider or  
17 group health plan submits a notification under  
18 paragraph (1)(B) (in this subsection referred to  
19 as a ‘qualified IDR air ambulance services’), a  
20 certified IDR entity under paragraph (4) deter-  
21 mines, subject to subparagraph (B) and in ac-  
22 cordance with the succeeding provisions of this  
23 subsection, the amount of payment under the  
24 plan for such services furnished by such pro-  
25 vider.

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          9816(a)(3)(K)(ii) as the amount agreed to by  
12          such parties for such services. In the case of an  
13          agreement described in the previous sentence,  
14          the independent dispute resolution process shall  
15          provide for a method to determine how to allo-  
16          cate between the parties to such determination  
17          the payment of the compensation of the entity  
18          selected with respect to such determination.

19          “(C) CLARIFICATION.—A nonparticipating  
20          provider may not, with respect to an item or  
21          service furnished by such provider, submit a no-  
22          tification under paragraph (1)(B) if such pro-  
23          vider is exempt from the requirement under  
24          subsection (a) of section 2799B–2 of the Public  
25          Health Service Act with respect to such item or

1 service pursuant to subsection (b) of such sec-  
2 tion.

3 “(3) TREATMENT OF BATCHING OF SERV-  
4 ICES.—The provisions of section 9816(c)(3) shall  
5 apply with respect to a notification submitted under  
6 this subsection with respect to air ambulance serv-  
7 ices in the same manner and to the same extent  
8 such provisions apply with respect to a notification  
9 submitted under section 9816(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 9816(c)(4).

15 “(B) SELECTION OF CERTIFIED IDR ENTI-  
16 TY.—The provisions of subparagraph (F) of  
17 section 9816(c)(4) shall apply with respect to  
18 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 9816(c) of an item or service. An entity selected  
2 pursuant to the previous sentence to make a de-  
3 termination described in such sentence shall be  
4 referred to in this subsection as the ‘certified  
5 IDR entity’ with respect to such determination.

6 “(5) PAYMENT DETERMINATION.—

7 “(A) IN GENERAL.—Not later than 30  
8 days after the date of selection of the certified  
9 IDR entity with respect to a determination for  
10 qualified IDR ambulance services, the certified  
11 IDR entity 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 services determined under this sub-  
17 section for purposes of subsection (a)(3);  
18 and

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

23 “(B) SUBMISSION OF OFFERS.—Not later  
24 than 10 days after the date of selection of the  
25 certified IDR entity with respect to a deter-

1           mination for qualified IDR air ambulance serv-  
2           ices, the provider and the group health plan  
3           party to such determination—

4                   “(i) shall each submit to the certified  
5           IDR entity with respect to such determina-  
6           tion—

7                           “(I) an offer for a payment  
8                           amount for such services furnished by  
9                           such provider; and

10                           “(II) such information as re-  
11                           quested by the certified IDR entity re-  
12                           lating to such offer; and

13                           “(ii) may each submit to the certified  
14           IDR entity with respect to such determina-  
15           tion any information relating to such offer  
16           submitted by either party, including infor-  
17           mation relating to any circumstance de-  
18           scribed in subparagraph (C)(ii).

19                           “(C) CONSIDERATIONS IN DETERMINA-  
20           TION.—

21                           “(i) IN GENERAL.—In determining  
22                           which offer is the payment to be applied  
23                           pursuant to this paragraph, the certified  
24                           IDR entity, with respect to the determina-

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1                   tion for a qualified IDR air ambulance  
2                   service shall consider—

3                   “(I) the qualifying payment  
4                   amounts (as defined in section  
5                   9816(a)(3)(E)) for the applicable year  
6                   for items or 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                  “(II) subject to clause (iii), infor-  
14                  mation on any circumstance described  
15                  in clause (ii), such information as re-  
16                  quested in subparagraph (B)(i)(II),  
17                  and any additional information pro-  
18                  vided in subparagraph (B)(ii).

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)(B) of a nonparticipating



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1 provider, or group health plan the fol-  
2 lowing:

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 to enter into network agree-  
24 ments and, if applicable, contracted

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1 rates between the provider and the  
2 plan during the previous 4 plan years.

3 “(iii) PROHIBITION ON CONSIDER-  
4 ATION OF CERTAIN FACTORS.—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, the amount  
11 that would have been billed by such pro-  
12 vider with respect to such services had the  
13 provisions of section 2799B–5 of the Pub-  
14 lic Health Service Act not applied, or the  
15 payment or reimbursement rate for such  
16 services furnished by such provider payable  
17 by a public payor, including under the  
18 Medicare program under title XVIII of the  
19 Social Security Act, under the Medicaid  
20 program under title XIX of such Act,  
21 under the Children’s Health Insurance  
22 Program under title XXI of such Act,  
23 under the TRICARE program under chap-  
24 ter 55 of title 10, United States Code, or

1 under chapter 17 of title 38, United States  
2 Code.

3 “(D) EFFECTS OF DETERMINATION.—The  
4 provisions of section 9816(c)(5)(E)) shall apply  
5 with respect to a determination of a certified  
6 IDR entity under subparagraph (A), the notifi-  
7 cation submitted with respect to such deter-  
8 mination, the services with respect to such noti-  
9 fication, and the parties to such notification in  
10 the same manner as such provisions apply with  
11 respect to a determination of a certified IDR  
12 entity under section 9816(c)(5)(E), the notifica-  
13 tion submitted with respect to such determina-  
14 tion, the items and services with respect to such  
15 notification, and the parties to such notifica-  
16 tion.

17 “(E) COSTS OF INDEPENDENT DISPUTE  
18 RESOLUTION PROCESS.—The provisions of sec-  
19 tion 9816(c)(5)(F) shall apply to a notification  
20 made under this subsection, the parties to such  
21 notification, and a determination under sub-  
22 paragraph (A) in the same manner and to the  
23 same extent such provisions apply to a notifica-  
24 tion under section 9816(c), the parties to such

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1 notification and a determination made under  
2 section 9816(e)(5)(A).

3 “(6) TIMING OF PAYMENT.—The total plan  
4 payment required pursuant to subsection (a)(3),  
5 with respect to qualified IDR air ambulance services  
6 for which a determination is made under paragraph  
7 (5)(A) or with respect to air ambulance services for  
8 which a payment amount is determined under open  
9 negotiations under paragraph (1), shall be made di-  
10 rectly to the nonparticipating provider not later than  
11 30 days after the date on which such determination  
12 is made.

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

15 “(A) IN GENERAL.—For each calendar  
16 quarter in 2022 and each calendar quarter in a  
17 subsequent year, the Secretary shall publish on  
18 the public website of the Department of the  
19 Treasury—

20 “(i) the number of notifications sub-  
21 mitted under the IDR process during such  
22 calendar quarter;

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

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1           “(iii) the information described in  
2           subparagraph (B) with respect to each no-  
3           tification with respect to which such a de-  
4           termination was so made.

5           “(iv) the number of times the pay-  
6           ment amount determined (or agreed to)  
7           under this subsection exceeds the quali-  
8           fying payment amount;

9           “(v) the amount of expenditures made  
10          by the Secretary during such calendar  
11          quarter to carry out the IDR process;

12          “(vi) the total amount of fees paid  
13          under paragraph (8) during such calendar  
14          quarter; and

15          “(vii) the total amount of compensa-  
16          tion paid to certified IDR entities under  
17          paragraph (5)(E) during such calendar  
18          quarter.

19          “(B) INFORMATION WITH RESPECT TO RE-  
20          QUESTS.—For purposes of subparagraph (A),  
21          the information described in this subparagraph  
22          is, with respect to a notification under the IDR  
23          process of a nonparticipating provider, or group  
24          health plan—

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1                   “(i) a description of each air ambu-  
2                   lance service included in such notification;

3                   “(ii) the geography in which the serv-  
4                   ices included in such notification were pro-  
5                   vided;

6                   “(iii) the amount of the offer sub-  
7                   mitted under paragraph (2) by the group  
8                   health plan and by the nonparticipating  
9                   provider expressed as a percentage of the  
10                  qualifying payment amount;

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

19                  “(v) ambulance vehicle type, including  
20                  the clinical capability level of such vehicle;

21                  “(vi) the identity of the group health  
22                  plan or health insurance issuer or air am-  
23                  bulance provider with respect to such noti-  
24                  fication;

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1                   “(vii) the length of time in making  
2                   each determination;

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

6                   “(ix) any other information specified  
7                   by the Secretary.

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

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

22                  “(8) ADMINISTRATIVE FEE.—

23                  “(A) IN GENERAL.—Each party to a deter-  
24                  mination under paragraph (5) to which an enti-  
25                  ty is selected under paragraph (4) in a year

1 shall pay to the Secretary, at such time and in  
2 such manner as specified by the Secretary, a  
3 fee for participating in the IDR process with re-  
4 spect to such determination in an amount de-  
5 scribed in subparagraph (B) for such year.

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

14 “(9) WAIVER AUTHORITY.—The Secretary may  
15 modify any deadline or other timing requirement  
16 specified under this subsection (other than the es-  
17 tablishment date for the IDR process under para-  
18 graph (2)(A) and other than under paragraph (6))  
19 in cases of extenuating circumstances, as specified  
20 by the Secretary, or to ensure that all claims that  
21 occur during a 90-day period applied through para-  
22 graph (5)(D), but with respect to which a notifica-  
23 tion is not permitted by reason of such paragraph to  
24 be submitted under paragraph (1)(B) during such  
25 period, are eligible for the IDR process.



1 “(c) DEFINITIONS.—For purposes of this section:

2 “(1) AIR AMBULANCE SERVICES.—The term  
3 ‘air ambulance service’ means medical transport by  
4 helicopter or airplane for patients.

5 “(2) QUALIFYING PAYMENT AMOUNT.—The  
6 term ‘qualifying payment amount’ has the meaning  
7 given such term in section 9816(a)(3).

8 “(3) NONPARTICIPATING PROVIDER.—The term  
9 ‘nonparticipating provider’ has the meaning given  
10 such term in section 9816(a)(3).”.

11 (B) CLERICAL AMENDMENT.—The table of  
12 sections for subchapter B of chapter 100 of the  
13 Internal Revenue Code of 1986, as amended by  
14 section 102(c)(3), is further amended by insert-  
15 ing after the item relating to section 9816 the  
16 following new item:

“Sec. 9817. Ending surprise air ambulance bills.”.

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

20 (b) AIR AMBULANCE PROVIDER BALANCE BILL-  
21 ING.—Part E of title XXVII of the Public Health Service  
22 Act, as added and amended by section 104, is further  
23 amended by adding at the end the following new section:

1 **“SEC. 2799B-5. AIR AMBULANCE SERVICES.**

2 “In the case of a participant, beneficiary, or enrollee  
3 with benefits under a group health plan or group or indi-  
4 vidual health insurance coverage offered by a health insur-  
5 ance issuer and who is furnished in a plan year beginning  
6 on or after January 1, 2022, air ambulance services (for  
7 which benefits are available under such plan or coverage)  
8 from a nonparticipating provider (as defined in section  
9 2799A-1(a)(3)(G)) with respect to such plan or coverage,  
10 such provider shall not bill, and shall not hold liable, such  
11 participant, beneficiary, or enrollee for a payment amount  
12 for such service furnished by such provider that is more  
13 than the cost-sharing amount for such service (as deter-  
14 mined in accordance with paragraphs (1) and (2) of sec-  
15 tion 2799A-2(a), section 717(a) of the Employee Retire-  
16 ment Income Security Act of 1974, or section 9817(a) of  
17 the Internal Revenue Code of 1986, as applicable).”.

18 **SEC. 106. REPORTING REQUIREMENTS REGARDING AIR AM-**  
19 **BULANCE SERVICES.**

20 (a) REPORTING REQUIREMENTS FOR PROVIDERS OF  
21 AIR AMBULANCE SERVICES.—

22 (1) IN GENERAL.—A provider of air ambulance  
23 services shall submit to the Secretary of Health and  
24 Human Services and the Secretary of Transpor-  
25 tation—

1 (A) not later than the date that is 90 days  
2 after the last day of the first calendar year be-  
3 ginning on or after the date on which a final  
4 rule is promulgated pursuant to the rulemaking  
5 described in subsection (d), the information de-  
6 scribed in paragraph (2) with respect to such  
7 plan year; and

8 (B) not later than the date that is 90 days  
9 after the last day of the plan year immediately  
10 succeeding the plan year described in subpara-  
11 graph (A), such information with respect to  
12 such immediately succeeding plan year.

13 (2) INFORMATION DESCRIBED.—For purposes  
14 of paragraph (1), information described in this para-  
15 graph, with respect to a provider of air ambulance  
16 services, is each of the following:

17 (A) Cost data, as determined appropriate  
18 by the Secretary of Health and Human Serv-  
19 ices, in consultation with the Secretary of  
20 Transportation, for air ambulance services fur-  
21 nished by such provider, separated to the max-  
22 imum extent possible by air transportation costs  
23 associated with furnishing such air ambulance  
24 services and costs of medical services and sup-

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1 plies associated with furnishing such air ambu-  
2 lance services.

3 (B) The number and location of all air am-  
4 bulance bases operated by such provider.

5 (C) The number and type of aircraft oper-  
6 ated by such provider.

7 (D) The number of air ambulance trans-  
8 ports, disaggregated by payor mix, including—

9 (i)(I) group health plans;

10 (II) health insurance issuers; and

11 (III) State and Federal Government  
12 payors; and

13 (ii) uninsured individuals.

14 (E) The number of claims of such provider  
15 that have been denied payment by a group  
16 health plan or health insurance issuer and the  
17 reasons for any such denials.

18 (F) The number of emergency and non-  
19 emergency air ambulance transports,  
20 disaggregated by air ambulance base and type  
21 of aircraft.

22 (G) Such other information regarding air  
23 ambulance services as the Secretary of Health  
24 and Human Services may specify.

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1 (b) REPORTING REQUIREMENTS FOR GROUP  
2 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

3 (1) PHSA.—Part D of title XXVII of the Pub-  
4 lic Health Service Act, as added by section  
5 102(a)(1), is amended by adding after section  
6 2799A–7, as added by section 102(a)(2)(A) of this  
7 Act, the following new section:

8 **“SEC. 2799A–8. AIR AMBULANCE REPORT REQUIREMENTS.**

9 “(a) IN GENERAL.—Each group health plan and  
10 health insurance issuer offering group or individual health  
11 insurance coverage shall submit to the Secretary, jointly  
12 with the Secretary of Labor and the Secretary of the  
13 Treasury—

14 “(1) not later than the date that is 90 days  
15 after the last day of the first calendar year begin-  
16 ning on or after the date on which a final rule is  
17 promulgated pursuant to the rulemaking described  
18 in section 106(d) of the No Surprises Act, the infor-  
19 mation described in subsection (b) with respect to  
20 such plan year; and

21 “(2) not later than the date that is 90 days  
22 after the last day of the calendar year immediately  
23 succeeding the plan year described in paragraph (1),  
24 such information with respect to such immediately  
25 succeeding plan year.

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1       “(b) INFORMATION DESCRIBED.—For purposes of  
2 subsection (a), information described in this subsection,  
3 with respect to a group health plan or a health insurance  
4 issuer offering group or individual health insurance cov-  
5 erage, is each of the following:

6           “(1) Claims data for air ambulance services  
7 furnished by providers of such services,  
8 disaggregated by each of the following factors:

9           “(A) Whether such services were furnished  
10 on an emergent or nonemergent basis.

11           “(B) Whether the provider of such services  
12 is part of a hospital-owned or sponsored pro-  
13 gram, municipality-sponsored program, hospital  
14 independent partnership (hybrid) program,  
15 independent program, or tribally operated pro-  
16 gram in Alaska.

17           “(C) Whether the transport in which the  
18 services were furnished originated in a rural or  
19 urban area.

20           “(D) The type of aircraft (such as rotor  
21 transport or fixed wing transport) used to fur-  
22 nish such services.

23           “(E) Whether the provider of such services  
24 has a contract with the plan or issuer, as appli-

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1 cable, to furnish such services under the plan or  
2 coverage, respectively.

3 “(2) Such other information regarding pro-  
4 viders of air ambulance services as the Secretary  
5 may specify.”.

6 (2) ERISA.—

7 (A) IN GENERAL.—Subpart B of part 7 of  
8 title I of the Employee Retirement Income Se-  
9 curity Act of 1974 (29 U.S.C. 1185 et seq.) is  
10 amended by adding after section 722, as added  
11 by section 102(b)(2)(A) of this Act, the fol-  
12 lowing new section:

13 **“SEC. 723. AIR AMBULANCE REPORT REQUIREMENTS.**

14 “(a) IN GENERAL.—Each group health plan and  
15 health insurance issuer offering group health insurance  
16 coverage shall submit to the Secretary, jointly with the  
17 Secretary of Health and Human Services and the Sec-  
18 retary of the Treasury—

19 “(1) not later than the date that is 90 days  
20 after the last day of the first calendar year begin-  
21 ning on or after the date on which a final rule is  
22 promulgated pursuant to the rulemaking described  
23 in section 106(d) of the No Surprises Act, the infor-  
24 mation described in subsection (b) with respect to  
25 such plan 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 calendar year described in paragraph  
4           (1), such information with respect to such imme-  
5           diately 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.



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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. 9823. AIR AMBULANCE REPORT REQUIREMENTS.**

23           “(a) IN GENERAL.—Each group health plan shall  
24 submit to the Secretary, jointly with the Secretary of  
25 Labor and the Secretary of Health and Human Services—

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1           “(1) not later than the date that is 90 days  
2           after the last day of the first calendar year begin-  
3           ning on or after the date on which a final rule is  
4           promulgated pursuant to the rulemaking described  
5           in section 106(d) of the No Surprises Act, the infor-  
6           mation described in subsection (b) with respect to  
7           such plan year; and

8           “(2) not later than the date that is 90 days  
9           after the last day of the calendar year immediately  
10          succeeding 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,

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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

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1 Service Act, of section 723 of the Employee Retirement  
2 ment 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

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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.

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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

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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 and the Secretary of Transportation, shall es-  
18       tablish an Advisory Committee on Air Ambulance  
19       Quality and Patient Safety (referred to in this sub-  
20       section as the “Committee”) for the purpose of re-  
21       viewing options to establish quality, patient safety,  
22       and clinical capability standards for each clinical ca-  
23       pability level of air ambulances.

24           (2) MEMBERSHIP.—The Committee shall be  
25       composed of the following members:

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1 (A) The Secretary of Health and Human  
2 Services, or a designee of the Secretary, who  
3 shall serve as the Chair of the Committee.

4 (B) The Secretary of Transportation, or a  
5 designee of the Secretary.

6 (C) One representative, to be appointed by  
7 the Secretary of Health and Human Services,  
8 of each of the following:

9 (i) State health insurance regulators.

10 (ii) Health care providers.

11 (iii) Group health plans and health in-  
12 surance issuers offering group or indi-  
13 vidual health insurance coverage.

14 (iv) Patient advocacy groups.

15 (v) Accrediting bodies with experience  
16 in quality measures.

17 (D) Three representatives of the air ambu-  
18 lance industry, to be appointed by the Secretary  
19 of Transportation.

20 (E) Additional three representatives not  
21 covered under subparagraphs (A) through (D),  
22 as determined necessary and appropriate by the  
23 Secretary of Health and Human Services and  
24 Secretary of Transportation.

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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 or beneficiaries in the plan or coverage  
24 the following:

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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 or  
22 beneficiaries 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 **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



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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

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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 2799B–2(b)(2) of  
15 the Public Health Service Act, for which such  
16 plans have no or a limited number of in-net-  
17 work providers; and

18 (4) such other relevant effects of such provi-  
19 sions and amendments.

20 (c) GAO REPORT ON ADEQUACY OF PROVIDER NET-  
21 WORKS.—Not later than January 1, 2023, the Comp-  
22 troller General of the United States shall submit to Con-  
23 gress, and make publicly available, a report on the ade-  
24 quacy of provider networks in group health plans and  
25 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 GENERAL.—In applying the provisions of sec-  
17 tion 2719(b) of the Public Health Service Act (42 U.S.C.  
18 300gg–19(b)) to group health plans and health insurance  
19 issuers offering group or individual health insurance cov-  
20 erage, the Secretary of Health and Human Services, Sec-  
21 retary of Labor, and Secretary of the Treasury, shall re-  
22 quire, beginning not later than January 1, 2022, the ex-  
23 ternal review process described in paragraph (1) of such  
24 section to apply with respect to any adverse determination  
25 by such a plan or issuer under section 2799A-1 or 2799A-

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1 2, section 716 or 717 of the Employee Retirement Income  
2 Security Act of 1974, or section 9816 or 9817 of the In-  
3 ternal Revenue Code of 1986, including with respect to  
4 whether an item or service that is the subject to such a  
5 determination is an item or service to which such respec-  
6 tive section applies.

7 (b) DEFINITIONS.—The terms “group health plan”;  
8 “health insurance issuer”; “group health insurance cov-  
9 erage”, and “individual health insurance coverage” have  
10 the meanings given such terms in section 2791 of the Pub-  
11 lic Health Service Act (42 U.S.C. 300gg–91), section 733  
12 of the Employee Retirement Income Security Act (29  
13 U.S.C. 1191b), and section 9832 of the Internal Revenue  
14 Code, as applicable.

15 **SEC. 111. CONSUMER PROTECTIONS THROUGH HEALTH**  
16 **PLAN REQUIREMENT FOR FAIR AND HONEST**  
17 **ADVANCE COST ESTIMATE.**

18 (a) PHSA AMENDMENT.—Section 2799A–1 of the  
19 Public Health Service Act (42 U.S.C. 300gg–19a), as  
20 added by section 102 and as further amended by the pre-  
21 vious provisions of this title, is further amended by adding  
22 at the end the following new subsection:

23 “(f) ADVANCED EXPLANATION OF BENEFITS.—

24 “(1) IN GENERAL.—For plan years beginning  
25 on or after January 1, 2022, each group health

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1 plan, or a health insurance issuer offering group or  
2 individual health insurance coverage shall, with re-  
3 spect to a notification submitted under section  
4 2799B–6 by a health care provider or health care fa-  
5 cility to the plan or issuer for a participant, bene-  
6 ficiary, or enrollee under plan or coverage scheduled  
7 to receive an item or service from the provider or fa-  
8 cility (or authorized representative of such partici-  
9 pant, beneficiary, or enrollee), not later than 1 busi-  
10 ness day (or, in the case such item or service was  
11 so scheduled at least 10 business days before such  
12 item or service is to be furnished (or in the case of  
13 a request made to such plan or coverage by such  
14 participant, beneficiary, or enrollee), 3 business  
15 days) after the date on which the plan or coverage  
16 receives such notification (or such request), provide  
17 to the participant, beneficiary, or enrollee (through  
18 mail or electronic means, as requested by the partici-  
19 pant, beneficiary, or enrollee) a notification (in clear  
20 and understandable language) including the fol-  
21 lowing:

22 “(A) Whether or not the provider or facil-  
23 ity is a participating provider or a participating  
24 facility with respect to the plan or coverage

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1 with respect to the furnishing of such item or  
2 service and—

3 “(i) in the case the provider or facility  
4 is a participating provider or facility with  
5 respect to the plan or coverage with re-  
6 spect to the furnishing of such item or  
7 service, the contracted rate under such  
8 plan or coverage for such item or service  
9 (based on the billing and diagnostic codes  
10 provided by such provider or facility); and

11 “(ii) in the case the provider or facil-  
12 ity is a nonparticipating provider or facility  
13 with respect to such plan or coverage, a  
14 description of how such individual may ob-  
15 tain information on providers and facilities  
16 that, with respect to such plan or coverage,  
17 are participating providers and facilities, if  
18 any.

19 “(B) The good faith estimate included in  
20 the notification received from the provider or  
21 facility (if applicable) based on such codes.

22 “(C) A good faith estimate of the amount  
23 the plan or coverage is responsible for paying  
24 for items and services included in the estimate  
25 described in subparagraph (B).

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1           “(D) A good faith estimate of the amount  
2           of any cost-sharing for which the participant,  
3           beneficiary, or enrollee would be responsible for  
4           such item or service (as of the date of such no-  
5           tification).

6           “(E) A good faith estimate of the amount  
7           that the participant, beneficiary, or enrollee has  
8           incurred toward meeting the limit of the finan-  
9           cial responsibility (including with respect to  
10          deductibles and out-of-pocket maximums) under  
11          the plan or coverage (as of the date of such no-  
12          tification).

13          “(F) In the case such item or service is  
14          subject to a medical management technique (in-  
15          cluding concurrent review, prior authorization,  
16          and step-therapy or fail-first protocols) for cov-  
17          erage under the plan or coverage, a disclaimer  
18          that coverage for such item or service is subject  
19          to such medical management technique.

20          “(G) A disclaimer that the information  
21          provided in the notification is only an estimate  
22          based on the items and services reasonably ex-  
23          pected, at the time of scheduling (or requesting)  
24          the item or service, to be furnished and is sub-  
25          ject to change.



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1           “(H) Any other information or disclaimer  
2           the plan or coverage determines appropriate  
3           that is consistent with information and dis-  
4           claimers required under this section.

5           “(2) AUTHORITY TO MODIFY TIMING REQUIRE-  
6           MENTS IN THE CASE OF SPECIFIED ITEMS AND  
7           SERVICES.—

8           “(A) IN GENERAL.—In the case of a par-  
9           ticipant, beneficiary, or enrollee scheduled to re-  
10          ceive an item or service that is a specified item  
11          or service (as defined in subparagraph (B)), the  
12          Secretary may modify any timing requirements  
13          relating to the provision of the notification de-  
14          scribed in paragraph (1) to such participant,  
15          beneficiary, or enrollee with respect to such  
16          item or service. Any modification made by the  
17          Secretary pursuant to the previous sentence  
18          may not result in the provision of such notifica-  
19          tion after such participant, beneficiary, or en-  
20          rollee has been furnished such item or service.

21          “(B) SPECIFIED ITEM OR SERVICE DE-  
22          FINED.—For purposes of subparagraph (A), the  
23          term ‘specified item or service’ means an item  
24          or service that has low utilization or significant  
25          variation in costs (such as when furnished as

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1 part of a complex treatment), as specified by  
2 the Secretary.”.

3 (b) IRC AMENDMENTS.—Section 9816 of the Inter-  
4 nal Revenue Code of 1986, as added by section 102 and  
5 further amended by the previous provisions of this title,  
6 is further amended by inserting after subsection (e) the  
7 following new subsection:

8 “(f) ADVANCED EXPLANATION OF BENEFITS.—

9 “(1) IN GENERAL.—For plan years beginning  
10 on or after January 1, 2022, each group health plan  
11 shall, with respect to a notification submitted under  
12 section 2799B–6 of the Public Health Service Act by  
13 a health care provider or health care facility to the  
14 plan for a participant or beneficiary under plan  
15 scheduled to receive an item or service from the pro-  
16 vider or facility (or authorized representative of such  
17 participant or beneficiary), not later than 1 business  
18 day (or, in the case such item or service was so  
19 scheduled at least 10 business days before such item  
20 or service is to be furnished (or in the case of a re-  
21 quest made to such plan or coverage by such partici-  
22 pant or beneficiary), 3 business days) after the date  
23 on which the plan receives such notification (or such  
24 request), provide to the participant or beneficiary  
25 (through mail or electronic means, as requested by

1 the participant or beneficiary) a notification (in clear  
2 and understandable language) including the fol-  
3 lowing:

4 “(A) Whether or not the provider or facil-  
5 ity is a participating provider or a participating  
6 facility with respect to the plan with respect to  
7 the furnishing of such item or service and—

8 “(i) in the case the provider or facility  
9 is a participating provider or facility with  
10 respect to the plan or coverage with re-  
11 spect to the furnishing of such item or  
12 service, the contracted rate under such  
13 plan for such item or service (based on the  
14 billing and diagnostic codes provided by  
15 such provider or facility); and

16 “(ii) in the case the provider or facil-  
17 ity is a nonparticipating provider or facility  
18 with respect to such plan, a description of  
19 how such individual may obtain informa-  
20 tion on providers and facilities that, with  
21 respect to such plan, are participating pro-  
22 viders and facilities, if any.

23 “(B) The good faith estimate included in  
24 the notification received from the provider or  
25 facility (if applicable) based on such codes.

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1           “(C) A good faith estimate of the amount  
2           the plan is responsible for paying for items and  
3           services included in the estimate described in  
4           subparagraph (B).

5           “(D) A good faith estimate of the amount  
6           of any cost-sharing for which the participant or  
7           beneficiary would be responsible for such item  
8           or service (as of the date of such notification).

9           “(E) A good faith estimate of the amount  
10          that the participant or beneficiary has incurred  
11          toward meeting the limit of the financial re-  
12          sponsibility (including with respect to  
13          deductibles and out-of-pocket maximums) under  
14          the plan (as of the date of such notification).

15          “(F) In the case such item or service is  
16          subject to a medical management technique (in-  
17          cluding concurrent review, prior authorization,  
18          and step-therapy or fail-first protocols) for cov-  
19          erage under the plan, a disclaimer that coverage  
20          for such item or service is subject to such med-  
21          ical management technique.

22          “(G) A disclaimer that the information  
23          provided in the notification is only an estimate  
24          based on the items and services reasonably ex-  
25          pected, at the time of scheduling (or requesting)

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1 the item or service, to be furnished and is sub-  
2 ject to change.

3 “(H) Any other information or disclaimer  
4 the plan determines appropriate that is con-  
5 sistent with information and disclaimers re-  
6 quired under this section.

7 “(2) AUTHORITY TO MODIFY TIMING REQUIRE-  
8 MENTS IN THE CASE OF SPECIFIED ITEMS AND  
9 SERVICES.—

10 “(A) IN GENERAL.—In the case of a par-  
11 ticipant or beneficiary scheduled to receive an  
12 item or service that is a specified item or serv-  
13 ice (as defined in subparagraph (B)), the Sec-  
14 retary may modify any timing requirements re-  
15 lating to the provision of the notification de-  
16 scribed in paragraph (1) to such participant or  
17 beneficiary with respect to such item or service.  
18 Any modification made by the Secretary pursu-  
19 ant to the previous sentence may not result in  
20 the provision of such notification after such  
21 participant or beneficiary has been furnished  
22 such item or service.

23 “(B) SPECIFIED ITEM OR SERVICE DE-  
24 FINED.—For purposes of subparagraph (A), the  
25 term ‘specified item or service’ means an item

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1 or service that has low utilization or significant  
2 variation in costs (such as when furnished as  
3 part of a complex treatment), as specified by  
4 the Secretary.”.

5 (c) ERISA AMENDMENTS.—Section 716 of the Em-  
6 ployee Retirement Income Security Act of 1974, as added  
7 by section 102 and further amended by the previous  
8 amendments of this title, is further amended by adding  
9 at the end the following new subsection:

10 “(f) ADVANCED EXPLANATION OF BENEFITS.—

11 “(1) IN GENERAL.—For plan years beginning  
12 on or after January 1, 2022, each group health  
13 plan, or a health insurance issuer offering group  
14 health insurance coverage shall, with respect to a no-  
15 tification submitted under section 2799B–6 of the  
16 Public Health Service Act by a health care provider  
17 or health care facility to the plan or issuer for a par-  
18 ticipant or beneficiary under plan or coverage sched-  
19 uled to receive an item or service from the provider  
20 or facility (or authorized representative of such par-  
21 ticipant or beneficiary), not later than 1 business  
22 day (or, in the case such item or service was so  
23 scheduled at least 10 business days before such item  
24 or service is to be furnished (or in the case of a re-  
25 quest made to such plan or coverage by such partici-

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1       pant or beneficiary), 3 business days) after the date  
2       on which the plan or coverage receives such notifica-  
3       tion (or such request), provide to the participant or  
4       beneficiary (through mail or electronic means, as re-  
5       quested by the participant or beneficiary) a notifica-  
6       tion (in clear and understandable language) includ-  
7       ing the following:

8               “(A) Whether or not the provider or facil-  
9               ity is a participating provider or a participating  
10              facility with respect to the plan or coverage  
11              with respect to the furnishing of such item or  
12              service and—

13               “(i) in the case the provider or facility  
14               is a participating provider or facility with  
15               respect to the plan or coverage with re-  
16               spect to the furnishing of such item or  
17               service, the contracted rate under such  
18               plan for such item or service (based on the  
19               billing and diagnostic codes provided by  
20               such provider or facility); and

21               “(ii) in the case the provider or facil-  
22               ity is a nonparticipating provider or facility  
23               with respect to such plan or coverage, a  
24               description of how such individual may ob-  
25               tain information on providers and facilities

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1           that, with respect to such plan or coverage,  
2           are participating providers and facilities, if  
3           any.

4           “(B) The good faith estimate included in  
5           the notification received from the provider or  
6           facility (if applicable) based on such codes.

7           “(C) A good faith estimate of the amount  
8           the health plan is responsible for paying for  
9           items and services included in the estimate de-  
10          scribed in subparagraph (B).

11          “(D) A good faith estimate of the amount  
12          of any cost-sharing for which the participant or  
13          beneficiary would be responsible for such item  
14          or service (as of the date of such notification).

15          “(E) A good faith estimate of the amount  
16          that the participant or beneficiary has incurred  
17          toward meeting the limit of the financial re-  
18          sponsibility (including with respect to  
19          deductibles and out-of-pocket maximums) under  
20          the plan or coverage (as of the date of such no-  
21          tification).

22          “(F) In the case such item or service is  
23          subject to a medical management technique (in-  
24          cluding concurrent review, prior authorization,  
25          and step-therapy or fail-first protocols) for cov-



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1 erage under the plan or coverage, a disclaimer  
2 that coverage for such item or service is subject  
3 to such medical management technique.

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

10 “(H) Any other information or disclaimer  
11 the plan or coverage determines appropriate  
12 that is consistent with information and dis-  
13 claimers required under this section.

14 “(2) AUTHORITY TO MODIFY TIMING REQUIRE-  
15 MENTS IN THE CASE OF SPECIFIED ITEMS AND  
16 SERVICES.—

17 “(A) IN GENERAL.—In the case of a par-  
18 ticipant or beneficiary scheduled to receive an  
19 item or service that is a specified item or serv-  
20 ice (as defined in subparagraph (B)), the Sec-  
21 retary may modify any timing requirements re-  
22 lating to the provision of the notification de-  
23 scribed in paragraph (1) to such participant or  
24 beneficiary with respect to such item or service.  
25 Any modification made by the Secretary pursu-

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1 ant to the previous sentence may not result in  
2 the provision of such notification after such  
3 participant or beneficiary has been furnished  
4 such item or service.

5 “(B) SPECIFIED ITEM OR SERVICE DE-  
6 FINED.—For purposes of subparagraph (A), the  
7 term ‘specified item or service’ means an item  
8 or service that has low utilization or significant  
9 variation in costs (such as when furnished as  
10 part of a complex treatment), as specified by  
11 the Secretary.”.

12 **SEC. 112. PATIENT PROTECTIONS THROUGH TRANS-**  
13 **PARENCY AND PATIENT-PROVIDER DISPUTE**  
14 **RESOLUTION.**

15 Part E of title XXVII of the Public Health Service  
16 Act (42 U.S.C. 300gg et seq.), as added by section 104  
17 and further amended by the previous provisions of this  
18 title, is further amended by adding at the end the fol-  
19 lowing new sections:

20 **“SEC. 2799B-6. PROVISION OF INFORMATION UPON RE-**  
21 **QUEST AND FOR SCHEDULED APPOINT-**  
22 **MENTS.**

23 “Each health care provider and health care facility  
24 shall, beginning January 1, 2022, in the case of an indi-  
25 vidual who schedules an item or service to be furnished

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1 to such individual by such provider or facility at least 3  
2 business days before the date such item or service is to  
3 be so furnished, not later than 1 business day after the  
4 date of such scheduling (or, in the case of such an item  
5 or service scheduled at least 10 business days before the  
6 date such item or service is to be so furnished (or if re-  
7 quested by the individual), not later than 3 business days  
8 after the date of such scheduling or such request)—

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

16           “(2) provide a notification (in clear and under-  
17       standable language) of the good faith estimate of the  
18       expected charges for furnishing such item or service  
19       (including any item or service that is reasonably ex-  
20       pected to be provided in conjunction with such  
21       scheduled item or service and such an item or serv-  
22       ice reasonably expected to be so provided by another  
23       health care provider or health care facility), with the  
24       expected billing and diagnostic codes for any such  
25       item or service, to—

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

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

9   **“SEC. 2799B-7. PATIENT-PROVIDER DISPUTE RESOLUTION.**

10          “(a) IN GENERAL.—Not later than January 1, 2022,  
11          the Secretary shall establish a process (in this subsection  
12          referred to as the ‘patient-provider dispute resolution  
13          process’) under which an uninsured individual, with re-  
14          spect to an item or service, who received, pursuant to sec-  
15          tion 2799B-6, from a health care provider or health care  
16          facility a good-faith estimate of the expected charges for  
17          furnishing such item or service to such individual and who  
18          after being furnished such item or service by such provider  
19          or facility is billed by such provider or facility for such  
20          item or service for charges that are substantially in excess  
21          of such estimate, may seek a determination from a se-  
22          lected dispute resolution entity for the charges to be paid  
23          by such individual (in lieu of such amount so billed) to  
24          such provider or facility for such item or service. For pur-  
25          poses of this subsection, the term ‘uninsured individual’

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1 means, with respect to an item or service, an individual  
2 who does not have benefits for such item or service under  
3 a group health plan, group or individual health insurance  
4 coverage offered by a health insurance issuer, Federal  
5 health care program (as defined in section 1128B(f) of  
6 the Social Security Act), or a health benefits plan under  
7 chapter 89 of title 5, United States Code (or an individual  
8 who has benefits for such item or service under a group  
9 health plan or individual or group health insurance cov-  
10 erage offered by a health insurance issuer, but who does  
11 not seek to have a claim for such item or service submitted  
12 to such plan or coverage).

13       “(b) SELECTION OF ENTITIES.—Under the patient-  
14 provider dispute resolution process, the Secretary shall,  
15 with respect to a determination sought by an individual  
16 under subsection (a), with respect to charges to be paid  
17 by such individual to a health care provider or health care  
18 facility described in such paragraph for an item or service  
19 furnished to such individual by such provider or facility,  
20 provide for—

21               “(1) a method to select to make such deter-  
22 mination an entity certified under subsection (d)  
23 that—

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

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1           “(B) does not have a material familial, fi-  
2           nancial, or professional relationship with such a  
3           party; and

4           “(C) does not otherwise have a conflict of  
5           interest with such a party (as determined by  
6           the Secretary); and

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

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

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

18           “(d) CERTIFICATION.—The Secretary shall establish  
19 or recognize a process to certify entities under this sub-  
20 paragraph. Such process shall ensure that an entity so cer-  
21 tified satisfies at least the criteria specified in section  
22 2799A–1(c).”.

23 **SEC. 113. ENSURING CONTINUITY OF CARE.**

24           (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of  
25 the Public Health Service Act (42 U.S.C. 300gg et seq.)

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1 is amended, in the part D, as added and amended by sec-  
2 tion 102(a) and further amended by the previous provi-  
3 sions of this title, by inserting after section 2799A–2 the  
4 following new section:

5 **“SEC. 2799A-3. CONTINUITY OF CARE.**

6 “(a) ENSURING CONTINUITY OF CARE WITH RE-  
7 SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL  
8 RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER  
9 NETWORK STATUS.—

10 “(1) IN GENERAL.—In the case of an individual  
11 with benefits under a group health plan or group or  
12 individual health insurance coverage offered by a  
13 health insurance issuer and with respect to a health  
14 care provider or facility that has a contractual rela-  
15 tionship with such plan or such issuer (as applica-  
16 ble) for furnishing items and services under such  
17 plan or such coverage, if, while such individual is a  
18 continuing care patient (as defined in subsection (b))  
19 with respect to such provider or facility—

20 “(A) such contractual relationship is termi-  
21 nated (as defined in subsection (b));

22 “(B) benefits provided under such plan or  
23 such health insurance coverage with respect to  
24 such provider or facility are terminated because  
25 of a change in the terms of the participation of

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1 such provider or facility in such plan or cov-  
2 erage; or

3 “(C) a contract between such group health  
4 plan and a health insurance issuer offering  
5 health insurance coverage in connection with  
6 such plan is terminated, resulting in a loss of  
7 benefits provided under such plan with respect  
8 to such provider or facility;

9 the plan or issuer, respectively, shall meet the re-  
10 quirements of paragraph (2) with respect to such in-  
11 dividual.

12 “(2) REQUIREMENTS.—The requirements of  
13 this paragraph are that the plan or issuer—

14 “(A) notify each individual enrolled under  
15 such plan or coverage who is a continuing care  
16 patient with respect to a provider or facility at  
17 the time of a termination described in para-  
18 graph (1) affecting such provider or facility on  
19 a timely basis of such termination and such in-  
20 dividual’s right to elect continued transitional  
21 care from such provider or facility under this  
22 section;

23 “(B) provide such individual with an op-  
24 portunity to notify the plan or issuer of the in-  
25 dividual’s need for transitional care; and



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1           “(C) permit the patient to elect to continue  
2           to have benefits provided under such plan or  
3           such coverage, under the same terms and condi-  
4           tions as would have applied and with respect to  
5           such items and services as would have been cov-  
6           ered under such plan or coverage had such ter-  
7           mination not occurred, with respect to the  
8           course of treatment furnished by such provider  
9           or facility relating to such individual’s status as  
10          a continuing care patient during the period be-  
11          ginning on the date on which the notice under  
12          subparagraph (A) is provided and ending on the  
13          earlier of—

14                   “(i) the 90-day period beginning on  
15                   such date; or

16                   “(ii) the date on which such individual  
17                   is no longer a continuing care patient with  
18                   respect to such provider or facility.

19          “(b) DEFINITIONS.—In this section:

20                   “(1) CONTINUING CARE PATIENT.—The term  
21                   ‘continuing care patient’ means an individual who,  
22                   with respect to a provider or facility—

23                   “(A) is undergoing a course of treatment  
24                   for a serious and complex condition from the  
25                   provider or facility;

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1           “(B) is undergoing a course of institu-  
2           tional or inpatient care from the provider or fa-  
3           cility;

4           “(C) is scheduled to undergo nonelective  
5           surgery from the provider, including receipt of  
6           postoperative care from such provider or facility  
7           with respect to such a surgery;

8           “(D) is pregnant and undergoing a course  
9           of treatment for the pregnancy from the pro-  
10          vider or facility; or

11          “(E) is or was determined to be terminally  
12          ill (as determined under section 1861(dd)(3)(A)  
13          of the Social Security Act) and is receiving  
14          treatment for such illness from such provider or  
15          facility.

16          “(2) SERIOUS AND COMPLEX CONDITION.—The  
17          term ‘serious and complex condition’ means, with re-  
18          spect to a participant, beneficiary, or enrollee under  
19          a group health plan or group or individual health in-  
20          surance coverage—

21                 “(A) in the case of an acute illness, a con-  
22                 dition that is serious enough to require special-  
23                 ized medical treatment to avoid the reasonable  
24                 possibility of death or permanent harm; or

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1           “(B) in the case of a chronic illness or con-  
2           dition, a condition that is—

3                   “(i) is life-threatening, degenerative,  
4                   potentially disabling, or congenital; and

5                   “(ii) requires specialized medical care  
6                   over a prolonged period of time.

7           “(3) TERMINATED.—The term ‘terminated’ in-  
8           cludes, with respect to a contract, the expiration or  
9           nonrenewal of the contract, but does not include a  
10          termination of the contract for failure to meet appli-  
11          cable quality standards or for fraud.”.

12          (b) INTERNAL REVENUE CODE.—

13               (1) IN GENERAL.—Subchapter B of chapter  
14          100 of the Internal Revenue Code of 1986, as  
15          amended by sections 102(c) and 105(a)(3), is fur-  
16          ther amended by inserting after section 9817 the fol-  
17          lowing new section:

18          **“SEC. 9818. CONTINUITY OF CARE.**

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

23                   “(1) IN GENERAL.—In the case of an individual  
24          with benefits under a group health plan and with re-  
25          spect to a health care provider or facility that has

1 a contractual relationship with such plan for fur-  
2 nishing items and services under such plan, if, while  
3 such individual is a continuing care patient (as de-  
4 fined in subsection (b)) with respect to such provider  
5 or facility—

6 “(A) such contractual relationship is termi-  
7 nated (as defined in paragraph (b));

8 “(B) benefits provided under such plan  
9 with respect to such provider or facility are ter-  
10 minated because of a change in the terms of the  
11 participation of such provider or facility in such  
12 plan; or

13 “(C) a contract between such group health  
14 plan and a health insurance issuer offering  
15 health insurance coverage in connection with  
16 such plan is terminated, resulting in a loss of  
17 benefits provided under such plan with respect  
18 to such provider or facility;

19 the plan shall meet the requirements of paragraph  
20 (2) with respect to such individual.

21 “(2) REQUIREMENTS.—The requirements of  
22 this paragraph are that the plan—

23 “(A) notify each individual enrolled under  
24 such plan who is a continuing care patient with  
25 respect to a provider or facility at the time of

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1 a termination described in paragraph (1) affect-  
2 ing such provider on a timely basis of such ter-  
3 mination and such individual's right to elect  
4 continued transitional care from such provider  
5 or facility under this section;

6 “(B) provide such individual with an op-  
7 portunity to notify the plan of the individual's  
8 need for transitional care; and

9 “(C) permit the patient to elect to continue  
10 to have benefits provided under such plan,  
11 under the same terms and conditions as would  
12 have applied and with respect to such items and  
13 services as would have been covered under such  
14 plan had such termination not occurred, with  
15 respect to the course of treatment furnished by  
16 such provider or facility relating to such indi-  
17 vidual's status as a continuing care patient dur-  
18 ing the period beginning on the date on which  
19 the notice under subparagraph (A) is provided  
20 and ending on the earlier of—

21 “(i) the 90-day period beginning on  
22 such date; or

23 “(ii) the date on which such individual  
24 is no longer a continuing care patient with  
25 respect to such provider or facility.

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1 “(b) DEFINITIONS.—In this section:

2 “(1) CONTINUING CARE PATIENT.—The term  
3 ‘continuing care patient’ means an individual who,  
4 with respect to a provider or facility—

5 “(A) is undergoing a course of treatment  
6 for a serious and complex condition from the  
7 provider or facility;

8 “(B) is undergoing a course of institu-  
9 tional or inpatient care from the provider or fa-  
10 cility;

11 “(C) is scheduled to undergo nonelective  
12 surgery from the provider or facility, including  
13 receipt of postoperative care from such provider  
14 or facility with respect to such a surgery;

15 “(D) is pregnant and undergoing a course  
16 of treatment for the pregnancy from the pro-  
17 vider or facility; or

18 “(E) is or was determined to be terminally  
19 ill (as determined under section 1861(dd)(3)(A)  
20 of the Social Security Act) and is receiving  
21 treatment for such illness from such provider or  
22 facility.

23 “(2) SERIOUS AND COMPLEX CONDITION.—The  
24 term ‘serious and complex condition’ means, with re-

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1 spect to a participant or beneficiary under a group  
2 health plan—

3 “(A) in the case of an acute illness, a con-  
4 dition that is serious enough to require special-  
5 ized medical treatment to avoid the reasonable  
6 possibility of death or permanent harm; or

7 “(B) in the case of a chronic illness or con-  
8 dition, a condition that—

9 “(i) is life-threatening, degenerative,  
10 potentially disabling, or congenital; and

11 “(ii) requires specialized medical care  
12 over a prolonged period of time.

13 “(3) TERMINATED.—The term ‘terminated’ in-  
14 cludes, with respect to a contract, the expiration or  
15 nonrenewal of the contract, but does not include a  
16 termination of the contract for failure to meet appli-  
17 cable quality standards or for fraud.”.

18 (2) CLERICAL AMENDMENT.—The table of sec-  
19 tions for such subchapter, as amended by the pre-  
20 vious sections, is further amended by inserting after  
21 the item relating to section 9817 the following new  
22 item:

“Sec. 9818. Continuity of care.”.

23 (c) EMPLOYEE RETIREMENT INCOME SECURITY  
24 ACT.—

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1           (1) IN GENERAL.—Subpart B of part 7 of sub-  
2           title B of title I of the Employee Retirement Income  
3           Security Act of 1974 (29 U.S.C. 1185 et seq.), as  
4           amended by section 102(e) and further amended by  
5           the previous provisions of this title, is further  
6           amended by inserting after section 717 the following  
7           new section:

8           **“SEC. 718. CONTINUITY OF CARE.**

9           “(a) ENSURING CONTINUITY OF CARE WITH RE-  
10          SPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL  
11          RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER  
12          NETWORK STATUS.—

13                 “(1) IN GENERAL.—In the case of an individual  
14                 with benefits under a group health plan or group  
15                 health insurance coverage offered by a health insur-  
16                 ance issuer and with respect to a health care pro-  
17                 vider or facility that has a contractual relationship  
18                 with such plan or such issuer (as applicable) for fur-  
19                 nishing items and services under such plan or such  
20                 coverage, if, while such individual is a continuing  
21                 care patient (as defined in subsection (b)) with re-  
22                 spect to such provider or facility—

23                         “(A) such contractual relationship is termi-  
24                         nated (as defined in paragraph (b));



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1           “(B) benefits provided under such plan or  
2           such health insurance coverage with respect to  
3           such provider or facility are terminated because  
4           of a change in the terms of the participation of  
5           the provider or facility in such plan or coverage;  
6           or

7           “(C) a contract between such group health  
8           plan and a health insurance issuer offering  
9           health insurance coverage in connection with  
10          such plan is terminated, resulting in a loss of  
11          benefits provided under such plan with respect  
12          to such provider or facility;

13          the plan or issuer, respectively, shall meet the re-  
14          quirements of paragraph (2) with respect to such in-  
15          dividual.

16          “(2) REQUIREMENTS.—The requirements of  
17          this paragraph are that the plan or issuer—

18                 “(A) notify each individual enrolled under  
19                 such plan or coverage who is a continuing care  
20                 patient with respect to a provider or facility at  
21                 the time of a termination described in para-  
22                 graph (1) affecting such provider or facility on  
23                 a timely basis of such termination and such in-  
24                 dividual’s right to elect continued transitional

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1 care from such provider or facility under this  
2 section;

3 “(B) provide such individual with an op-  
4 portunity to notify the plan or issuer of the in-  
5 dividual’s need for transitional care; and

6 “(C) permit the patient to elect to continue  
7 to have benefits provided under such plan or  
8 such coverage, under the same terms and condi-  
9 tions as would have applied and with respect to  
10 such items and services as would have been cov-  
11 ered under such plan or coverage had such ter-  
12 mination not occurred, with respect to the  
13 course of treatment furnished by such provider  
14 or facility relating to such individual’s status as  
15 a continuing care patient during the period be-  
16 ginning on the date on which the notice under  
17 subparagraph (A) is provided and ending on the  
18 earlier of—

19 “(i) the 90-day period beginning on  
20 such date; or

21 “(ii) the date on which such individual  
22 is no longer a continuing care patient with  
23 respect to such provider or facility.

24 “(b) DEFINITIONS.—In this section:

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1           “(1) CONTINUING CARE PATIENT.—The term  
2           ‘continuing care patient’ means an individual who,  
3           with respect to a provider or facility—

4                   “(A) is undergoing a course of treatment  
5                   for a serious and complex condition from the  
6                   provider or facility;

7                   “(B) is undergoing a course of institu-  
8                   tional or inpatient care from the provider or fa-  
9                   cility;

10                  “(C) is scheduled to undergo nonelective  
11                  surgery from the provide or facility, including  
12                  receipt of postoperative care from such provider  
13                  or facility with respect to such a surgery;

14                  “(D) is pregnant and undergoing a course  
15                  of treatment for the pregnancy from the pro-  
16                  vider or facility; or

17                  “(E) is or was determined to be terminally  
18                  ill (as determined under section 1861(dd)(3)(A)  
19                  of the Social Security Act) and is receiving  
20                  treatment for such illness from such provider or  
21                  facility.

22           “(2) SERIOUS AND COMPLEX CONDITION.—The  
23           term ‘serious and complex condition’ means, with re-  
24           spect to a participant or beneficiary under a group  
25           health plan or group health insurance coverage—

## 1951

1           “(A) in the case of an acute illness, a con-  
2           dition that is serious enough to require special-  
3           ized medical treatment to avoid the reasonable  
4           possibility of death or permanent harm; or

5           “(B) in the case of a chronic illness or con-  
6           dition, a condition that—

7                   “(i) is life-threatening, degenerative,  
8                   potentially disabling, or congenital; and

9                   “(ii) requires specialized medical care  
10                  over a prolonged period of time.

11           “(3) TERMINATED.—The term ‘terminated’ in-  
12           cludes, with respect to a contract, the expiration or  
13           nonrenewal of the contract, but does not include a  
14           termination of the contract for failure to meet appli-  
15           cable quality standards or for fraud.”.

16           (2) CLERICAL AMENDMENT.—The table of con-  
17           tents in section 1 of the Employee Retirement In-  
18           come Security Act of 1974 is amended by inserting  
19           after the item relating to section 716 the following  
20           new item:

          “Sec. 718. Continuity of care.”.

21           (d) PROVIDER REQUIREMENT.—Part E of title  
22           XXVII of the Public Health Service Act (42 U.S.C. 300gg  
23           et seq.), as added by section 104 and further amended  
24           by the previous provisions of this title, is further amended  
25           by adding at the end the following new section:

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**1 “SEC. 2799B-8. CONTINUITY OF CARE.**

2 “A health care provider or health care facility shall,  
3 in the case of an individual furnished items and services  
4 by such provider or facility for which coverage is provided  
5 under a group health plan or group or individual health  
6 insurance coverage pursuant to section 2799A-3, section  
7 9818 of the Internal Revenue Code of 1986, or section  
8 718 of the Employee Retirement Income Security Act of  
9 1974—

10 “(1) accept payment from such plan or such  
11 issuer (as applicable) (and cost-sharing from such  
12 individual, if applicable, in accordance with sub-  
13 section (a)(2)(C) of such section 2799A-3, 9818, or  
14 718) for such items and services as payment in full  
15 for such items and services; and

16 “(2) continue to adhere to all policies, proce-  
17 dures, and quality standards imposed by such plan  
18 or issuer with respect to such individual and such  
19 items and services in the same manner as if such  
20 termination had not occurred.”.

21 (e) EFFECTIVE DATE.—The amendments made by  
22 subsections (a), (b), and (c) shall apply with respect to  
23 plan years beginning on or after January 1, 2022.

**24 SEC. 114. MAINTENANCE OF PRICE COMPARISON TOOL.**

25 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of  
26 the Public Health Service Act (42 U.S.C. 300gg et seq.)

1 is amended, in part D, as added and amended by section  
2 102 and further amended by the previous provisions of  
3 this title, by inserting after section 2799A–3 the following  
4 new section:

5 **“SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON**  
6 **TOOL.**

7 “A group health plan or a health insurance issuer of-  
8 fering group or individual health insurance coverage shall  
9 offer price comparison guidance by telephone and make  
10 available on the Internet website of the plan or issuer a  
11 price comparison tool that (to the extent practicable) al-  
12 lows an individual enrolled under such plan or coverage,  
13 with respect to such plan year, such geographic region,  
14 and participating providers with respect to such plan or  
15 coverage, to compare the amount of cost-sharing that the  
16 individual would be responsible for paying under such plan  
17 or coverage with respect to the furnishing of a specific  
18 item or service by any such provider.”.

19 (b) INTERNAL REVENUE CODE.—

20 (1) IN GENERAL.—Subchapter B of chapter  
21 100 of the Internal Revenue Code of 1986, as  
22 amended by sections 102, 105, and 113, is further  
23 amended by inserting after section 9818 the fol-  
24 lowing new section:

1 **“SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.**

2 “A group health plan shall offer price comparison  
3 guidance by telephone and make available on the Internet  
4 website of the plan or issuer a price comparison tool that  
5 (to the extent practicable) allows an individual enrolled  
6 under such plan, with respect to such plan year, such geo-  
7 graphic region, and participating providers with respect  
8 to such plan or coverage, to compare the amount of cost-  
9 sharing that the individual would be responsible for paying  
10 under such plan with respect to the furnishing of a specific  
11 item or service by any such provider.”.

12 (2) CLERICAL AMENDMENT.—The table of sec-  
13 tions for such subchapter, as amended by the pre-  
14 vious sections, is further amended by inserting after  
15 the item relating to section 9818 the following new  
16 item:

“Sec. 9819. Maintenance of price comparison tool.”.

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

19 (1) IN GENERAL.—Subpart B of part 7 of sub-  
20 title B of title I of the Employee Retirement Income  
21 Security Act of 1974 (29 U.S.C. 1185 et seq.), as  
22 amended by sections 102, 105, and 113, is further  
23 amended by inserting after section 718 the following  
24 new section:

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1 **“SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.**

2 “A group health plan or a health insurance issuer of-  
3 fering group health insurance coverage shall offer price  
4 comparison guidance by telephone and make available on  
5 the Internet website of the plan or issuer a price compari-  
6 son tool that (to the extent practicable) allows an indi-  
7 vidual enrolled under such plan or coverage, with respect  
8 to such plan year, such geographic region, and partici-  
9 pating providers with respect to such plan or coverage, to  
10 compare the amount of cost-sharing that the individual  
11 would be responsible for paying under such plan or cov-  
12 erage with respect to the furnishing of a specific item or  
13 service by any such provider.”.

14 (2) CLERICAL AMENDMENT.—The table of con-  
15 tents in section 1 of the Employee Retirement In-  
16 come Security Act of 1974, as amended by the pre-  
17 vious provisions of this title, is further amended by  
18 inserting after the item relating to section 716 the  
19 following new item:

“Sec. 719. Maintenance of price comparison tool.”.

20 (d) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply with respect to plan years begin-  
22 ning on or after January 1, 2022.



1 **SEC. 115. STATE ALL PAYER CLAIMS DATABASES.**

2 (a) GRANTS TO STATES.—Part B of title III of the  
3 Public Health Service Act (42 U.S.C. 243 et seq.) is  
4 amended by adding at the end the following:

5 **“SEC. 320B. STATE ALL PAYER CLAIMS DATABASES.**

6 “(a) IN GENERAL.—The Secretary shall make one-  
7 time grants to eligible States for the purposes described  
8 in subsection (b).

9 “(b) USES.—A State may use a grant received under  
10 subsection (a) for one of the following purposes:

11 “(1) To establish a State All Payer Claims  
12 Database.

13 “(2) To improve an existing State All Payer  
14 Claims Databases.

15 “(c) ELIGIBILITY.—To be eligible to receive a grant  
16 under subsection (a), a State shall submit to the Secretary  
17 an application at such time, in such manner, and con-  
18 taining such information as the Secretary specifies, includ-  
19 ing, with respect to a State All Payer Claims Database,  
20 at least specifics on how the State will ensure uniform  
21 data collection and the privacy and security of such data.

22 “(d) GRANT PERIOD AND AMOUNT.—Grants award-  
23 ed under this section shall be for a period of 3-years, and  
24 in an amount of \$2,500,000, of which \$1,000,000 shall  
25 be made available to the State for each of the first 2 years

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1 of the grant period, and \$500,000 shall be made available  
2 to the State for the third year of the grant period.

3 “(e) AUTHORIZED USERS.—

4 “(1) APPLICATION.—An entity desiring author-  
5 ization for access to a State All Payer Claims Data-  
6 base that has received a grant under this section  
7 shall submit to the State All Payer Claims Database  
8 an application for such access, which shall include—

9 “(A) in the case of an entity requesting ac-  
10 cess for research purposes—

11 “(i) a description of the uses and  
12 methodologies for evaluating health system  
13 performance using such data; and

14 “(ii) documentation of approval of the  
15 research by an institutional review board,  
16 if applicable for a particular plan of re-  
17 search; or

18 “(B) in the case of an entity such as an  
19 employer, health insurance issuer, third-party  
20 administrator, or health care provider, request-  
21 ing access for the purpose of quality improve-  
22 ment or cost-containment, a description of the  
23 intended uses for such data.

24 “(2) REQUIREMENTS.—

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1           “(A) ACCESS FOR RESEARCH PURPOSES.—

2           Upon approval of an application for research  
3           purposes under paragraph (1)(A), the author-  
4           ized user shall enter into a data use and con-  
5           fidentiality agreement with the State All Payer  
6           Claims Database that has received a grant  
7           under this subsection, which shall include a pro-  
8           hibition on attempts to reidentify and disclose  
9           individually identifiable health information and  
10          proprietary financial information.

11          “(B) CUSTOMIZED REPORTS.—Employers  
12          and employer organizations may request cus-  
13          tomized reports from a State All Payer Claims  
14          Database that has received a grant under this  
15          section, at cost, subject to the requirements of  
16          this section with respect to privacy, security,  
17          and proprietary financial information.

18          “(C) NON-CUSTOMIZED REPORTS.—A  
19          State All Payer Claims Database that has re-  
20          ceived a grant under this section shall make  
21          available to all authorized users aggregate data  
22          sets available through the State All Payer  
23          Claims Database, free of charge.

24          “(3) WAIVERS.—The Secretary may waive the  
25          requirements of this subsection of a State All Payer

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1 Claims Database to provide access of entities to such  
2 database if such State All Payer Claims Database is  
3 substantially in compliance with this subsection.

4 “(f) EXPANDED ACCESS.—

5 “(1) MULTI-STATE APPLICATIONS.—The Sec-  
6 retary may prioritize applications submitted by a  
7 State whose application demonstrates that the State  
8 will work with other State All Payer Claims Data-  
9 bases to establish a single application for access to  
10 data by authorized users across multiple States.

11 “(2) EXPANSION OF DATA SETS.—The Sec-  
12 retary may prioritize applications submitted by a  
13 State whose application demonstrates that the State  
14 will implement the reporting format for self-insured  
15 group health plans described in section 735 of the  
16 Employee Retirement Income Security Act of 1974.

17 “(g) DEFINITIONS.—In this section—

18 “(1) the term ‘individually identifiable health  
19 information’ has the meaning given such term in  
20 section 1171(6) of the Social Security Act;

21 “(2) the term ‘proprietary financial informa-  
22 tion’ means data that would disclose the terms of a  
23 specific contract between an individual health care  
24 provider or facility and a specific group health plan,  
25 managed care entity (as defined in section

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1 1932(a)(1)(B) of the Social Security Act) or other  
2 managed care organization, or health insurance  
3 issuer offering group or individual health insurance  
4 coverage; and

5 “(3) the term ‘State All Payer Claims Data-  
6 base’ means, with respect to a State, a database that  
7 may include medical claims, pharmacy claims, dental  
8 claims, and eligibility and provider files, which are  
9 collected from private and public payers.

10 “(h) AUTHORIZATION OF APPROPRIATIONS.—To  
11 carry out this section, there is authorized to be appro-  
12 priated \$50,000,000 for each of fiscal years 2022 and  
13 2023, and \$25,000,000 for fiscal year 2024, to remain  
14 available until expended.”.

15 (b) STANDARDIZED REPORTING FORMAT.—

16 Subpart C of part 7 of subtitle B of title I of  
17 the Employee Retirement Income Security Act of  
18 1974 (29 U.S.C. 1191 et seq.) is amended by adding  
19 at the end the following:

20 **“SEC. 735. STANDARDIZED REPORTING FORMAT.**

21 “(a) IN GENERAL.—Not later than 1 year after the  
22 date of enactment of this section, the Secretary shall es-  
23 tablish (and periodically update) a standardized reporting  
24 format for the voluntary reporting, by group health plans  
25 to State All Payer Claims Databases, of medical claims,

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1 pharmacy claims, dental claims, and eligibility and pro-  
2 vider files that are collected from private and public pay-  
3 ers, and shall provide guidance to States on the process  
4 by which States may collect such data from such plans  
5 in the standardized reporting format.

6 “(b) CONSULTATION.—

7 “(1) ADVISORY COMMITTEE.—Not later than  
8 90 days after the date of enactment of this section,  
9 the Secretary shall convene an Advisory Committee  
10 (referred to in this section as the ‘Committee’), con-  
11 sisting of 15 members to advise the Secretary re-  
12 garding the format and guidance described in para-  
13 graph (1).

14 “(2) MEMBERSHIP.—

15 “(A) APPOINTMENT.—In accordance with  
16 subparagraph (B), not later than 90 days after  
17 the date of enactment this section, the Sec-  
18 retary, in coordination with the Secretary of  
19 Health and Human Services, shall appoint  
20 under subparagraph (B)(iii), and the Comp-  
21 troller General of the United States shall ap-  
22 point under subparagraph (B)(iv), members  
23 who have distinguished themselves in the fields  
24 of health services research, health economics,  
25 health informatics, data privacy and security, or

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1 the governance of State All Payer Claims Data-  
2 bases, or who represent organizations likely to  
3 submit data to or use the database, including  
4 patients, employers, or employee organizations  
5 that sponsor group health plans, health care  
6 providers, health insurance issuers, or third-  
7 party administrators of group health plans.  
8 Such members shall serve 3-year terms on a  
9 staggered basis. Vacancies on the Committee  
10 shall be filled by appointment consistent with  
11 this paragraph not later than 3 months after  
12 the vacancy arises.

13 “(B) COMPOSITION.—The Committee shall  
14 be comprised of—

15 “(i) the Assistant Secretary of Em-  
16 ployee Benefits and Security Administra-  
17 tion of the Department of Labor, or a des-  
18 ignee of such Assistant Secretary;

19 “(ii) the Assistant Secretary for Plan-  
20 ning and Evaluation of the Department of  
21 Health and Human Services, or a designee  
22 of such Assistant Secretary;

23 “(iii) members appointed by the Sec-  
24 retary, in coordination with the Secretary

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1 of Health and Human Services, includ-  
2 ing—

3 “(I) 1 member to serve as the  
4 chair of the Committee;

5 “(II) 1 representative of the Cen-  
6 ters for Medicare & Medicaid Services;

7 “(III) 1 representative of the  
8 Agency for Healthcare Research and  
9 Quality;

10 “(IV) 1 representative of the Of-  
11 fice for Civil Rights of the Depart-  
12 ment of Health and Human Services  
13 with expertise in data privacy and se-  
14 curity;

15 “(V) 1 representative of the Na-  
16 tional Center for Health Statistics;

17 “(VI) 1 representative of the Of-  
18 fice of the National Coordinator for  
19 Health Information Technology; and

20 “(VII) 1 representative of a  
21 State All-Payer Claims Database;

22 “(iv) members appointed by the  
23 Comptroller General of the United States,  
24 including—



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1                   “(I) 1 representative of an em-  
2                   ployer that sponsors a group health  
3                   plan;

4                   “(II) 1 representative of an em-  
5                   ployee organization that sponsors a  
6                   group health plan;

7                   “(III) 1 academic researcher with  
8                   expertise in health economics or  
9                   health services research;

10                   “(IV) 1 consumer advocate; and

11                   “(V) 2 additional members.

12                   “(3) REPORT.—Not later than 180 days after  
13                   the date of enactment of this section, the Committee  
14                   shall report to the Secretary, the Committee on  
15                   Health, Education, Labor, and Pensions of the Sen-  
16                   ate, and the Committee on Energy and Commerce  
17                   and the Committee on Education and Labor of the  
18                   House of Representatives. Such report shall include  
19                   recommendations on the establishment of the format  
20                   and guidance described in subsection (a).

21                   “(c) STATE ALL PAYER CLAIMS DATABASE.—In this  
22                   section, the term ‘State All Payer Claims Database’  
23                   means, with respect to a State, a database that may in-  
24                   clude medical claims, pharmacy claims, dental claims, and

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1 eligibility and provider files, which are collected from pri-  
2 vate and public payers.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—To  
4 carry out this section, there are authorized to be appro-  
5 priated \$5,000,000 for fiscal year 2021, to remain avail-  
6 able until expended or, if sooner, until the date described  
7 in subsection (e).

8 “(e) SUNSET.—Beginning on the date on which the  
9 report is submitted under subsection (b)(3), subsection (b)  
10 shall have no force or effect.”.

11 **SEC. 116. PROTECTING PATIENTS AND IMPROVING THE AC-**  
12 **CURACY OF PROVIDER DIRECTORY INFOR-**  
13 **MATION.**

14 (a) PHSA.—Part D of title XXVII of the Public  
15 Health Service Act (42 U.S.C. 300gg et seq.), as added  
16 and amended by section 102 and further amended by the  
17 previous provisions of this title, is further amended by in-  
18 serting after section 2799A–4 the following:

19 **“SEC. 2799A–5. PROTECTING PATIENTS AND IMPROVING**  
20 **THE ACCURACY OF PROVIDER DIRECTORY**  
21 **INFORMATION.**

22 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-  
23 MENTS.—

24 “(1) IN GENERAL.—For plan years beginning  
25 on or after January 1, 2022, each group health plan

1966

1 and health insurance issuer offering group or indi-  
2 vidual health insurance coverage shall—

3 “(A) establish the verification process de-  
4 scribed in paragraph (2);

5 “(B) establish the response protocol de-  
6 scribed in paragraph (3);

7 “(C) establish the database described in  
8 paragraph (4); and

9 “(D) include in any directory (other than  
10 the database described in subparagraph (C))  
11 containing provider directory information with  
12 respect to such plan or such coverage the infor-  
13 mation described in paragraph (5).

14 “(2) VERIFICATION PROCESS.—The verification  
15 process described in this paragraph is, with respect  
16 to a group health plan or a health insurance issuer  
17 offering group or individual health insurance cov-  
18 erage, a process—

19 “(A) under which, not less frequently than  
20 once every 90 days, such plan or such issuer (as  
21 applicable) verifies and updates the provider di-  
22 rectory information included on the database  
23 described in paragraph (4) of such plan or  
24 issuer of each health care provider and health  
25 care facility included in such database;

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1           “(B) that establishes a procedure for the  
2           removal of such a provider or facility with re-  
3           spect to which such plan or issuer has been un-  
4           able to verify such information during a period  
5           specified by the plan or issuer; and

6           “(C) that provides for the update of such  
7           database within 2 business days of such plan or  
8           issuer receiving from such a provider or facility  
9           information pursuant to section 2799B-9.

10          “(3) RESPONSE PROTOCOL.—The response pro-  
11          tocol described in this paragraph is, in the case of  
12          an individual enrolled under a group health plan or  
13          group or individual health insurance coverage of-  
14          fered by a health insurance issuer who requests in-  
15          formation through a telephone call or electronic,  
16          web-based, or Internet-based means on whether a  
17          health care provider or health care facility has a  
18          contractual relationship to furnish items and services  
19          under such plan or such coverage, a protocol under  
20          which such plan or such issuer (as applicable), in the  
21          case such request is made through a telephone call—

22                 “(A) responds to such individual as soon  
23                 as practicable and in no case later than 1 busi-  
24                 ness day after such call is received, through a

1968

1 written electronic or print (as requested by such  
2 individual) communication; and

3 “(B) retains such communication in such  
4 individual’s file for at least 2 years following  
5 such response.

6 “(4) DATABASE.—The database described in  
7 this paragraph is, with respect to a group health  
8 plan or health insurance issuer offering group or in-  
9 dividual health insurance coverage, a database on  
10 the public website of such plan or issuer that con-  
11 tains—

12 “(A) a list of each health care provider and  
13 health care facility with which such plan or  
14 such issuer has a direct or indirect contractual  
15 relationship for furnishing items and services  
16 under such plan or such coverage; and

17 “(B) provider directory information with  
18 respect to each such provider and facility.

19 “(5) INFORMATION.—The information de-  
20 scribed in this paragraph is, with respect to a print  
21 directory containing provider directory information  
22 with respect to a group health plan or individual or  
23 group health insurance coverage offered by a health  
24 insurance issuer, a notification that such informa-  
25 tion contained in such directory was accurate as of

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1 the date of publication of such directory and that an  
2 individual enrolled under such plan or such coverage  
3 should consult the database described in paragraph  
4 (4) with respect to such plan or such coverage or  
5 contact such plan or the issuer of such coverage to  
6 obtain the most current provider directory informa-  
7 tion with respect to such plan or such coverage.

8 “(6) DEFINITION.—For purposes of this sub-  
9 section, the term ‘provider directory information’ in-  
10 cludes, with respect to a group health plan and a  
11 health insurance issuer offering group or individual  
12 health insurance coverage, the name, address, spe-  
13 cialty, telephone number, and digital contact infor-  
14 mation of each health care provider or health care  
15 facility with which such plan or such issuer has a  
16 contractual relationship for furnishing items and  
17 services under such plan or such coverage.

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.—

## 1970

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 or group or indi-  
5           vidual health insurance coverage offered by a health  
6           insurance issuer by a nonparticipating provider or a  
7           nonparticipating facility, if such item or service  
8           would otherwise be covered under such plan or cov-  
9           erage if furnished by a participating provider or par-  
10          ticipating facility and if either of the criteria de-  
11          scribed in paragraph (2) applies with respect to such  
12          participant, beneficiary, or enrollee and item or serv-  
13          ice, the plan or coverage—

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

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

## 1971

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

9           “(A) The participant, beneficiary, or en-  
10 rollee received through a database, provider di-  
11 rectory, or response protocol described in sub-  
12 section (a) information with respect to such  
13 item and service to be furnished and such infor-  
14 mation provided that the provider was a partici-  
15 pating provider or facility was a participating  
16 facility, with respect to the plan for furnishing  
17 such item or service.

18           “(B) The information was not provided, in  
19 accordance with subsection (a), to the partici-  
20 pant, beneficiary, or enrollee and the partici-  
21 pant, beneficiary, or enrollee requested through  
22 the response protocol described in subsection  
23 (a)(3) of the plan or coverage information on  
24 whether the provider was a participating pro-  
25 vider or facility was a participating facility with



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1           respect to the plan for furnishing such item or  
2           service and was informed through such protocol  
3           that the provider was such a participating pro-  
4           vider or facility was such a participating facil-  
5           ity.

6           “(c) DISCLOSURE ON PATIENT PROTECTIONS  
7 AGAINST BALANCE BILLING.—For plan years beginning  
8 on or after January 1, 2022, each group health plan and  
9 health insurance issuer offering group or individual health  
10 insurance coverage shall make publicly available, post on  
11 a public website of such plan or issuer, and include on  
12 each explanation of benefits for an item or service with  
13 respect to which the requirements under section 2799A–  
14 1 applies—

15           “(1) information in plain language on—

16           “(A) the requirements and prohibitions ap-  
17           plied under sections 2799B–1 and 2799B–2  
18           (relating to prohibitions on balance billing in  
19           certain circumstances);

20           “(B) if provided for under applicable State  
21           law, any other requirements on providers and  
22           facilities regarding the amounts such providers  
23           and facilities may, with respect to an item or  
24           service, charge a participant, beneficiary, or en-  
25           rollee of such plan or coverage with respect to

1973

1           which such a provider or facility does not have  
2           a contractual relationship for furnishing such  
3           item or service under the plan or coverage after  
4           receiving payment from the plan or coverage for  
5           such item or service and any applicable cost  
6           sharing payment from such participant, bene-  
7           ficiary, or enrollee; and

8                   “(C) the requirements applied under sec-  
9                   tion 2799A-1; and

10           “(2) information on contacting appropriate  
11           State and Federal agencies in the case that an indi-  
12           vidual believes that such a provider or facility has  
13           violated any requirement described in paragraph (1)  
14           with respect to such individual.”.

15           (b) ERISA.—Subpart B of part 7 of subtitle B of  
16           title I of the Employee Retirement Income Security Act  
17           of 1974 (29 U.S.C. 1185 et seq.), as amended by sections  
18           102, 105, 113, and 114, is further amended by inserting  
19           after section 719 the following:

20           **“SEC. 720. PROTECTING PATIENTS AND IMPROVING THE**  
21                           **ACCURACY OF PROVIDER DIRECTORY INFOR-**  
22                           **MATION.**

23           “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-  
24           MENTS.—

1974

1           “(1) IN GENERAL.—For plan years beginning  
2           on or after January 1, 2022, each group health plan  
3           and health insurance issuer offering group health in-  
4           surance coverage shall—

5                   “(A) establish the verification process de-  
6                   scribed in paragraph (2);

7                   “(B) establish the response protocol de-  
8                   scribed in paragraph (3);

9                   “(C) establish the database described in  
10                  paragraph (4); and

11                  “(D) include in any directory (other than  
12                  the database described in subparagraph (C))  
13                  containing provider directory information with  
14                  respect to such plan or such coverage the infor-  
15                  mation described in paragraph (5).

16           “(2) VERIFICATION PROCESS.—The verification  
17           process described in this paragraph is, with respect  
18           to a group health plan or a health insurance issuer  
19           offering group health insurance coverage, a proc-  
20           ess—

21                   “(A) under which, not less frequently than  
22                   once every 90 days, such plan or such issuer (as  
23                   applicable) verifies and updates the provider di-  
24                   rectory information included on the database  
25                   described in paragraph (4) of such plan or

1975

1 issuer of each health care provider and health  
2 care facility included in such database;

3 “(B) that establishes a procedure for the  
4 removal of such a provider or facility with re-  
5 spect to which such plan or issuer has been un-  
6 able to verify such information during a period  
7 specified by the plan or issuer; and

8 “(C) that provides for the update of such  
9 database within 2 business days of such plan or  
10 issuer receiving from such a provider or facility  
11 information pursuant to section 2799B-9 of the  
12 Public Health Service Act.

13 “(3) RESPONSE PROTOCOL.—The response pro-  
14 tocol described in this paragraph is, in the case of  
15 an individual enrolled under a group health plan or  
16 group health insurance coverage offered by a health  
17 insurance issuer who requests information through a  
18 telephone call or electronic, web-based, or Internet-  
19 based means on whether a health care provider or  
20 health care facility has a contractual relationship to  
21 furnish items and services under such plan or such  
22 coverage, a protocol under which such plan or such  
23 issuer (as applicable), in the case such request is  
24 made through a telephone call—

1976

1           “(A) responds to such individual as soon  
2           as practicable and in no case later than 1 busi-  
3           ness day after such call is received, through a  
4           written electronic or print (as requested by such  
5           individual) communication; and

6           “(B) retains such communication in such  
7           individual’s file for at least 2 years following  
8           such response.

9           “(4) DATABASE.—The database described in  
10          this paragraph is, with respect to a group health  
11          plan or health insurance issuer offering group health  
12          insurance coverage, a database on the public website  
13          of such plan or issuer that contains—

14                 “(A) a list of each health care provider and  
15                 health care facility with which such plan or  
16                 such issuer has a direct or indirect contractual  
17                 relationship for furnishing items and services  
18                 under such plan or such coverage; and

19                 “(B) provider directory information with  
20                 respect to each such provider and facility.

21           “(5) INFORMATION.—The information de-  
22          scribed in this paragraph is, with respect to a print  
23          directory containing provider directory information  
24          with respect to a group health plan or group health  
25          insurance coverage offered by a health insurance

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1 issuer, a notification that such information con-  
2 tained in such directory was accurate as of the date  
3 of publication of such directory and that an indi-  
4 vidual enrolled under such plan or such coverage  
5 should consult the database described in paragraph  
6 (4) with respect to such plan or such coverage or  
7 contact such plan or the issuer of such coverage to  
8 obtain the most current provider directory informa-  
9 tion with respect to such plan or such coverage.

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 and a  
13 health insurance issuer offering group health insur-  
14 ance coverage, the name, address, specialty, tele-  
15 phone number, and digital contact information of  
16 each health care provider or health care facility with  
17 which such plan or such issuer has a contractual re-  
18 lationship for furnishing items and services under  
19 such plan or such coverage.

20 “(7) RULE OF CONSTRUCTION.—Nothing in  
21 this section shall be construed to preempt any provi-  
22 sion of State law relating to health care provider di-  
23 rectories, to the extent such State law applies to  
24 such plan, coverage, or issuer, subject to section  
25 514.

1978

1       “(b) COST-SHARING FOR SERVICES PROVIDED  
2 BASED ON RELIANCE ON INCORRECT PROVIDER NET-  
3 WORK INFORMATION.—

4           “(1) IN GENERAL.—For plan years beginning  
5 on or after January 1, 2022, in the case of an item  
6 or service furnished to a participant or beneficiary of  
7 a group health plan or group health insurance cov-  
8 erage offered by a health insurance issuer by a non-  
9 participating provider or a nonparticipating facility,  
10 if such item or service would otherwise be covered  
11 under such plan or coverage if furnished by a par-  
12 ticipating provider or participating facility and if ei-  
13 ther of the criteria described in paragraph (2) ap-  
14 plies with respect to such participant or beneficiary  
15 and item or service, the plan or coverage—

16           “(A) shall not impose on such participant  
17 or beneficiary a cost-sharing amount for such  
18 item or service so furnished that is greater than  
19 the cost-sharing amount that would apply under  
20 such plan or coverage had such item or service  
21 been furnished by a participating provider; and

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

## 1979

1           “(2) CRITERIA DESCRIBED.—For purposes of  
2 paragraph (1), the criteria described in this para-  
3 graph, with respect to an item or service furnished  
4 to a participant or beneficiary of a group health plan  
5 or group health insurance coverage offered by a  
6 health insurance issuer by a nonparticipating pro-  
7 vider or a nonparticipating facility, are the following:

8           “(A) The participant or beneficiary re-  
9 ceived through a database, provider directory,  
10 or response protocol described in subsection (a)  
11 information with respect to such item and serv-  
12 ice to be furnished and such information pro-  
13 vided that the provider was a participating pro-  
14 vider or facility was a participating facility,  
15 with respect to the plan for furnishing such  
16 item or service.

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



1980

1           formed through such protocol that the provider  
2           was such a participating provider or facility was  
3           such a participating facility.

4           “(c) DISCLOSURE ON PATIENT PROTECTIONS  
5 AGAINST BALANCE BILLING.—For plan years beginning  
6 on or after January 1, 2022, each group health plan and  
7 health insurance issuer offering group health insurance  
8 coverage shall make publicly available, post on a public  
9 website of such plan or issuer, and include on each expla-  
10 nation of benefits for an item or service with respect to  
11 which the requirements under section 716 applies—

12           “(1) information in plain language on—

13                   “(A) the requirements and prohibitions ap-  
14 plied under sections 2799B–1 and 2799B–2 of  
15 the Public Health Service Act (relating to pro-  
16 hibitions on balance billing in certain cir-  
17 cumstances);

18                   “(B) if provided for under applicable State  
19 law, any other requirements on providers and  
20 facilities regarding the amounts such providers  
21 and facilities may, with respect to an item or  
22 service, charge a participant or beneficiary of  
23 such plan or coverage with respect to which  
24 such a provider or facility does not have a con-  
25 tractual relationship for furnishing such item or

1981

1 service under the plan or coverage after receiv-  
2 ing payment from the plan or coverage for such  
3 item or service and any applicable cost sharing  
4 payment from such participant or beneficiary;  
5 and

6 “(C) the requirements applied under sec-  
7 tion 716; and

8 “(2) information on contacting appropriate  
9 State and Federal agencies in the case that an indi-  
10 vidual believes that such a provider or facility has  
11 violated any requirement described in paragraph (1)  
12 with respect to such individual.”.

13 (c) IRC.—Subchapter B of chapter 100 of the Inter-  
14 nal Revenue Code of 1986, as amended by sections 102,  
15 105, 113, and 114, is further amended by inserting after  
16 section 9819 the following:

17 **“SEC. 9820. PROTECTING PATIENTS AND IMPROVING THE**  
18 **ACCURACY OF PROVIDER DIRECTORY INFOR-**  
19 **MATION.**

20 “(a) PROVIDER DIRECTORY INFORMATION REQUIRE-  
21 MENTS.—

22 “(1) IN GENERAL.—For plan years beginning  
23 on or after January 1, 2022, each group health plan  
24 shall—

1982

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

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

5           “(C) establish the database described in  
6           paragraph (4); and

7           “(D) include in any directory (other than  
8           the database described in subparagraph (C))  
9           containing provider directory information with  
10          respect to such plan the information described  
11          in paragraph (5).

12          “(2) VERIFICATION PROCESS.—The verification  
13          process described in this paragraph is, with respect  
14          to a group health plan, a process—

15               “(A) under which, not less frequently than  
16               once every 90 days, such plan verifies and up-  
17               dates the provider directory information in-  
18               cluded on the database described in paragraph  
19               (4) of such plan or issuer of each health care  
20               provider and health care facility included in  
21               such database;

22               “(B) that establishes a procedure for the  
23               removal of such a provider or facility with re-  
24               spect to which such plan or issuer has been un-

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1 able to verify such information during a period  
2 specified by the plan or issuer; and

3 “(C) that provides for the update of such  
4 database within 2 business days of such plan or  
5 issuer receiving from such a provider or facility  
6 information pursuant to section 2799B–9 of the  
7 Public Health Service Act.

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

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

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

1984

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

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

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

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

23           “(6) DEFINITION.—For purposes of this sub-  
24 section, the term ‘provider directory information’ in-  
25 cludes, with respect to a group health plan, the

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1 name, address, specialty, telephone number, and dig-  
2 ital contact information of each health care provider  
3 or health care facility with which such plan has a  
4 contractual relationship for furnishing items and  
5 services under such plan.

6 “(7) RULE OF CONSTRUCTION.—Nothing in  
7 this section shall be construed to preempt any provi-  
8 sion of State law relating to health care provider di-  
9 rectories.

10 “(b) COST-SHARING FOR SERVICES PROVIDED  
11 BASED ON RELIANCE ON INCORRECT PROVIDER NET-  
12 WORK INFORMATION.—

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

23 “(A) shall not impose on such participant  
24 or beneficiary a cost-sharing amount for such  
25 item or service so furnished that is greater than

1986

1 the cost-sharing amount that would apply under  
2 such plan had such item or service been fur-  
3 nished by a participating provider; and

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

8 “(2) CRITERIA DESCRIBED.—For purposes of  
9 paragraph (1), the criteria described in this para-  
10 graph, with respect to an item or service furnished  
11 to a participant or beneficiary of a group health plan  
12 by a nonparticipating provider or a nonparticipating  
13 facility, are the following:

14 “(A) The participant or beneficiary re-  
15 ceived through a database, provider directory,  
16 or response protocol described in subsection (a)  
17 information with respect to such item and serv-  
18 ice to be furnished and such information pro-  
19 vided that the provider was a participating pro-  
20 vider or facility was a participating facility,  
21 with respect to the plan for furnishing such  
22 item or service.

23 “(B) The information was not provided, in  
24 accordance with subsection (a), to the partici-  
25 pant or beneficiary and the participant or bene-

1987

1           ficiary requested through the response protocol  
2           described in subsection (a)(3) of the plan infor-  
3           mation on whether the provider was a partici-  
4           pating provider or facility was a participating  
5           facility with respect to the plan for furnishing  
6           such item or service and was informed through  
7           such protocol that the provider was such a par-  
8           ticipating provider or facility was such a par-  
9           ticipating facility.

10       “(c) DISCLOSURE ON PATIENT PROTECTIONS  
11 AGAINST BALANCE BILLING.—For plan years beginning  
12 on or after January 1, 2022, each group health plan shall  
13 make publicly available, post on a public website of such  
14 plan or issuer, and include on each explanation of benefits  
15 for an item or service with respect to which the require-  
16 ments under section 9816 applies—

17           “(1) information in plain language on—

18           “(A) the requirements and prohibitions ap-  
19           plied under sections 2799B–1 and 2799B–2 of  
20           the Public Health Service Act(relating to prohi-  
21           bitions on balance billing in certain cir-  
22           cumstances);

23           “(B) if provided for under applicable State  
24           law, any other requirements on providers and  
25           facilities regarding the amounts such providers



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1 and facilities may, with respect to an item or  
2 service, charge a participant or beneficiary of  
3 such plan with respect to which such a provider  
4 or facility does not have a contractual relation-  
5 ship for furnishing such item or service under  
6 the plan after receiving payment from the plan  
7 for such item or service and any applicable cost  
8 sharing payment from such participant or bene-  
9 ficiary; and

10 “(C) the requirements applied under sec-  
11 tion 9816; and

12 “(2) information on contacting appropriate  
13 State and Federal agencies in the case that an indi-  
14 vidual believes that such a provider or facility has  
15 violated any requirement described in paragraph (1)  
16 with respect to such individual.”.

17 (d) CLERICAL AMENDMENTS.—

18 (1) ERISA.—The table of contents in section 1  
19 of the Employee Retirement Income Security Act of  
20 1974 (29 U.S.C. 1001 et seq.), as amended by the  
21 previous provisions of this title, is further amended  
22 by inserting after the item relating to section 719  
23 the following new item:

“720. Protecting patients and improving the accuracy of provider directory in-  
formation.”.

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1           (2) IRC.—The table of sections for subchapter  
2           B of chapter 100 of the Internal Revenue Code of  
3           1986, as amended by the previous provisions of this  
4           title, is further amended by inserting after the item  
5           relating to section 9819 the following new item:

          “9820. Protecting patients and improving the accuracy of provider directory in-  
          formation.”.

6           (e) PROVIDER REQUIREMENTS.—Part E of title  
7           XXVII of the Public Health Service Act (42 U.S.C. 300gg  
8           et seq.), as added by section 104 and as further amended  
9           by the previous provisions of this title, is further amended  
10          by adding at the end the following:

11        **“SEC. 2799B-9. PROVIDER REQUIREMENTS TO PROTECT PA-**  
12                               **TIENTS AND IMPROVE THE ACCURACY OF**  
13                               **PROVIDER DIRECTORY INFORMATION.**

14          “(a) PROVIDER BUSINESS PROCESSES.—Beginning  
15          not later than January 1, 2022, each health care provider  
16          and each health care facility shall have in place business  
17          processes to ensure the timely provision of provider direc-  
18          tory information to a group health plan or a health insur-  
19          ance issuer offering group or individual health insurance  
20          coverage to support compliance by such plans or issuers  
21          with section 2799A-5(a)(1), section 720(a)(1) of the Em-  
22          ployee Retirement Income Security Act of 1974, or section  
23          9820(a)(1) of the Internal Revenue Code of 1986, as ap-

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1 plicable. Such providers shall submit provider directory in-  
2 formation to a plan or issuers, at a minimum—

3 “(1) when the provider or facility begins a net-  
4 work agreement with a plan or with an issuer with  
5 respect to certain coverage;

6 “(2) when the provider or facility terminates a  
7 network agreement with a plan or with an issuer  
8 with respect to certain coverage;

9 “(3) when there are material changes to the  
10 content of provider directory information of the pro-  
11 vider or facility described in section 2799A–5(a)(1),  
12 section 720(a)(1) of the Employee Retirement In-  
13 come Security Act of 1974, or section 9820(a)(1) of  
14 the Internal Revenue Code of 1986, as applicable;  
15 and

16 “(4) at any other time (including upon the re-  
17 quest of such issuer or plan) determined appropriate  
18 by the provider, facility, or the Secretary.

19 “(b) REFUNDS TO ENROLLEES.—If a health care  
20 provider submits a bill to an enrollee based on cost-sharing  
21 for treatment or services provided by the health care pro-  
22 vider that is in excess of the normal cost-sharing applied  
23 for such treatment or services provided in-network, as pro-  
24 hibited under section 2799A–5(b), section 720(b) of the  
25 Employee Retirement Income Security Act of 1974, or

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1 section 9820(b) of the Internal Revenue Code of 1986,  
2 as applicable, and the enrollee pays such bill, the provider  
3 shall reimburse the enrollee for the full amount paid by  
4 the enrollee in excess of the in-network cost-sharing  
5 amount for the treatment or services involved, plus inter-  
6 est, at an interest rate determined by the Secretary.

7 “(c) LIMITATION.—Nothing in this section shall pro-  
8 hibit a provider from requiring in the terms of a contract,  
9 or contract termination, with a group health plan or health  
10 insurance issuer—

11 “(1) that the plan or issuer remove, at the time  
12 of termination of such contract, the provider from a  
13 directory of the plan or issuer described in section  
14 2799A–5(a), section 720(a) of the Employee Retirement  
15 Income Security Act of 1974, or section  
16 9820(a) of the Internal Revenue Code of 1986, as  
17 applicable; or

18 “(2) that the plan or issuer bear financial re-  
19 sponsibility, including under section 2799A–5(b),  
20 section 720(b) of the Employee Retirement Income  
21 Security Act of 1974, or section 9820(b) of the In-  
22 ternal Revenue Code of 1986, as applicable, for pro-  
23 viding inaccurate network status information to an  
24 enrollee.

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1 “(d) DEFINITION.—For purposes of this section, the  
2 term ‘provider directory information’ includes the names,  
3 addresses, specialty, telephone numbers, and digital con-  
4 tact information of individual health care providers, and  
5 the names, addresses, telephone numbers, and digital con-  
6 tact information of each medical group, clinic, or facility  
7 contracted to participate in any of the networks of the  
8 group health plan or health insurance coverage involved.

9 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-  
10 tion shall be construed to preempt any provision of State  
11 law relating to health care provider directories.”

12 **SEC. 117. ADVISORY COMMITTEE ON GROUND AMBULANCE**  
13 **AND PATIENT BILLING.**

14 (a) IN GENERAL.—Not later than 90 days after the  
15 date of enactment of this Act, the Secretary of Labor, Sec-  
16 retary of Health and Human Services, and the Secretary  
17 of the Treasury (the Secretaries) shall jointly establish an  
18 advisory committee for the purpose of reviewing options  
19 to improve the disclosure of charges and fees for ground  
20 ambulance services, better inform consumers of insurance  
21 options for such services, and protect consumers from bal-  
22 ance billing.

23 (b) COMPOSITION OF THE ADVISORY COMMITTEE.—  
24 The advisory committee shall be composed of the following  
25 members:

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1           (1) The Secretary of Labor, or the Secretary's  
2           designee.

3           (2) The Secretary of Health and Human Serv-  
4           ices, or the Secretary's designee.

5           (3) The Secretary of the Treasury, or the Sec-  
6           retary's designee.

7           (4) One representative, to be appointed jointly  
8           by the Secretaries, for each of the following:

9                   (A) Each relevant Federal agency, as de-  
10                  termined by the Secretaries.

11                   (B) State insurance regulators.

12                   (C) Health insurance providers.

13                   (D) Patient advocacy groups.

14                   (E) Consumer advocacy groups.

15                   (F) State and local governments.

16                   (G) Physician specializing in emergency,  
17                  trauma, cardiac, or stroke.

18                   (H) State Emergency Medical Services Of-  
19                  ficials.

20                   (I) Emergency medical technicians, para-  
21                  medics, and other emergency medical services  
22                  personnel.

23           (5) Three representatives, to be appointed joint-  
24           ly by the Secretaries, to represent the various seg-  
25           ments of the ground ambulance industry.

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1           (6) Up to an additional 2 representatives other-  
2           wise not described in paragraphs (1) through (5), as  
3           determined necessary and appropriate by the Secre-  
4           taries.

5           (c) CONSULTATION.—The advisory committee shall,  
6           as appropriate, consult with relevant experts and stake-  
7           holders, including those not otherwise included under sub-  
8           section (b), while conducting the review described in sub-  
9           section (a).

10          (d) RECOMMENDATIONS.—The advisory committee  
11          shall make recommendations with respect to disclosure of  
12          charges and fees for ground ambulance services and insur-  
13          ance coverage, consumer protection and enforcement au-  
14          thorities of the Departments of Labor, Health and Human  
15          Services, and the Treasury and State authorities, and the  
16          prevention of balance billing to consumers. The rec-  
17          ommendations shall address, at a minimum—

18                 (1) options, best practices, and identified stand-  
19                 ards to prevent instances of balance billing;

20                 (2) steps that can be taken by State legisla-  
21                 tures, State insurance regulators, State attorneys  
22                 general, and other State officials as appropriate,  
23                 consistent with current legal authorities regarding  
24                 consumer protection; and

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1           (3) legislative options for Congress to prevent  
2           balance billing.

3           (e) REPORT.—Not later than 180 days after the date  
4 of the first meeting of the advisory committee, the advi-  
5 sory committee shall submit to the Secretaries, and the  
6 Committees on Education and Labor, Energy and Com-  
7 merce, and Ways and Means of the House of Representa-  
8 tives and the Committees on Finance and Health, Edu-  
9 cation, Labor, and Pensions a report containing the rec-  
10 ommendations made under subsection (d).

11 **SEC. 118. IMPLEMENTATION FUNDING.**

12           (a) IN GENERAL.—For the purposes described in  
13 subsection (b), there are appropriated, out of amounts in  
14 the Treasury not otherwise appropriated, to the Secretary  
15 of Health and Human Services, the Secretary of Labor,  
16 and the Secretary of the Treasury, \$500,000,000 for fiscal  
17 year 2021, to remain available until expended through  
18 2024.

19           (b) PERMITTED PURPOSES.—The purposes described  
20 in this subsection are limited to the following purposes,  
21 insofar as such purposes are to carry out the provisions  
22 of, including the amendments made by, this title and title  
23 II:

24           (1) Preparing, drafting, and issuing proposed  
25           and final regulations or interim regulations.



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1           (2) Preparing, drafting, and issuing guidance  
2           and public information.

3           (3) Preparing and holding public meetings.

4           (4) Preparing, drafting, and publishing reports.

5           (5) Enforcement of such provisions.

6           (6) Reporting, collection, and analysis of data.

7           (7) Establishment and initial implementation of  
8           the processes for independent dispute resolution and  
9           implementation of patient-provider dispute resolution  
10          under such provisions.

11          (8) Conducting audits.

12          (9) Other administrative duties necessary for  
13          implementation of such provisions.

14          (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—

15          Each Secretary described in subsection (a) shall annually  
16          submit to the Committees on Energy and Commerce, on  
17          Ways and Means, on Education and Labor, and on Appro-  
18          priations of the House of Representatives and on the Com-  
19          mittees on Health, Education, Labor, and Pensions and  
20          on Appropriations of the Senate a report on funds ex-  
21          pended pursuant to funds appropriated under this section.