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

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Consumer Protections Against Surprise Medical Bills Act of 2020''.

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

SEC. 2. CONSUMER PROTECTIONS THROUGH REQUIREMENTS ON HEALTH PLANS TO PREVENT SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES.

(a) PHSA AMENDMENTS.—

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

(A) in subsection (b)—

(i) in the heading, by striking ''COVERAGE'' and inserting ''COST-SHARING AND PAYMENT'';

(ii) in paragraph (1)—

(I) in the matter preceding subparagraph (A)—

(aa) by striking ''a group health plan, or a health insurance issuer offering group or individual health insurance issuer,'' and inserting ''a health plan'';

(bb) by inserting ''and, for plan year 2022 or a subsequent plan year, with respect to emergency services in an independent freestanding emergency depart-

ment'' after ''emergency department of a hospital'';

(cc) by striking ''the plan or issuer'' and inserting ''the plan''; and

(dd) by striking ''(as defined in paragraph (2)(B))'';

(II) in subparagraph (B), by inserting ''or a participating facility that is an emergency department of a hospital or an independent freestanding emergency department (in this subsection referred to as a 'participating emergency facility')'' after ''participating provider''; and

(III) in subparagraph (C)—

(aa) in the matter preceding clause (i), by inserting ''by a nonparticipating provider or a nonparticipating facility that is an emergency department of a hospital or an independent freestanding emergency department'' after ''enrollee'';

(bb) by striking clause (i);

(cc) by striking ''(ii)(I) such services'' and inserting ''(i) such services'';

(dd) by striking ''where the provider of services does not have a contractual relationship with the plan for the providing of services'';

(ee) by striking ''emergency department services received from providers who do have such a contractual relationship with the plan; and'' and inserting ''emergency services received from participating providers and participating emergency facilities with respect to such plan;'';

(ff) by striking ''(II) if such services'' and all that follows through ''were provided in-network'' and inserting the following:

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

by a participating provider or a participating emergency facility, as applicable;''; and

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

''(iii) such cost-sharing requirement is calculated as if the contracted rate for such services if furnished by a participating provider or a participating emergency facility were equal to the recognized amount for such services;

''(iv) the health plan pays to such provider or facility, respectively, the amount by which the out-of-network rate for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

''(v) any deductible or out-of-pocket maximum that would apply if such services were furnished by a participating provider or a participating emergency facility shall be the deductible or out-of-pocket maximum that applies; and''; and

(iii) by striking paragraph (2) and inserting the following new paragraph:

''(2) AUDIT PROCESS AND RULEMAKING PROCESS FOR MEDIAN CONTRACTED RATES.—

''(A) AUDIT PROCESS.—

''(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of the Treasury and the Secretary of Labor and in consultation with the National Association of Insurance Commissioners, shall establish through rulemaking a process, in accordance with clause (ii), under which health plans are audited by the Secretary to ensure that—

''(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

''(II) that such median contracted rate so applied satisfies the definition under subsection (k)(8) with respect to the year involved.

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

''(I) shall conduct audits described in such clause of a sample of health plans; and

''(II) may audit any health plan if the Secretary has received any complaint about such plan that involves the compliance of the plan with the requirement described in such clause.

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

''(i) the methodology the sponsor or issuer of a health plan shall use to determine the median contracted rate, which shall account for relevant payment adjustments that take into account facility type that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities; and

''(ii) the information such sponsor or issuer shall share with the nonparticipating provider involved when making such a determination.''; and

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

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

''(1) CONTRACTED RATE.—The term 'contracted rate' means, with respect to a health plan and a health care provider or health care facility furnishing an item or service to a beneficiary, participant, or enrollee of such plan, the agreed upon total payment amount (inclusive of any cost-sharing) to such provider or facility for such item or service.

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

''(3) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.

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

''(5) EMERGENCY SERVICES.—

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

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

emergency department to evaluate such emergency medical condition; and

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

''(B) INCLUSION OF ADDITIONAL SERVICES.—In the case of an individual enrolled in a health plan who is furnished services described in subparagraph (A) by a provider or hospital or independent freestanding emergency department to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, in addition to those described in subparagraph (A), items and services furnished as part of out-

patient observation or an inpatient or outpatient stay during a visit in which such individual is so stabilized with respect to such emergency condition if—

''(i) such items and services would otherwise be covered under such plan if furnished by a participating provider or participating facility; and

''(ii) such items and services are furnished—

''(I) to maintain, improve, or resolve the individual's stabilization with respect to such condition, unless any circumstance described in subparagraph (C) has occurred with respect to such individual before such items and services are furnished; or

''(II) for any purpose not described in subclause (I), unless each of the criteria described in subparagraph (D) have been met with respect to such individual and such item or service.

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

scribed in this subparagraph is any of the following, with respect to an individual who is a beneficiary, participant, or enrollee of a health plan who is furnished services described in subparagraph (A) by a hospital or independent freestanding emergency department with respect to an emergency medical condition:

''(i) A participating provider, with respect to such plan, with privileges at the hospital or independent freestanding emergency department assumes responsibility for the care of the individual.

''(ii) A participating provider, with respect to such plan, assumes responsibility for the care of the individual through transfer of the individual.

''(iii) The health plan and the provider treating such individual at the hospital or independent freestanding emergency department for such condition reach an agreement concerning the care for the individual.

''(iv) The individual is discharged.

''(D) SIGNED NOTICE CRITERIA.—For purposes of subparagraph (B)(ii)(II), the criteria

described in this subparagraph, with respect to an individual and an item or service furnished by a nonparticipating provider or nonparticipating facility that is a hospital or an independent freestanding emergency department, are the following:

''(i) A written notice (as specified by the Secretary and in a clear and understandable manner) is provided by such provider or facility to such individual, before such item or service is furnished, that includes the following information:

''(I) That such provider or facility is a nonparticipating provider or nonparticipating facility (as applicable).

''(II) To the extent practicable, the estimated amount that such nonparticipating facility or nonparticipating provider may charge the individual for such item or service.

''(III) A statement that the individual may seek such item or service from a provider that is a participating provider or a hospital or independent

freestanding emergency department that is a participating facility and a list, if feasible, of participating facilities or participating providers, as applicable, who are able to furnish such item or service.

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

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

''(6) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market and includes a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act).

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

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

''(B) provides emergency services.

''(8) MEDIAN CONTRACTED RATE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'median contracted rate' means, with respect to a health plan—

''(i) for an item or service furnished during 2022, the median of the contracted rates recognized by the sponsor or issuer of such plan (determined with respect to all such plans of such sponsor or such issuer that are within the same line of business (as specified in subparagraph (C)) as the plan involved) as the total maximum payment under such plans in 2019 for the same or a similar item or service that is provided by a provider or facility in the same or similar specialty and provided in the geographic region (established (and updated, as appropriate) by the Secretary, in consultation with the National Association of Insurance Commissioners) in which the item or service is furnished, consistent with

the methodology established by the Secretary under subsection (b)(2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, 2020, and 2021;

''(ii) for an item or service furnished during 2023 or a subsequent year through 2026, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(iii) for an item or service furnished during a rebasing year (as defined in subparagraph (D)), the median of the contracted rates recognized by the sponsor or issuer of such plan (determined with respect to all such plans of such sponsor or such issuer that are within the same line of business (as specified in subparagraph (C)) as the plan involved) as the total maximum payment under such plans in such year for the same or a similar item or service that is provided by a provider or facility

in the same or similar specialty and provided in the geographic region (as established pursuant to clause (i)) in which the item or service is furnished, consistent with the methodology established by the Secretary under subsection (b)(2)(B); and

''(iv) for an item or service furnished during any of the 4 years following a rebasing year, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(B) USE OF SUBSTITUTE RATE IN CASE OF INSUFFICIENT DATA.—

''(i) IN GENERAL.—In the case the sponsor or issuer of a health plan has insufficient information (as specified by the Secretary) to calculate the median of the contracted rates in accordance with subparagraph (A) for a year for an item or service furnished in a particular geographic region (as established pursuant to subparagraph (A)(i)) by a type of provider or facil-

ity, the substitute rate (as defined in clause (ii)) for such item or service shall be deemed to be the median contracted rate for such item or service furnished in such region during such year by such a provider or facility for such year under such subparagraph (A) for such plan.

''(ii) SUBSTITUTE RATE.—For purposes of clause (i), the term 'substitute rate' means, with respect to an item or service furnished by a provider or facility in a geographic region (established pursuant to subparagraph (A)(i)) during a year for which a health plan is required to make payment pursuant to subsection (b)(1), (e)(1), or (i)(1)—

''(I) if sufficient information (as specified by the Secretary) exists to determine the median of the contracted rates recognized by all health plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan or health insurance issuer for such an item or service furnished in such re-

gion by such a provider or facility during such year using a database or other source of information determined appropriate by the Secretary, such median; and

''(II) if such sufficient information does not exist, the median of the contracted rates recognized by all health plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan or health insurance issuer for such an item or service furnished in a similarly situated geographic region (as determined by the Secretary) with such sufficient information by such a provider or facility during such year using such a database or such other source of information.

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

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

''(C) LINE OF BUSINESS.—A line of business specified in this subparagraph is one of the following:

''(i) The individual market.

''(ii) The small group market.

''(iii) The large group market.

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

''(D) REBASING YEAR DEFINED.—For purposes of subparagraph (A), the term 'rebasing year' means 2027 and every 5 years thereafter.

''(9) NONPARTICIPATING FACILITY; PARTICIPATING FACILITY.—

''(A) NONPARTICIPATING FACILITY.—The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a health care facility described in subparagraph (B)(ii) that does not have a contractual relationship with the plan for furnishing such item or service.

''(B) PARTICIPATING FACILITY.—

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

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

''(I) A hospital (as defined in 1861(e) of the Social Security Act), including an emergency department of a hospital.

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

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

''(IV) A laboratory.

''(V) A radiology facility or imaging center.

''(VI) An independent freestanding emergency department.

"(VII) Any other facility specified by the Secretary.

"(10) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(A) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who does not have a contractual relationship with the plan for furnishing such item or service under the plan.

"(B) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who has a contractual relationship with the plan for furnishing such item or service under the plan.

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

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

law that provides for a method for determining the total amount payable under such health plan regulated by such State with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such law;

''(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

''(i) subject to clause (ii), if the provider or facility (as applicable) and such plan agree on an amount of payment (including if agreed on through open negotiations under subsection (j)(1)) with respect to such item or service, such agreed on amount; or

''(ii) if such provider or facility (as applicable) and such plan enter the mediated dispute process under subsection (j) and do not so agree before the date on which a selected independent entity (as defined in paragraph (3) of such subsection) makes a determination with respect to

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

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

''(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under such health plan with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such method.

''(12) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished in a State during a year to a participant, beneficiary, or enrollee of a health plan by a nonparticipating provider or nonparticipating facility—

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

"(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law, an amount that is the median contracted rate for such item or service for such year;

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

"(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under such health plan with respect to such item or

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

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

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

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

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

(b) IRC AMENDMENTS.—

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

"SEC. 9816. PATIENT PROTECTIONS.

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

"(b) COST-SHARING AND PAYMENT OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a health plan provides or covers any benefits with respect to services in an emergency department of a hospital and, for plan year 2022 or a subsequent plan year, with respect to emergency services in an independent freestanding emergency department, the plan shall cover emergency services—

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

"(B) whether the health care provider furnishing such services is a participating provider or a participating facility that is an emergency department of a hospital or an independent freestanding emergency department (in this subsection referred to as a 'participating emergency facility') with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating facility that is an emergency department of a hospital or an independent freestanding emergency department—

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

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

''(iii) such cost-sharing requirement is calculated as if the contracted rate for such services if furnished by a participating provider or a participating emer-

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

''(iv) the health plan pays to such provider or facility, respectively, the amount by which the out-of-network rate for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

''(v) any deductible or out-of-pocket maximum that would apply if such services were furnished by a participating provider or a participating emergency facility shall be the deductible or out-of-pocket maximum that applies; and

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

''(2) AUDIT PROCESS AND RULEMAKING PROCESS FOR MEDIAN CONTRACTED RATES.—

"(A) AUDIT PROCESS.—

"(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of Labor and in consultation with the National Association of Insurance Commissioners, shall establish through rulemaking a process, in accordance with clause (ii), under which health plans are audited by the Secretary to ensure that—

"(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

"(II) that such median contracted rate so applied satisfies the definition under subsection (k)(8) with respect to the year involved.

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

"(I) shall conduct audits described in such clause of a sample of health plans; and

''(II) may audit any health plan if the Secretary has received any complaint about such plan that involves the compliance of the plan with the requirement described in such clause.

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

''(i) the methodology the sponsor of a health plan shall use to determine the median contracted rate, which shall account for relevant payment adjustments that take into account facility type that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities; and

''(ii) the information such sponsor shall share with the nonparticipating provider involved when making such a determination.

''(c) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

''(1) GENERAL RIGHTS.—

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

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

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

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

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

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

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

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

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

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

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

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

provider furnishing such items or services is at the facility.

''(3) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.

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

''(5) EMERGENCY SERVICES.—

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

''(i) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency

department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

''(B) INCLUSION OF ADDITIONAL SERVICES.—In the case of an individual enrolled in a health plan who is furnished services described in subparagraph (A) by a provider or hospital or independent freestanding emergency

department to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, in addition to those described in subparagraph (A), items and services furnished as part of outpatient observation or an inpatient or outpatient stay during a visit in which such individual is so stabilized with respect to such emergency condition if—

''(i) such items and services would otherwise be covered under such plan if furnished by a participating provider or participating facility; and

''(ii) such items and services are furnished—

''(I) to maintain, improve, or resolve the individual's stabilization with respect to such condition, unless any circumstance described in subparagraph (C) has occurred with respect to such individual before such items and services are furnished; or

''(II) for any purpose not described in subclause (I), unless each of the criteria described in subpara-

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

''(C) CIRCUMSTANCES.—For purposes of subparagraph (B)(ii)(I), a circumstance described in this subparagraph is any of the following, with respect to an individual who is a beneficiary, participant, or enrollee of a health plan who is furnished services described in subparagraph (A) by a hospital or independent freestanding emergency department with respect to an emergency medical condition:

''(i) A participating provider, with respect to such plan, with privileges at the hospital or independent freestanding emergency department assumes responsibility for the care of the individual.

''(ii) A participating provider, with respect to such plan, assumes responsibility for the care of the individual through transfer of the individual.

''(iii) The health plan and the provider treating such individual at the hospital or independent freestanding emergency department for such condition reach

an agreement concerning the care for the individual.

''(iv) The individual is discharged.

''(D) SIGNED NOTICE CRITERIA.—For purposes of subparagraph (B)(ii)(II), the criteria described in this subparagraph, with respect to an individual and an item or service furnished by a nonparticipating provider or nonparticipating facility that is a hospital or an independent freestanding emergency department, are the following:

''(i) A written notice (as specified by the Secretary and in a clear and understandable manner) is provided by such provider or facility to such individual, before such item or service is furnished, that includes the following information:

''(I) That such provider or facility is a nonparticipating provider or nonparticipating facility (as applicable).

''(II) To the extent practicable, the estimated amount that such nonparticipating facility or nonpartici-

pating provider may charge the individual for such item or service.

''(III) A statement that the individual may seek such item or service from a provider that is a participating provider or a hospital or independent freestanding emergency department that is a participating facility and a list, if feasible, of participating facilities or participating providers, as applicable, who are able to furnish such item or service.

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

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

''(6) HEALTH PLAN.—The term 'health plan' means a group health plan, including any group health plan that is a grandfathered health plan (as

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

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

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

''(B) provides emergency services.

''(8) MEDIAN CONTRACTED RATE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'median contracted rate' means, with respect to a health plan—

''(i) for an item or service furnished during 2022, the median of the contracted rates recognized by the sponsor of such plan (determined with respect to all such plans of such sponsor that are within the same line of business (as specified in subparagraph (C)) as the plan involved) as the total maximum payment under such plans in 2019 for the same or a similar item or service that is provided by a provider or facility in the same or similar specialty and

provided in the geographic region (established (and updated, as appropriate) by the Secretary, in consultation with the National Association of Insurance Commissioners) in which the item or service is furnished, consistent with the methodology established by the Secretary under subsection (b)(2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, 2020, and 2021;

''(ii) for an item or service furnished during 2023 or a subsequent year through 2026, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(iii) for an item or service furnished during a rebasing year (as defined in subparagraph (D)), the median of the contracted rates recognized by the sponsor of such plan (determined with respect to all such plans of such sponsor that are within the same line of business (as specified in

subparagraph (C)) as the plan involved) as the total maximum payment under such plans in such year for the same or a similar item or service that is provided by a provider or facility in the same or similar specialty and provided in the geographic region (as established pursuant to clause (i)) in which the item or service is furnished, consistent with the methodology established by the Secretary under subsection (b)(2)(B); and

''(iv) for an item or service furnished during any of the 4 years following a rebasing year, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(B) USE OF SUBSTITUTE RATE IN CASE OF INSUFFICIENT DATA.—

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

rates in accordance with subparagraph (A) for a year for an item or service furnished in a particular geographic region (as established pursuant to subparagraph (A)(i)) by a type of provider or facility, the substitute rate (as defined in clause (ii)) for such item or service shall be deemed to be the median contracted rate for such item or service furnished in such region during such year by such a provider or facility for such year under such subparagraph (A) for such plan.

''(ii) SUBSTITUTE RATE.—For purposes of clause (i), the term 'substitute rate' means, with respect to an item or service furnished by a provider or facility in a geographic region (established pursuant to subparagraph (A)(i)) during a year for which a health plan is required to make payment pursuant to subsection (b)(1), (e)(1), or (i)(1)—

''(I) if sufficient information (as specified by the Secretary) exists to determine the median of the contracted rates recognized by all health

plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan for such an item or service furnished in such region by such a provider or facility during such year using a database or other source of information determined appropriate by the Secretary, such median; and

''(II) if such sufficient information does not exist, the median of the contracted rates recognized by all health plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan for such an item or service furnished in a similarly situated geographic region (as determined by the Secretary) with such sufficient information by such a provider or facility during such year using such a database or such other source of information.

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

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

''(C) LINE OF BUSINESS.—A line of business specified in this subparagraph is one of the following:

''(i) The small group market.

''(ii) The large group market.

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

''(D) REBASING YEAR DEFINED.—For purposes of subparagraph (A), the term 'rebasing year' means 2027 and every 5 years thereafter.

''(9) NONPARTICIPATING FACILITY; PARTICIPATING FACILITY.—

''(A) NONPARTICIPATING FACILITY.—The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a health care facility described in subparagraph (B)(ii) that does not have a contractual relationship with the plan for furnishing such item or service.

"(B) PARTICIPATING FACILITY.—

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

"(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

"(I) A hospital (as defined in 1861(e) of the Social Security Act), including an emergency department of a hospital.

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

"(III) An ambulatory surgical center (as described in section 1833(i)(1)(A) of such Act).

"(IV) A laboratory.

"(V) A radiology facility or imaging center.

"(VI) An independent freestanding emergency department.

"(VII) Any other facility specified by the Secretary.

"(10) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(A) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who does not have a contractual relationship with the plan for furnishing such item or service under the plan.

"(B) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who has a contractual relationship with the plan for furnishing such item or service under the plan.

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

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

law that provides for a method for determining the total amount payable under such health plan regulated by such State with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such law;

''(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

''(i) subject to clause (ii), if the provider or facility (as applicable) and such plan agree on an amount of payment (including if agreed on through open negotiations under subsection (j)(1)) with respect to such item or service, such agreed on amount; or

''(ii) if such provider or facility (as applicable) and such plan enter the mediated dispute process under subsection (j) and do not so agree before the date on which a selected independent entity (as defined in paragraph (3) of such subsection) makes a determination with respect to

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

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

''(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under such health plan with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such method.

''(12) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished in a State during a year to a participant or beneficiary of a health plan by a nonparticipating provider or nonparticipating facility—

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

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

''(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law, an amount that is the median contracted rate for such item or service for such year;

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

''(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under such health plan with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such method.

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

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

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

(2) CONFORMING AMENDMENTS.—

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

(i) in paragraph (1), by striking ''(as amended by the Patient Protection and Affordable Care Act)'' and inserting ''(other than, with respect to a plan year beginning on or after January 1, 2022, the provisions of section 2719A of such Act)''; and

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

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

(B) APPLICATION TO RETIREE-ONLY PLANS.—Section 9831(a) of the Internal Revenue Code of 1986 is amended by inserting ''(other than, with respect to a group health plan described in paragraph (2), the requirements of section 9816)'' before ''shall not apply''.

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

''Sec. 9815. Additional market reforms.
''Sec. 9816. Patient protections.''.

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

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

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

"SEC. 716. PATIENT PROTECTIONS.

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

"(b) COST-SHARING AND PAYMENT OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a health plan provides or covers any benefits with respect to services in an emergency department of a hospital and, for plan year 2022 or a subsequent plan year, with respect to emergency services in an independent freestanding emergency department, the plan shall cover emergency services—

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

"(B) whether the health care provider furnishing such services is a participating provider or a participating facility that is an emergency department of a hospital or an independent freestanding emergency department (in this subsection referred to as a 'participating emergency facility') with respect to such services;

''(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating facility that is an emergency department of a hospital or an independent freestanding emergency department—

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

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

''(iii) such cost-sharing requirement is calculated as if the contracted rate for such services if furnished by a participating provider or a participating emer-

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

''(iv) the health plan pays to such provider or facility, respectively, the amount by which the out-of-network rate for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

''(v) any deductible or out-of-pocket maximum that would apply if such services were furnished by a participating provider or a participating emergency facility shall be the deductible or out-of-pocket maximum that applies; and

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

''(2) AUDIT PROCESS AND RULEMAKING PROCESS FOR MEDIAN CONTRACTED RATES.—

''(A) AUDIT PROCESS.—

"(i) IN GENERAL.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury and in consultation with the National Association of Insurance Commissioners, shall establish through rulemaking a process, in accordance with clause (ii), under which health plans are audited by the Secretary to ensure that—

"(I) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

"(II) that such median contracted rate so applied satisfies the definition under subsection (k)(8) with respect to the year involved.

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

"(I) shall conduct audits described in such clause of a sample of health plans; and

''(II) may audit any health plan if the Secretary has received any complaint about such plan that involves the compliance of the plan with the requirement described in such clause.

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

''(i) the methodology the sponsor or issuer of a health plan shall use to determine the median contracted rate, which shall account for relevant payment adjustments that take into account facility type that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities; and

''(ii) the information such sponsor or issuer shall share with the nonparticipating provider involved when making such a determination.

''(c) ACCESS TO PEDIATRIC CARE.—

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

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

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

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

''(1) GENERAL RIGHTS.—

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

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

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

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

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

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

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

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

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

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

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

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

provider furnishing such items or services is at the facility.

''(3) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.

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

''(5) EMERGENCY SERVICES.—

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

''(i) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency

department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

''(B) INCLUSION OF ADDITIONAL SERVICES.—In the case of an individual enrolled in a health plan who is furnished services described in subparagraph (A) by a provider or hospital or independent freestanding emergency

department to stabilize such individual with respect to an emergency medical condition, the term 'emergency services' shall include, in addition to those described in subparagraph (A), items and services furnished as part of outpatient observation or an inpatient or outpatient stay during a visit in which such individual is so stabilized with respect to such emergency condition if—

''(i) such items and services would otherwise be covered under such plan if furnished by a participating provider or participating facility; and

''(ii) such items and services are furnished—

''(I) to maintain, improve, or resolve the individual's stabilization with respect to such condition, unless any circumstance described in subparagraph (C) has occurred with respect to such individual before such items and services are furnished; or

''(II) for any purpose not described in subclause (I), unless each of the criteria described in subpara-

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

''(C) CIRCUMSTANCES.—For purposes of subparagraph (B)(ii)(I), a circumstance described in this subparagraph is any of the following, with respect to an individual who is a beneficiary, participant, or enrollee of a health plan who is furnished services described in subparagraph (A) by a hospital or independent freestanding emergency department with respect to an emergency medical condition:

''(i) A participating provider, with respect to such plan, with privileges at the hospital or independent freestanding emergency department assumes responsibility for the care of the individual.

''(ii) A participating provider, with respect to such plan, assumes responsibility for the care of the individual through transfer of the individual.

''(iii) The health plan and the provider treating such individual at the hospital or independent freestanding emergency department for such condition reach

an agreement concerning the care for the individual.

''(iv) The individual is discharged.

''(D) SIGNED NOTICE CRITERIA.—For purposes of subparagraph (B)(ii)(II), the criteria described in this subparagraph, with respect to an individual and an item or service furnished by a nonparticipating provider or nonparticipating facility that is a hospital or an independent freestanding emergency department, are the following:

''(i) A written notice (as specified by the Secretary and in a clear and understandable manner) is provided by such provider or facility to such individual, before such item or service is furnished, that includes the following information:

''(I) That such provider or facility is a nonparticipating provider or nonparticipating facility (as applicable).

''(II) To the extent practicable, the estimated amount that such nonparticipating facility or nonpartici-

pating provider may charge the individual for such item or service.

''(III) A statement that the individual may seek such item or service from a provider that is a participating provider or a hospital or independent freestanding emergency department that is a participating facility and a list, if feasible, of participating facilities or participating providers, as applicable, who are able to furnish such item or service.

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

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

''(6) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a health insurance issuer in the group market and includes a grandfathered health

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

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

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

''(B) provides emergency services.

''(8) MEDIAN CONTRACTED RATE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'median contracted rate' means, with respect to a health plan—

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

provided by a provider or facility in the same or similar specialty and provided in the geographic region (established (and updated, as appropriate) by the Secretary, in consultation with the National Association of Insurance Commissioners) in which the item or service is furnished, consistent with the methodology established by the Secretary under subsection (b)(2)(B), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, 2020, and 2021;

''(ii) for an item or service furnished during 2023 or a subsequent year through 2026, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

''(iii) for an item or service furnished during a rebasing year (as defined in subparagraph (D)), the median of the contracted rates recognized by the sponsor or issuer of such plan (determined with re-

spect to all such plans of such sponsor or issuer that are within the same line of business (as specified in subparagraph (C)) as the plan involved) as the total maximum payment under such plans in such year for the same or a similar item or service that is provided by a provider or facility in the same or similar specialty and provided in the geographic region (as established pursuant to clause (i)) in which the item or service is furnished, consistent with the methodology established by the Secretary under subsection (b)(2)(B); and

''(iv) for an item or service furnished during any of the 4 years following a rebasing year, the median contracted rate for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(B) USE OF SUBSTITUTE RATE IN CASE OF INSUFFICIENT DATA.—

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

sufficient information (as specified by the Secretary) to calculate the median of the contracted rates in accordance with subparagraph (A) for a year for an item or service furnished in a particular geographic region (as established pursuant to subparagraph (A)(i)) by a type of provider or facility, the substitute rate (as defined in clause (ii)) for such item or service shall be deemed to be the median contracted rate for such item or service furnished in such region during such year by such a provider or facility for such year under such subparagraph (A) for such plan.

''(ii) SUBSTITUTE RATE.—For purposes of clause (i), the term 'substitute rate' means, with respect to an item or service furnished by a provider or facility in a geographic region (established pursuant to subparagraph (A)(i)) during a year for which a health plan is required to make payment pursuant to subsection (b)(1), (e)(1), or (i)(1)—

''(I) if sufficient information (as specified by the Secretary) exists to

determine the median of the contracted rates recognized by all health plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan for such an item or service furnished in such region by such a provider or facility during such year using a database or other source of information determined appropriate by the Secretary, such median; and

''(II) if such sufficient information does not exist, the median of the contracted rates recognized by all health plans offered in the same line of business (as specified in subparagraph (C)) by any group health plan for such an item or service furnished in a similarly situated geographic region (as determined by the Secretary) with such sufficient information by such a provider or facility during such year using such a database or such other source of information.

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

''(C) LINE OF BUSINESS.—A line of business specified in this subparagraph is one of the following:

''(i) The small group market.

''(ii) The large group market.

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

''(D) REBASING YEAR DEFINED.—For purposes of subparagraph (A), the term 'rebasing year' means 2027 and every 5 years thereafter.

''(9) NONPARTICIPATING FACILITY; PARTICIPATING FACILITY.—

''(A) NONPARTICIPATING FACILITY.—The term 'nonparticipating facility' means, with respect to an item or service and a health plan, a health care facility described in subparagraph

(B)(ii) that does not have a contractual relationship with the plan for furnishing such item or service.

''(B) PARTICIPATING FACILITY.—

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

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

''(I) A hospital (as defined in 1861(e) of the Social Security Act), including an emergency department of a hospital.

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

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

''(IV) A laboratory.

"(V) A radiology facility or imaging center.

"(VI) An independent freestanding emergency department.

"(VII) Any other facility specified by the Secretary.

"(10) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

"(A) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who does not have a contractual relationship with the plan for furnishing such item or service under the plan.

"(B) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who has a contractual relationship with the plan for furnishing such item or service under the plan.

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

such item or service from a nonparticipating provider or facility—

"(A) subject to subparagraphs (C) and (D), in the case such State has in effect a State law that provides for a method for determining the total amount payable under such health plan regulated by such State with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such law;

"(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

"(i) subject to clause (ii), if the provider or facility (as applicable) and such plan agree on an amount of payment (including if agreed on through open negotiations under subsection (j)(1)) with respect to such item or service, such agreed on amount; or

"(ii) if such provider or facility (as applicable) and such plan enter the mediated dispute process under subsection (j) and do not so agree before the date on

which a selected independent entity (as defined in paragraph (3) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination;

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

''(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under such health plan with respect to such item or service furnished by such provider or facility, such amount determined in accordance with such method.

''(12) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service furnished in a State during a year to a par-

ticipant or beneficiary of a health plan by a nonparticipating provider or nonparticipating facility—

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

"(B) subject to subparagraphs (C) and (D), in the case such State does not have in effect such a law, an amount that is the median contracted rate for such item or service for such year;

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

"(D) in the case such health plan is a self-insured group health plan and in the case of a State with an agreement with such plan in effect as of the date of the enactment of the Consumer Protections Against Surprise Medical Bills Act of 2020, that provides for a method for determining the total amount payable under

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

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

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

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

(2) CONFORMING AMENDMENT.—

(A) APPLICATION PROVISIONS.—Section 715(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d(a)) is amended—

(i) in paragraph (1), by striking ''(as amended by the Patient Protection and Affordable Care Act)'' and inserting ''(other

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

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

(B) APPLICATION TO RETIREE-ONLY PLANS.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(3) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new items:

''Sec. 715. Additional market reforms.
''Sec. 716. Patient protections.''.

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

SEC. 3. CONSUMER PROTECTIONS THROUGH REQUIREMENTS ON HEALTH PLANS TO PREVENT SURPRISE MEDICAL BILLS FOR NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

(a) PHSA AMENDMENTS.—

(1) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as amended by section 2(a), is further amended by inserting before subsection (k) the following new subsection:

''(e) COST-SHARING AND PAYMENT OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of items or services (other than emergency services to which subsection (b) applies or items and services to which subsection (i) applies) furnished to a participant, beneficiary, or enrollee of a health plan by a nonparticipating provider during a visit (as defined by the Secretary in accordance with subsection (k)(2)) at a participating facility, if such items and services would otherwise be covered under such plan if furnished by a participating provider, the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a participating provider;

''(B) shall calculate such cost-sharing amount as if the contracted rate for such services if furnished by a participating provider were equal to the recognized amount for such items and services;

''(C) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the out-of-network rate for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

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

''(2) EXCEPTION.—Paragraph (1) shall not apply to a health plan in the case of items or services furnished to a participant, beneficiary, or enrollee of a health plan by a nonparticipating provider during a visit (as so defined by the Secretary in accordance with subsection (k)(2)) at a participating facility if the requirement described in paragraph (1) of section 1150C(b) of the Social Security Act does not apply with respect to such provider and such items and services due to the application of paragraph (2) of such section.''.

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

(b) IRC AMENDMENTS.—

(1) IN GENERAL.—Section 9816 of the Internal Revenue Code of 1986, as added by section 2(b), is amended by inserting before subsection (k) the following new subsection:

''(e) COST-SHARING AND PAYMENT OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of items or services (other than emergency services to which subsection (b) applies or

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

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

''(B) shall calculate such cost-sharing amount as if the contracted rate for such services if furnished by a participating provider were equal to the recognized amount for such items and services;

''(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the out-of-network rate for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined

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

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

''(2) EXCEPTION.—Paragraph (1) shall not apply to a health plan in the case of items or services furnished to a participant or beneficiary of a health plan by a nonparticipating provider during a visit (as so defined by the Secretary in accordance with subsection (k)(2)) at a participating facility if the requirement described in paragraph (1) of section 1150C(b) of the Social Security Act does not apply with respect to such provider and such items and services due to the application of paragraph (2) of such section.''.

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

(c) ERISA AMENDMENTS.—

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

''(e) COST-SHARING AND PAYMENT OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of items or services (other than emergency services to which subsection (b) applies or items and services to which subsection (i) applies) furnished to a participant or beneficiary of a health plan by a nonparticipating provider during a visit (as defined by the Secretary in accordance with subsection (k)(2)) at a participating facility, if such items and services would otherwise be covered under such plan if furnished by a participating provider, the plan—

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

''(B) shall calculate such cost-sharing amount as if the contracted rate for such services if furnished by a participating provider were equal to the recognized amount for such items and services;

''(C) shall pay to such provider furnishing such items and services to such participant or beneficiary the amount by which the out-of-network rate for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

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

''(2) EXCEPTION.—Paragraph (1) shall not apply to a health plan in the case of items or services furnished to a participant or beneficiary of a health plan by a nonparticipating provider during a visit (as so defined by the Secretary in accordance with subsection (k)(2)) at a participating facility if the requirement described in paragraph (1) of section 1150C(b) of the Social Security Act does not apply with respect to such provider and such items and services due to the application of paragraph (2) of such section.''.

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

SEC. 4. CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS.

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

(1) by striking ''at a minimum, includes'' and inserting ''at a minimum—

''(A) includes'';

(2) by striking at the end ''or'' and inserting ''and''; and

(3) by adding at the end the following new subparagraph:

''(B) beginning not later than January 1, 2022, applies such external review process with respect to any adverse determination by such plan or issuer under subsection (b) of section 2719A, subsection (e) of such section, or subsection (i) of such section, including with respect to whether an item or service that is the subject to such a determination is an item or

service to which such subsection (b), (e), or (i) applies; or''.

SEC. 5. CONSUMER PROTECTIONS THROUGH HEALTH PLAN TRANSPARENCY REQUIREMENTS.

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

''(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

''(C) establish the database described in paragraph (4); and

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

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

''(A) under which such plan verifies and updates the provider directory information included on the database described in paragraph (4) of such plan of—

''(i) not less frequently than once every 90 days, a random sample of at least 10 percent of health care providers and health care facilities included in such database; and

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

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

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

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

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

''(A) responds to such individual as soon as practicable, and in no case later than 1 business day after such call or email is received, through a written electronic or paper (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

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

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

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

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a directory containing provider directory information with respect to a health plan, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan should consult the database described in paragraph (4) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

''(6) DEFINITION.—For purposes of this section, the term 'provider directory information' includes, with respect to a health plan, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan has a contractual relationship for furnishing items and services under such plan.

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

available, post on a website of such plan available to individuals enrolled under such plan, and include on each explanation of benefits for an item or service with respect to which the requirements under subsection (b), (e), or (i) applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under section 1150C of the Social Security Act (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan with respect to which such a provider is a nonparticipating provider or facility is a nonparticipating facility, with respect to such plan, for furnishing such item or service after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under subsections (b), (e), and (i); and

''(2) information in plain language on contacting appropriate State and Federal agencies in the case that an individual believes that such a health plan, provider, or facility has violated any requirement described in paragraph (1) with respect to such individual.''.

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

''(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

''(C) establish the database described in paragraph (4); and

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

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

''(A) under which such plan verifies and updates the provider directory information included on the database described in paragraph (4) of such plan of—

''(i) not less frequently than once every 90 days, a random sample of at least 10 percent of health care providers and health care facilities included in such database; and

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

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

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

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

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

''(A) responds to such individual as soon as practicable, and in no case later than 1 business day after such call or email is received, through a written electronic or paper (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

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

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

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

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a directory containing provider directory information with respect to a health plan, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan should consult the database described in paragraph (4) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

''(6) DEFINITION.—For purposes of this section, the term 'provider directory information' includes, with respect to a health plan, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan has a contractual relationship for furnishing items and services under such plan.

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

available, post on a website of such plan available to individuals enrolled under such plan, and include on each explanation of benefits for an item or service with respect to which the requirements under subsection (b), (e), or (i) applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under section 1150C of the Social Security Act (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant or beneficiary of such plan with respect to which such a provider is a nonparticipating provider or facility is a nonparticipating facility, with respect to such plan, for furnishing such item or service after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant or beneficiary; and

''(C) the requirements applied under subsections (b), (e), and (i); and

''(2) information in plain language on contacting appropriate State and Federal agencies in the case that an individual believes that such a health plan, provider, or facility has violated any requirement described in paragraph (1) with respect to such individual.''.

(c) ERISA AMENDMENTS.—Section 716 of the Employee Retirement Income Security Act of 1974, as added by section 2(c) and amended by section 3(c), is further amended by inserting before subsection (k) the following new subsections:

''(f) PROVIDER DIRECTORY REQUIREMENTS.—

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

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

''(C) establish the database described in paragraph (4); and

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

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

''(A) under which such plan verifies and updates the provider directory information included on the database described in paragraph (4) of such plan of—

''(i) not less frequently than once every 90 days, a random sample of at least 10 percent of health care providers and health care facilities included in such database; and

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

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

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

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

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

''(A) responds to such individual as soon as practicable, and in no case later than 1 business day after such call or email is received, through a written electronic or paper (as requested by such individual) communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

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

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

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

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a directory containing provider directory information with respect to a health plan, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan should consult the database described in paragraph (4) with respect to such plan or contact such plan to obtain the most current provider directory information with respect to such plan.

''(6) DEFINITION.—For purposes of this section, the term 'provider directory information' includes, with respect to a health plan, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan has a contractual relationship for furnishing items and services under such plan.

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

available, post on a website of such plan available to individuals enrolled under such plan, and include on each explanation of benefits for an item or service with respect to which the requirements under subsection (b), (e), or (i) applies—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under section 1150C of the Social Security Act (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant or beneficiary of such plan with respect to which such a provider is a nonparticipating provider or facility is a nonparticipating facility, with respect to such plan, for furnishing such item or service after receiving payment from the plan for such item or service and any applicable cost-sharing payment from such participant or beneficiary; and

''(C) the requirements applied under subsections (b), (e), and (i); and

''(2) information in plain language on contacting appropriate State and Federal agencies in the case that an individual believes that such a health plan, provider, or facility has violated any requirement described in paragraph (1) with respect to such individual.''.

SEC. 6. CONSUMER PROTECTIONS THROUGH HEALTH PLAN REQUIREMENT FOR FAIR AND HONEST ADVANCE COST ESTIMATE.

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

''(h) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each health plan shall, with respect to a notification submitted under section 1150D(b)(2)(A) of the Social Security Act by a health care provider or health care facility, respectively, to the health plan for a participant, beneficiary, or enrollee under such health plan scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case such notification was made

pursuant to a request by such participant, beneficiary, or enrollee), 3 business days) after the date on which the health plan receives such notification, provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language) including the following:

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

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

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan, a description of how such individual may obtain information on providers and facilities that, with respect to such health plan, are participating providers and facilities.

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

''(3) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing (including with respect to the deductible and any copayment or coinsurance obligation) for which the participant, beneficiary, or enrollee would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the health plan (as of the date of such notification).

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the health plan, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or of participating providers, as applicable, who are able to furnish such items and services involved.

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

''(i) COST-SHARING AND PAYMENT FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant, beneficiary, or enrollee of a health plan by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such partici-

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

"(A) shall not impose on such enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan had such item or service been furnished by a participating provider;

"(B) shall calculate such cost-sharing amount as if the contracted rate for such item or service furnished by such a participating provider or facility were equal to—

"(i) the most recent (as of the date such item or service was furnished) contracted rate in effect between such provider or facility and such plan for such item or service furnished under such plan, if any; or

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

"(C) shall pay to such nonparticipating provider or facility furnishing such item or service to such participant, beneficiary, or enrollee the amount by which—

''(i) if a contracted rate described in subparagraph (B)(i) exists, the most recent (as of the date such item or services was furnished) such rate; or

''(ii) if no contracted rate described in such subparagraph exists, the out-of-network rate;

for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

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

''(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant, beneficiary, or enrollee of a health plan by a nonparticipating provider or a nonparticipating facility, are the following:

''(A) The participant, beneficiary, or enrollee received a notification under subsection (h) with respect to such item and service to be furnished and such notification provided infor-

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

''(B) A notification was not provided, in accordance with subsection (h), to the participant, beneficiary, or enrollee, and the participant, beneficiary, or enrollee requested through the response protocol of the plan under subsection (f)(3) information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.''.

(b) IRC AMENDMENTS.—Section 9816 of the Internal Revenue Code of 1986, as added by section 2(b) and amended by sections 3(b) and 5(b), is further amended by inserting before subsection (k) the following new subsections:

''(h) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each health plan shall, with respect to a notification submitted under section 1150D(b)(2)(A) of the Social Security Act by a health

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

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

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

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan, a description of how such

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

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

''(3) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing (including with respect to the deductible and any copayment or coinsurance obligation) for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the health plan (as of the date of such notification).

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the health

plan, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or of participating providers, as applicable, who are able to furnish such items and services involved.

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

''(i) COST-SHARING AND PAYMENT FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

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

nonparticipating facility, if such item or service would otherwise be covered under such plan if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant or beneficiary and item or service, the plan—

''(A) shall not impose on such enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan had such item or service been furnished by a participating provider;

''(B) shall calculate such cost-sharing amount as if the contracted rate for such item or service furnished by such a participating provider or facility were equal to—

''(i) the most recent (as of the date such item or service was furnished) contracted rate in effect between such provider or facility and such plan for such item or service furnished under such plan, if any; or

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

''(C) shall pay to such nonparticipating provider or facility furnishing such item or service to such participant or beneficiary the amount by which—

''(i) if a contracted rate described in subparagraph (B)(i) exists, the most recent (as of the date such item or services was furnished) such rate; or

''(ii) if no contracted rate described in such subparagraph exists, the out-of-network rate;

for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

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

''(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant or beneficiary of a health plan by a nonparticipating provider or a nonparticipating facility, are the following:

''(A) The participant or beneficiary received a notification under subsection (h) with respect to such item and service to be furnished and such notification provided information that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) A notification was not provided, in accordance with subsection (h), to the participant or beneficiary and the participant or beneficiary requested through the response protocol of the plan under subsection (f)(3) information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.''.

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

''(h) ADVANCED EXPLANATION OF BENEFITS.—Beginning on January 1, 2022, each health plan shall, with respect to a notification submitted under section 1150D(b)(2)(A) of the Social Security Act by a health care provider or health care facility, respectively, to the health plan for a participant or beneficiary under such health plan scheduled to receive an item or service from the provider or facility, not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case such notification was made pursuant to a request by such participant or beneficiary), 3 business days) after the date on which the health plan receives such notification, provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language) including the following:

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

''(A) in the case the provider or facility is a participating provider or facility with respect to the health plan with respect to the furnishing

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

''(B) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan, a description of how such individual may obtain information on providers and facilities that, with respect to such health plan, are participating providers and facilities.

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

''(3) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in paragraph (2).

''(4) A good faith estimate of the amount of any cost-sharing (including with respect to the deductible and any copayment or coinsurance obligation) for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

''(5) A good faith estimate of the amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket

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

''(6) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the health plan, a disclaimer that coverage for such item or service is subject to such medical management technique.

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

''(8) A statement that the individual may seek such an item or service from a provider that is a participating provider or a facility that is a participating facility and a list of participating facilities, or of participating providers, as applicable, who are able to furnish such items and services involved.

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

''(i) COST-SHARING AND PAYMENT FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT PROVIDER NETWORK INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant or beneficiary of a health plan by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant or beneficiary and item or service, the plan—

''(A) shall not impose on such enrollee a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan had such item or service been furnished by a participating provider;

''(B) shall calculate such cost-sharing amount as if the contracted rate for such item or service furnished by such a participating provider or facility were equal to—

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

tracted rate in effect between such provider or facility and such plan for such item or service furnished under such plan, if any; or

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

''(C) shall pay to such nonparticipating provider or facility furnishing such item or service to such participant or beneficiary the amount by which—

''(i) if a contracted rate described in subparagraph (B)(i) exists, the most recent (as of the date such item or services was furnished) such rate; or

''(ii) if no contracted rate described in such subparagraph exists, the out-of-network rate;

for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

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

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

''(2) CRITERIA DESCRIBED.—For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant or beneficiary of a health plan by a nonparticipating provider or a nonparticipating facility, are the following:

''(A) The participant or beneficiary received a notification under subsection (h) with respect to such item and service to be furnished and such notification provided information that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

''(B) A notification was not provided, in accordance with subsection (h), to the participant or beneficiary and the participant or beneficiary requested through the response protocol of the plan under subsection (f)(3) information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a partici-

pating provider or facility was such a participating facility.''.

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

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

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a health plan, in a State described in subparagraph (B) of subsection (k)(11) with respect to such plan and provider or facility, and for which a payment is required to be made by the health plan pursuant to subsection (b)(1), (e)(1), or (i)(1), the provider or facility (as applicable) or plan may, during the 30-day period beginning on the day the provider

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

''(B) EXCHANGE OF INFORMATION.—In carrying out negotiations initiated under subparagraph (A), with respect to an item or service described in such subparagraph furnished in a year, not later than the fifth business day of the open negotiation period described in such subparagraph with respect to such item or service—

''(i) the health plan that is party to such negotiations shall notify the provider or facility that is party to such negotia-

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

''(ii) such provider or facility shall notify such health plan of—

''(I) the median of the total amount of reimbursement (including any cost-sharing) paid, for the most recent year for which information is available, to such provider or facility for furnishing such item or service to a participant, beneficiary, or enrollee of a health plan that, at the time such item or service was furnished, had a contract in effect with such provider or facility with respect to the furnishing of such item or service;

''(II) in the case that information described in subclause (I) is not available, such information as specified by the Secretary; and

''(III) any additional information specified by the Secretary.

''(C) ACCESSING MEDIATED DISPUTE PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to

subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or health plan that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the mediated dispute process under paragraph (2) with respect to such item or service. The mediated dispute process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

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

"(A) ESTABLISHMENT.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of the Treasury and the Secretary of Labor, shall establish a process (in this subsection referred to as the 'mediated dispute process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or health plan submits a notification under paragraph (1)(C) (in this subsection referred to as a 'qualified mediated dispute item or service'), an entity selected under paragraph (3) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the health plan for such item or service furnished by such provider or facility.

"(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the mediated dispute process, in the case that the parties to a determination for a qualified mediated dispute item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (3) makes

such determination, such amount shall be treated for purposes of subsection (k)(11)(B) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the mediated dispute process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

''(A) that allows the parties to such determination to jointly select, not later than the last day of the 3-day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under paragraph (7) that—

"(i) is not a party to such determination or an employee or agent of such a party;

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

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

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

"(i) select such an entity that satisfies clauses (i) through (iii) of subparagraph (A); and

"(ii) provide notification of such selection to the provider or facility (as applicable) and the health plan party to such determination.

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

"(4) TREATMENT OF CONSIDERATION OF MULTIPLE ITEMS AND SERVICES.—

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

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

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

"(iii) such items and services are related to the treatment of a similar condition.

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

such items and services included in such bundled payment may be part of a single determination under this subsection.

''(C) WAIVER OF DEADLINES.—For purposes of permitting joint consideration of qualified mediated dispute items and services as part of a single determination under the criteria specified pursuant to subparagraph (A), the Secretary may waive any deadline specified in this subsection.

''(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of initiation of the mediated dispute resolution with respect to a determination for a qualified mediated dispute item or service, the provider or facility and the health plan party to such determination shall each submit to the selected independent entity—

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

''(ii) information relating to such offer; and

''(iii) such other information as requested by the selected independent entity.

''(C) CONSIDERATIONS.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the considerations specified in this subparagraph, with respect to

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

"(I) The median contracted rate for such item or service.

"(II) Subject to clause (ii), information that is submitted pursuant to subparagraph (B).

"(ii) TREATMENT OF CERTAIN CONSIDERATIONS.—In making a determination with respect to a qualified mediated dispute item or service pursuant to subparagraph (A)(i), a selected independent entity may not take into account usual and customary charges for the item or service nor charges billed by the provider or facility for the item or service.

"(6) SELECTED INDEPENDENT ENTITY COMPENSATION.—

"(A) IN GENERAL.—Not later than 5 days after receiving a notification described in paragraph (5)(A)(ii) from a selected independent entity with respect to the determination of a payment amount for a qualified mediated dispute item or service, the party to such determination whose offer submitted under para-

graph (5)(B) was not selected by the entity shall pay to such entity a fee in compensation for the services of such entity in accordance with the guidelines on such compensation established by the Secretary under subparagraph (B).

''(B) GUIDELINES ON COMPENSATION.—For purposes of subparagraph (A), the Secretary shall establish guidelines with respect to the compensation of a selected independent entity for the services of such entity with respect to determinations under the mediated dispute process. Such guidelines shall provide that such compensation reimburses the entity for at least the costs of such entity in performing the duties of the entity under the mediated dispute process.

''(7) CERTIFICATION OF ENTITIES.—

''(A) IN GENERAL.—The Secretary shall establish or recognize a process to certify (including recertification of) entities under this paragraph. Such process shall ensure that an entity so certified—

''(i) has (directly or through contracts or other arrangements) sufficient medical,

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

''(ii) is not—

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

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

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

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

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

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

''(vi) does not under the mediated dispute process carry out any determination

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

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

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

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

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

''(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (2).

''(F) PROVISION OF INFORMATION.—

''(i) IN GENERAL.—An entity certified under this paragraph shall provide to the Secretary, in such manner as the Secretary may require and on a quarterly basis (as specified by the Secretary), such information as the Secretary determines appropriate to assure compliance with the requirements described in subparagraph (A) and to monitor and assess the determinations made by such entity and to ensure the absence of bias in making such determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable health information.

''(ii) INFORMATION TO BE INCLUDED.—The information described in

this clause with respect to an entity is the following:

''(I) The number of payment determinations described in paragraph (2) made by such entity, disaggregated by—

''(aa) the line of business (as specified in subsection (k)(8)(C)) of the health plans party to such determinations; and

''(bb) the type of providers and facilities party to such determinations.

''(II) A description of each item or service included in each such determination.

''(III) The amount of each offer submitted to the entity for each such determination.

''(IV) The amount of each such determination.

''(V) The length of time in making each such determination.

"(VI) The compensation paid to such entity with respect to each such determination.

"(VII) Any other information specified by the Secretary.

"(8) ADMINISTRATIVE FEE.—

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

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

"(9) SECRETARIAL REPORT; PUBLICATION OF INFORMATION.—

"(A) SECRETARIAL REPORT.—Beginning not later than July 1, 2023, the Secretary shall, in coordination with the Secretary of the Treasury and the Secretary of Labor, periodically study and submit to Congress a report on—

"(i) the extent to which the payment amount determined under this subsection for an item or service furnished in a year (or otherwise agreed to by a health plan and provider or facility for purposes of determining payment by the plan to the provider or facility pursuant to subsection (b)(1), (e)(1), or (i)(1))) differs from the median contracted rate for such item or service and year, including the number of times such determined (or agreed to) amount exceeds such median contracted rate; and

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

"(B) PUBLICATION OF INFORMATION.—Beginning with July 1, 2023, and for each calendar quarter thereafter, the Secretary shall, in

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

''(i) The information described in subclauses (I) through (V) of clause (ii) of paragraph (7)(F) that was submitted to the Secretary under clause (i) of such paragraph during such quarter.

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

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

''(iv) The total amount of compensation paid to selected independent entities under paragraph (6) during such quarter.''.

(b) IRC AMENDMENTS.—Section 9816 of the Internal Revenue Code of 1986, as added by section 2(b) and amended by sections 3(b), 5(b), and 6(b), is further amended by inserting before subsection (k) the following new subsection:

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a health plan, in a State described in subparagraph (B) of subsection (k)(11) with respect to such plan and provider or facility, and for which a payment is required to be made by the health plan pursuant to subsection (b)(1), (e)(1), or (i)(1), the provider or facility (as applicable) or plan may, during the 30-day period beginning on the day the provider or facility receives a response from the plan regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the

negotiations with respect to such item or service.

''(B) EXCHANGE OF INFORMATION.—In carrying out negotiations initiated under subparagraph (A), with respect to an item or service described in such subparagraph furnished in a year, not later than the fifth business day of the open negotiation period described in such subparagraph with respect to such item or service—

''(i) the health plan that is party to such negotiations shall notify the provider or facility that is party to such negotiations of the median contracted rate for such item or service and year; and

''(ii) such provider or facility shall notify such health plan of—

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

item or service was furnished, had a contract in effect with such provider or facility with respect to the furnishing of such item or service;

''(II) in the case that information described in subclause (I) is not available, such information as specified by the Secretary; and

''(III) any additional information specified by the Secretary.

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

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

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

''(A) ESTABLISHMENT.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall establish a process (in this subsection referred to as the 'mediated dispute process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or health plan submits a notification under paragraph (1)(C) (in this subsection referred to as a 'qualified mediated dispute item or service'), an entity selected under paragraph (3) determines,

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

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the mediated dispute process, in the case that the parties to a determination for a qualified mediated dispute item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (3) makes such determination, such amount shall be treated for purposes of subsection (k)(11)(B) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the mediated dispute process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

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

''(A) that allows the parties to such determination to jointly select, not later than the last day of the 3-day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under paragraph (7) that—

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

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

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

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

''(i) select such an entity that satisfies clauses (i) through (iii) of subparagraph (A); and

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

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

''(4) TREATMENT OF CONSIDERATION OF MULTIPLE ITEMS AND SERVICES.—

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

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

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

''(iii) such items and services are related to the treatment of a similar condition.

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

''(C) WAIVER OF DEADLINES.—For purposes of permitting joint consideration of qualified mediated dispute items and services as part of a single determination under the criteria specified pursuant to subparagraph (A), the Secretary may waive any deadline specified in this subsection.

''(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

each submit to the selected independent entity—

"(i) an offer for a payment amount under for such item or service furnished by such provider or facility;

"(ii) information relating to such offer; and

"(iii) such other information as requested by the selected independent entity.

"(C) CONSIDERATIONS.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the considerations specified in this subparagraph, with respect to a determination for a qualified mediated dispute item or service, are the following:

"(I) The median contracted rate for such item or service.

"(II) Subject to clause (ii), information that is submitted pursuant to subparagraph (B).

"(ii) TREATMENT OF CERTAIN CONSIDERATIONS.—In making a determination with respect to a qualified mediated dispute item or service pursuant to subparagraph (A)(i), a selected independent entity

may not take into account usual and customary charges for the item or service nor charges billed by the provider or facility for the item or service.

''(6) SELECTED INDEPENDENT ENTITY COMPENSATION.—

''(A) IN GENERAL.—Not later than 5 days after receiving a notification described in paragraph (5)(A)(ii) from a selected independent entity with respect to the determination of a payment amount for a qualified mediated dispute item or service, the party to such determination whose offer submitted under paragraph (5)(B) was not selected by the entity shall pay to such entity a fee in compensation for the services of such entity in accordance with the guidelines on such compensation established by the Secretary under subparagraph (B).

''(B) GUIDELINES ON COMPENSATION.—For purposes of subparagraph (A), the Secretary shall establish guidelines with respect to the compensation of a selected independent entity for the services of such entity with respect to determinations under the mediated dispute

process. Such guidelines shall provide that such compensation reimburses the entity for at least the costs of such entity in performing the duties of the entity under the mediated dispute process.

''(7) CERTIFICATION OF ENTITIES.—

''(A) IN GENERAL.—The Secretary shall establish or recognize a process to certify (including recertification of) entities under this paragraph. Such process shall ensure that an entity so certified—

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

''(ii) is not—

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

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

''(III) an affiliate or subsidiary of a professional or trade association of

health plans or of providers or facilities;

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

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

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

''(vi) does not under the mediated dispute process carry out any determination with respect to which the entity would not pursuant to clause (i), (ii), or (iii) of paragraph (3)(A) be eligible for selection; and

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

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

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

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

"(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (2).

"(F) PROVISION OF INFORMATION.—

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

specified by the Secretary), such information as the Secretary determines appropriate to assure compliance with the requirements described in subparagraph (A) and to monitor and assess the determinations made by such entity and to ensure the absence of bias in making such determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable health information.

''(ii) INFORMATION TO BE INCLUDED.—The information described in this clause with respect to an entity is the following:

''(I) The number of payment determinations described in paragraph (2) made by such entity, disaggregated by—

''(aa) the line of business (as specified in subsection (k)(8)(C)) of the health plans party to such determinations; and

''(bb) the type of providers and facilities party to such determinations.

''(II) A description of each item or service included in each such determination.

''(III) The amount of each offer submitted to the entity for each such determination.

''(IV) The amount of each such determination.

''(V) The length of time in making each such determination.

''(VI) The compensation paid to such entity with respect to each such determination.

''(VII) Any other information specified by the Secretary.

''(8) ADMINISTRATIVE FEE.—

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

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

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

''(9) SECRETARIAL REPORT; PUBLICATION OF INFORMATION.—

''(A) SECRETARIAL REPORT.—Beginning not later than July 1, 2023, the Secretary shall, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, periodically study and submit to Congress a report on—

''(i) the extent to which the payment amount determined under this subsection for an item or service furnished in a year (or otherwise agreed to by a health plan and provider or facility for purposes of determining payment by the plan to the pro-

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

''(ii) the effect of such difference on the cost-sharing for such item or service for a participant or beneficiary of a health plan.

''(B) PUBLICATION OF INFORMATION.—Beginning with July 1, 2023, and for each calendar quarter thereafter, the Secretary shall, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, make publicly available a summary of the following:

''(i) The information described in subclauses (I) through (V) of clause (ii) of paragraph (7)(F) that was submitted to the Secretary under clause (i) of such paragraph during such quarter.

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

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

''(iv) The total amount of compensation paid to selected independent entities under paragraph (6) during such quarter.''.

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

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

''(1) DETERMINATION THROUGH OPEN NEGOTIATION.—

''(A) IN GENERAL.—With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a health plan, in a State described in subparagraph (B) of subsection (k)(11) with respect to such plan and provider or facility, and for which a payment is required

to be made by the health plan pursuant to subsection (b)(1), (e)(1), or (i)(1), the provider or facility (as applicable) or plan may, during the 30-day period beginning on the day the provider or facility receives a response from the plan regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

''(B) EXCHANGE OF INFORMATION.—In carrying out negotiations initiated under subparagraph (A), with respect to an item or service described in such subparagraph furnished in a year, not later than the fifth business day of the open negotiation period described in such

subparagraph with respect to such item or service—

''(i) the health plan that is party to such negotiations shall notify the provider or facility that is party to such negotiations of the median contracted rate for such item or service and year; and

''(ii) such provider or facility shall notify such health plan of—

''(I) the median of the total amount of reimbursement (including any cost-sharing) paid, for the most recent year for which information is available, to such provider or facility for furnishing such item or service to a participant or beneficiary of a health plan that, at the time such item or service was furnished, had a contract in effect with such provider or facility with respect to the furnishing of such item or service;

''(II) in the case that information described in subclause (I) is not available, such information as specified by the Secretary; and

"(III) any additional information specified by the Secretary.

"(C) ACCESSING MEDIATED DISPUTE PROCESS IN CASE OF FAILED NEGOTIATIONS.—In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or health plan that was party to such negotiations may, during the 2-day period beginning on the day after such open negotiation period, initiate the mediated dispute process under paragraph (2) with respect to such item or service. The mediated dispute process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regula-

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

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

''(A) ESTABLISHMENT.—Not later than July 1, 2021, the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish a process (in this subsection referred to as the 'mediated dispute process') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or health plan submits a notification under paragraph (1)(C) (in this subsection referred to as a 'qualified mediated dispute item or service'), an entity selected under paragraph (3) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the health plan for such item or service furnished by such provider or facility.

''(B) AUTHORITY TO CONTINUE NEGOTIATIONS.—Under the mediated dispute process, in the case that the parties to a determination for

a qualified mediated dispute item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (3) makes such determination, such amount shall be treated for purposes of subsection (k)(11)(B) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the mediated dispute process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

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

''(A) that allows the parties to such determination to jointly select, not later than the last day of the 3-day period following the date of the initiation of the process with respect to such

item or service, for purposes of making such determination, an entity certified under paragraph (7) that—

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

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

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

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

''(i) select such an entity that satisfies clauses (i) through (iii) of subparagraph (A); and

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

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

shall be referred to in this subsection as the 'selected independent entity' with respect to such determination.

''(4) TREATMENT OF CONSIDERATION OF MULTIPLE ITEMS AND SERVICES.—

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

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

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

''(iii) such items and services are related to the treatment of a similar condition.

''(B) TREATMENT OF BUNDLED PAYMENTS.—In carrying out subparagraph (A), the

Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

''(C) WAIVER OF DEADLINES.—For purposes of permitting joint consideration of qualified mediated dispute items and services as part of a single determination under the criteria specified pursuant to subparagraph (A), the Secretary may waive any deadline specified in this subsection.

''(5) DETERMINATION OF PAYMENT AMOUNT.—

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

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

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

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

''(B) SUBMISSION OF OFFERS.—Not later than 10 days after the date of initiation of the mediated dispute resolution with respect to a determination for a qualified mediated dispute item or service, the provider or facility and the health plan party to such determination shall each submit to the selected independent entity—

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

''(ii) information relating to such offer; and

''(iii) such other information as requested by the selected independent entity.

''(C) CONSIDERATIONS.—

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

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

"(I) The median contracted rate for such item or service.

"(II) Subject to clause (ii), information that is submitted pursuant to subparagraph (B).

"(ii) TREATMENT OF CERTAIN CONSIDERATIONS.—In making a determination with respect to a qualified mediated dispute item or service pursuant to subparagraph (A)(i), a selected independent entity may not take into account usual and customary charges for the item or service nor charges billed by the provider or facility for the item or service.

"(6) SELECTED INDEPENDENT ENTITY COMPENSATION.—

"(A) IN GENERAL.—Not later than 5 days after receiving a notification described in paragraph (5)(A)(ii) from a selected independent entity with respect to the determination of a payment amount for a qualified mediated dispute item or service, the party to such deter-

mination whose offer submitted under paragraph (5)(B) was not selected by the entity shall pay to such entity a fee in compensation for the services of such entity in accordance with the guidelines on such compensation established by the Secretary under subparagraph (B).

''(B) GUIDELINES ON COMPENSATION.—For purposes of subparagraph (A), the Secretary shall establish guidelines with respect to the compensation of a selected independent entity for the services of such entity with respect to determinations under the mediated dispute process. Such guidelines shall provide that such compensation reimburses the entity for at least the costs of such entity in performing the duties of the entity under the mediated dispute process.

''(7) CERTIFICATION OF ENTITIES.—

''(A) IN GENERAL.—The Secretary shall establish or recognize a process to certify (including recertification of) entities under this paragraph. Such process shall ensure that an entity so certified—

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

''(ii) is not—

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

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

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

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

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

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

"(vi) does not under the mediated dispute process carry out any determination with respect to which the entity would not pursuant to clause (i), (ii), or (iii) of paragraph (3)(A) be eligible for selection; and

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

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

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

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

paragraph for failure of meeting a requirement of this subsection.

''(E) SUFFICIENT NUMBER OF ENTITIES.—The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (2).

''(F) PROVISION OF INFORMATION.—

''(i) IN GENERAL.—An entity certified under this paragraph shall provide to the Secretary, in such manner as the Secretary may require and on a quarterly basis (as specified by the Secretary), such information as the Secretary determines appropriate to assure compliance with the requirements described in subparagraph (A) and to monitor and assess the determinations made by such entity and to ensure the absence of bias in making such determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable health information.

"(ii) INFORMATION TO BE INCLUDED.—The information described in this clause with respect to an entity is the following:

"(I) The number of payment determinations described in paragraph (2) made by such entity, disaggregated by—

"(aa) the line of business (as specified in subsection (k)(8)(C)) of the health plans party to such determinations; and

"(bb) the type of providers and facilities party to such determinations.

"(II) A description of each item or service included in each such determination.

"(III) The amount of each offer submitted to the entity for each such determination.

"(IV) The amount of each such determination.

"(V) The length of time in making each such determination.

"(VI) The compensation paid to such entity with respect to each such determination.

"(VII) Any other information specified by the Secretary.

"(8) ADMINISTRATIVE FEE.—

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

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

''(9) SECRETARIAL REPORT; PUBLICATION OF INFORMATION.—

''(A) SECRETARIAL REPORT.—Beginning not later than July 1, 2023, the Secretary shall, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, periodically study and submit to Congress a report on—

''(i) the extent to which the payment amount determined under this subsection for an item or service furnished in a year (or otherwise agreed to by a health plan and provider or facility for purposes of determining payment by the plan to the provider or facility pursuant to subsection (b)(1), (e)(1), or (i)(1)) differs from the median contracted rate for such item or service and year, including the number of times such determined (or agreed to) amount exceeds such median contracted rate; and

''(ii) the effect of such difference on the cost-sharing for such item or service for a participant or beneficiary of a health plan.

"(B) PUBLICATION OF INFORMATION.—Beginning with July 1, 2023, and for each calendar quarter thereafter, the Secretary shall, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, make publicly available a summary of the following:

"(i) The information described in subclauses (I) through (V) of clause (ii) of paragraph (7)(F) that was submitted to the Secretary under clause (i) of such paragraph during such quarter.

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

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

"(iv) The total amount of compensation paid to selected independent entities under paragraph (6) during such quarter.".

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

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

SEC. 8. PROHIBITING BALANCE BILLING PRACTICES BY PROVIDERS FOR EMERGENCY SERVICES, FOR SERVICES FURNISHED BY NONPARTICIPATING PROVIDER AT PARTICIPATING FACILITY, AND IN CERTAIN CASES OF MISINFORMATION.

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

"SEC. 1150C. PROHIBITION ON CERTAIN BALANCE BILLING PRACTICES.

''(a) EMERGENCY SERVICES.—In the case of an individual with benefits under a group health plan or health insurance coverage offered in the group or individual market who is furnished in a plan year that begins on or after January 1, 2022, emergency services with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent freestanding emergency department—

''(1) if the hospital or independent freestanding emergency department does not have a contractual relationship with such plan or coverage for furnishing such services, the hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the individual for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with section 2719A(b) of the Public Health Service Act, section 716(b) of the Employee Retirement Income Security Act of 1974, or section 9816(b) of the Internal Revenue Code of 1986, as applicable); and

''(2) a health care provider without a contractual relationship with such plan or coverage for furnishing such services shall not bill, and shall not hold liable, such individual for a payment amount for such services furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the emergency department of the hospital or independent freestanding emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with section

2719A(b) of the Public Health Service Act, section 716(b) of the Employee Retirement Income Security Act of 1974, or section 9816(b) of the Internal Revenue Code of 1986, as applicable).

''(b) SERVICES FURNISHED BY NONPARTICIPATING PROVIDER AT PARTICIPATING FACILITY.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of an individual with benefits under a health plan who is furnished items or services (other than emergency services to which subsection (a) applies or items and services to which subsection (c) applies) in a plan year that, with respect to such plan or such coverage (as applicable), begins on or after January 1, 2022, at a participating facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such individual for a payment amount for such an item or service furnished by such provider during a visit at such facility that is more than the cost-sharing amount for such item or service (as determined in accordance with section 2719A(e) of the Public Health Service Act, section 716(e) of the Employee Retirement Income Security Act of 1974, or section 9816(e) of the Internal Revenue Code of 1986, as applicable).

''(2) EXCEPTION IN CASE NOTICE PROVIDED.—Paragraph (1) shall not apply with respect to items and services (other than items and services described in paragraph (3)) furnished to an individual enrolled in a group health plan or in health insurance coverage offered in the group or individual market by a health care provider that does not have a contractual relationship with such plan or coverage for furnishing such items and services if the following criteria are met:

''(A) A written notice (as specified by the Secretary and in clear and understandable language) is provided by the provider to such individual, not later than 48 hours before such items and services are to be so furnished, that includes the following information:

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

''(ii) The estimated amount that such provider may charge the individual for such items and services.

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

contractual relationship and a list, if feasible, of providers with such a relationship who are able to furnish such items and services involved.

''(B) On the date such item or service is to be furnished, before such item or service is so furnished, the individual signs and dates such notice confirming receipt of the notice and consent of the individual to be so furnished such items and services.

''(C) A copy of such signed and dated notice is provided by the provider to the plan or coverage.

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

''(c) RELIANCE ON INCORRECT PROVIDER INFORMATION.—In the case of an individual who is furnished items or services by a health care provider or health care facility for which a group health plan or health insurance issuer is required to make payment under section 2719A(i) of the Public Health Service Act, section 716(i) of the Employee Retirement Income Security Act of 1974, or section 9816(i) of the Internal Revenue Code of 1986, such pro-

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

''(d) COMPLIANCE WITH REQUIREMENTS UNDER OPEN NEGOTIATION AND MEDIATED DISPUTE RESOLUTION PROCESSES.—A health care provider or health care facility shall comply with any requirement imposed on such provider or facility, respectively, under section 2719A(j) of the Public Health Service Act, 9816(j) of the Internal Revenue Code of 1986, or 716(j) of the Employee Retirement Income Security Act of 1974.

''(e) PENALTY.—

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

''(2) APPLICATION OF PROVISIONS.—The provisions of section 1128A (other than subsection (a), subsection (b), the first sentence of subsection

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

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

''(1) The terms 'during a visit','emergency department of a hospital', 'emergency medical condition', 'emergency services', 'independent freestanding emergency department', 'nonparticipating provider', 'nonparticipating facility', 'participating facility', 'participating provider' have the meanings given such terms, respectively, in section 2719A(k) of the Public Health Service Act.

''(2) The terms 'group health plan', 'group market', 'health insurance issuer', 'health insurance coverage', and 'individual market' have the meanings given such terms, respectively, in section 2791 of the Public Health Service Act.

''(3) The term 'specified provider', with respect to an individual with benefits under a group health plan or health insurance coverage and a hospital with a contractual relationship with such plan or coverage for furnishing items and services—

''(A) means an ancillary health care provider, including emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers determined by the Secretary (including providers who furnish similar items and services as the providers specified in this paragraph); and

''(B) includes, with respect to an item or service, any health care provider furnishing such item or service at such hospital if there is no health care provider at such hospital who can furnish such item or service who has such a relationship with such plan or coverage for furnishing such item or service.''.

(b) PROVIDER DIRECTORY; PATIENT-PROVIDER DISPUTE RESOLUTION PROCESS.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by subsection (a), is further amended by adding at the end the following new sections:

''SEC. 1150D. PATIENT PROTECTIONS AGAINST SURPRISE BILLING THROUGH TRANSPARENCY.

''(a) SUBMISSION OF INFORMATION TO HEALTH PLANS OF CERTAIN PROVIDER INFORMATION.—Beginning not later than 1 year after the date of the enactment

of this section, each health care provider and health care facility shall establish a process under which such provider or facility transmits, to each health insurance issuer offering group or individual health insurance coverage and group health plan with which such provider or supplier has in effect a contractual relationship for furnishing items and services under such coverage or such plan, provider directory information (as defined in section 2719A(f)(6) of the Public Health Service Act, section 716(f)(6) of the Employee Retirement Income Security Act of 1974, or section 9816(f)(6) of the Internal Revenue Code of 1986, as applicable) with respect to such provider or facility, as applicable. Such provider or facility shall so transmit such information to such issuer offering such coverage or such group health plan—

''(1) when there are any material changes (including a change in address, telephone number, or other contact information) to such provider directory information of the provider or facility with respect to such coverage offered by such issuer or with respect to such plan; and

''(2) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

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

''(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

''(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably ex-

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

''(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

''(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

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

''(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 2730, 9817, or 717) for such items and services as payment in full for such items and services; and

''(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.

''(d) LIMITATION.—Beginning on January 1, 2022, a health care provider or health care facility may not initiate a process to seek reimbursement of payment for items and services furnished to an individual enrolled in a group health plan or health insurance coverage offered in the group or individual market more than 1 year after the date on which such items and services were so furnished.

''(e) PENALTY.—

''(1) GENERAL PENALTY.—

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

''(B) APPLICATION OF PROVISIONS.—The provisions of section 1128A (other than subsection (a), subsection (b), the first sentence of subsection (c)(1), and subsection (o)) shall

apply with respect to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under subsection (a) of such section.

''(2) PROVIDER DIRECTORY INFORMATION PENALTY.—

''(A) IN GENERAL.—Each health care provider or health care facility that fails to transmit information as required under subsection (a) shall be subject to a civil monetary penalty of $1,000 for each day such provider or facility (as applicable) fails to so transmit such information.

''(B) APPLICATION OF PROVISIONS.—The provisions of section 1128A (other than subsection (a), subsection (b), the first sentence of subsection (c)(1), subsection (d), and subsection (o)) shall apply with respect to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under subsection (a) of such section.

"SEC. 1150E. PATIENT-PROVIDER DISPUTE RESOLUTION.

"(a) IN GENERAL.—Not later than July 1, 2021, the Secretary shall establish a process (in this subsection referred to as the 'patient-provider dispute resolution process') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 1150D(b), from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term 'uninsured individual' means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, health insurance coverage offered in the group or individual market by a health insurance issuer, Federal health care program (as defined in section 1128B(f)), or a health benefits plan under chapter 89 of title 5, United States Code (or an individual who has benefits for such item or service under a group health plan or health insurance coverage offered in the group or indi-

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

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

''(1) a method to select to make such determination an entity certified under subsection (d) that—

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

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

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

''(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

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

''(c) ADMINISTRATIVE FEE.—The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

''(d) CERTIFICATION.—The Secretary shall establish or recognize a process to certify entities under this subparagraph. Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 2719A(j)(7) of the Public Health Service Act.''.

SEC. 9. ADDITIONAL CONSUMER PROTECTIONS.

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

''SEC. 2730. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or group or

individual health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

''(A) such contractual relationship is terminated (as defined in subsection (b));

''(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under

subparagraph (A) is provided and ending on the earlier of—

"(i) the 90-day period beginning on such date; or

"(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

"(b) DEFINITIONS.—In this section:

"(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

"(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

"(B) is undergoing a course of institutional or inpatient care from the provider or facility;

"(C) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

"(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that is—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

"SEC. 2731. INFORMATION REQUIRED TO BE INCLUDED ON HEALTH INSURANCE MEMBERSHIP CARDS.

''In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that provides a physical or electronic card indicating membership in such plan or coverage to an individual enrolled under such plan or coverage, such group health plan or issuer shall include on such card each of the following:

''(1) The nearest hospital to the primary residence of such individual that has in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

''(2) A telephone number or Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

''(3) Any deductible applicable to such individual.

''(4) Any out-of-pocket maximum applicable to such individual.

''(5) Any cost-sharing obligation applicable to such individual for a visit at an emergency department, or urgent care facility, that has in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

''SEC. 2732. MAINTENANCE OF PRICE COMPARISON TOOL.

''In connection with the offering of a group health plan or group or individual health insurance coverage in a geographic region for a plan year, a plan sponsor or health insurance issuer, respectively, shall employ an individual to offer price comparison guidance, or make available on an Internet website a price comparison tool, that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year and such geographic region, to compare the amount (determined by historic claims data of participating providers with respect to such plan or coverage) of cost-sharing (including deductibles, copayments, and coinsurance) that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(b) INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as

amended by the previous sections, is further amended by adding at the end the following new sections:

"SEC. 9817. CONTINUITY OF CARE.

"(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

"(1) IN GENERAL.—In the case of an individual with benefits under a group health plan and with respect to a health care provider or facility that has a contractual relationship with such plan for furnishing items and services under such plan, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

"(A) such contractual relationship is terminated (as defined in paragraph (b));

"(B) benefits provided under such plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan; or

"(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with

such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan—

''(A) notify each individual enrolled under such plan who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had such termination not occurred, with respect to the course of treatment furnished by

such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

''(i) the 90-day period beginning on such date; or

''(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

''(b) DEFINITIONS.—In this section:

''(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

''(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

''(B) is undergoing a course of institutional or inpatient care from the provider or facility;

''(C) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

''(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

''(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

''(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan—

''(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, a condition that—

''(i) is life-threatening, degenerative, potentially disabling, or congenital; and

''(ii) requires specialized medical care over a prolonged period of time.

''(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a

termination of the contract for failure to meet applicable quality standards or for fraud.

"SEC. 9818. INFORMATION REQUIRED TO BE INCLUDED ON HEALTH INSURANCE MEMBERSHIP CARDS.

"In the case of a group health plan that provides a physical or electronic card indicating membership in such plan to an individual enrolled under such plan, such group health plan shall include on such card each of the following:

"(1) The nearest hospital to the primary residence of such individual that has in effect a contractual relationship with such plan for furnishing items and services under such plan.

"(2) A telephone number or Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan for furnishing items and services under such plan.

"(3) Any deductible applicable to such individual.

"(4) Any out-of-pocket maximum applicable to such individual.

''(5) Any cost-sharing obligation applicable to such individual for a visit at an emergency department, or urgent care facility, that has in effect a contractual relationship with such plan for furnishing items and services under such plan.

''SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.

''In connection with the offering of a group health plan in a geographic region for a plan year, a plan sponsor shall employ an individual to offer price comparison guidance, or make available on an Internet website a price comparison tool, that (to the extent practicable) allows an individual enrolled under such plan, with respect to such plan year and such geographic region, to compare the amount (determined by historic claims data of participating providers with respect to such plan) of cost-sharing (including deductibles, copayments, and coinsurance) that the individual would be responsible for paying under such plan with respect to the furnishing of a specific item or service by any such provider.''.

(2) CONFORMING AMENDMENT.—Section 9815(a) of the Internal Revenue Code of 1986, as amended by section 2(b), is further amended—

(A) in paragraph (1), by striking ''section 2719A'' and inserting ''section 2719A, 2730, 2731, or 2732''; and

(B) in paragraph (2), by striking ''section 2719A'' and inserting ''section 2719A, 2730, 2731, or 2732''.

(3) CLERICAL AMENDMENT.—The table of sections for such subchapter, as amended by section 2(b), is further amended by adding at the end the following new items:

''Sec. 9817. Continuity of care.
''Sec. 9818. Information required to be included on health insurance membership cards.
''Sec. 9819. Maintenance of price comparison tool.''.

(c) EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 2(c), is further amended by adding at the end the following new sections:

''SEC. 717. CONTINUITY OF CARE.

''(a) ENSURING CONTINUITY OF CARE WITH RESPECT TO TERMINATIONS OF CERTAIN CONTRACTUAL RELATIONSHIPS RESULTING IN CHANGES IN PROVIDER NETWORK STATUS.—

''(1) IN GENERAL.—In the case of an individual with benefits under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan and

with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

''(A) such contractual relationship is terminated (as defined in paragraph (b));

''(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

''(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

''(2) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

''(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

''(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

''(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under

subparagraph (A) is provided and ending on the earlier of—

"(i) the 90-day period beginning on such date; or

"(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

"(b) DEFINITIONS.—In this section:

"(1) CONTINUING CARE PATIENT.—The term 'continuing care patient' means an individual who, with respect to a provider or facility—

"(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

"(B) is undergoing a course of institutional or inpatient care from the provider or facility;

"(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

"(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

"(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

"(2) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage—

"(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

"(B) in the case of a chronic illness or condition, a condition that—

"(i) is life-threatening, degenerative, potentially disabling, or congenital; and

"(ii) requires specialized medical care over a prolonged period of time.

"(3) TERMINATED.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

"SEC. 718. INFORMATION REQUIRED TO BE INCLUDED ON HEALTH INSURANCE MEMBERSHIP CARDS.

''In the case of a group health plan or health insurance issuer offering group health insurance coverage that provides a physical or electronic card indicating membership in such plan or coverage to an individual enrolled under such plan or coverage, such group health plan or issuer shall include on such card each of the following:

''(1) The nearest hospital to the primary residence of such individual that has in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

''(2) A telephone number or Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

''(3) Any deductible applicable to such individual.

''(4) Any out-of-pocket maximum applicable to such individual.

''(5) Any cost-sharing obligation applicable to such individual for a visit at an emergency depart-

ment, or urgent care facility, that has in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

"SEC. 719. MAINTENANCE OF PRICE COMPARISON TOOL.

''In connection with the offering of a group health plan or group health insurance coverage in a geographic region for a plan year, a plan sponsor or health insurance issuer, respectively, shall employ an individual to offer price comparison guidance, or make available on an Internet website a price comparison tool, that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year and such geographic region, to compare the amount (determined by historic claims data of participating providers with respect to such plan or coverage) of cost-sharing (including deductibles, copayments, and coinsurance) that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.''.

(2) CONFORMING AMENDMENT.—Section 715(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d(a)), as amended by section 2(c), is further amended—

(A) in paragraph (1), by striking ''section 2719A'' and inserting ''section 2719A, 2730, 2731, or 2732''; and

(B) in paragraph (2), by striking ''section 2719A'' and inserting ''section 2719A, 2730, 2731, or 2732''.

(3) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 716 the following new items:

''Sec. 717. Continuity of care.
''Sec. 718. Information required to be included on health insurance membership cards.
''Sec. 719. Maintenance of price comparison tool.''.

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

SEC. 10. REPORTING REQUIREMENTS REGARDING AIR AMBULANCE SERVICES.

(a) REPORTING REQUIREMENTS FOR PROVIDERS OF AIR AMBULANCE SERVICES.—

(1) IN GENERAL.—A provider of air ambulance services shall submit to the Secretary of Health and Human Services and the Secretary of Transportation—

(A) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in subsection (d), the information described in paragraph (2) with respect to such plan year; and

(B) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in subparagraph (A), such information with respect to such immediately succeeding plan year.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), information described in this paragraph, with respect to a provider of air ambulance services, is each of the following:

(A) Cost data, as determined appropriate by the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and sup-

plies associated with furnishing such air ambulance services.

(B) The number and location of all air ambulance bases operated by such provider.

(C) The number and type of aircraft operated by such provider.

(D) The number of air ambulance transports, disaggregated by payor mix, including group health plans, health insurance issuers, and Government payors.

(E) The number of claims of such provider that have been denied payment by a group health plan or health insurance issuer and the reasons for any such denials.

(F) The number of emergency and non-emergency air ambulance transports, disaggregated by air ambulance base and type of aircraft.

(b) REPORTING REQUIREMENTS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Each group health plan and health insurance issuer offering health insurance coverage in the individual or group market shall submit to the Secretary of Health and Human Services—

(A) not later than the date that is 90 days after the last day of the first plan year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in subsection (d), the information described in paragraph (2) with respect to such plan year; and

(B) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in subparagraph (A), such information with respect to such immediately succeeding plan year.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), information described in this paragraph, with respect to a group health plan or a health insurance issuer offering health insurance coverage in the individual or group market, is each of the following:

(A) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(i) Whether such services were furnished on an emergent or nonemergent basis.

(ii) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, or independent program.

(iii) Whether such services were furnished in a rural or urban area.

(iv) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(v) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

(B) Such other information regarding providers of air ambulance services as the Secretary of Health and Human Services may specify.

(c) PUBLICATION OF COMPREHENSIVE REPORT.—

(1) IN GENERAL.—Not later than the date that is one year after the date described in subsection (b)(1)(B), the Secretary of Health and Human Services, in consultation with the Secretary of Transportation (referred to in this section as the ''Secretaries''), shall develop, and make publicly available

(subject to paragraph (3)), a comprehensive report summarizing the information submitted under subsections (a) and (b) and including each of the following:

(A) The percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program.

(B) An assessment of the extent of competition among providers of air ambulance services on the basis of price and services offered, and any changes in such competition over time.

(C) An assessment of the average charges for air ambulance services, amounts paid by group health plans and health insurance issuers offering health insurance coverage in the individual or group market to providers of air ambulance services for furnishing such services, and amounts paid out-of-pocket by consumers, and any changes in such amounts paid over time.

(D) An assessment of the presence of air ambulance bases in, or with the capability to

serve, rural areas, and the relative growth in air ambulance bases in rural and urban areas over time.

(E) Any evidence of gaps in rural access to providers of air ambulance services.

(F) The percentage of providers of air ambulance services that have contracts with group health plans or health insurance issuers offering health insurance coverage in the individual or group market to furnish such services under such plans or coverage, respectively.

(G) An assessment of whether there are instances of unfair, deceptive, or predatory practices by providers of air ambulance services in collecting payments from patients to whom such services are furnished, such as referral of such patients to collections, lawsuits, and liens or wage garnishment actions.

(H) An assessment of whether there are instances of group health plans or health insurance issuers not providing substantial reasons for refusing to enter into contract negotiations with providers of air ambulance services

(I) An assessment of whether there are, within the air ambulance industry, instances of

unreasonable industry concentration, excessive market domination, or other conditions that would allow at least one provider of air ambulance services to unreasonably increase prices or exclude competition in air ambulance services in a given geographic region.

(J) An assessment of the frequency of patient balance billing, patient referrals to collections, lawsuits to collect balance bills, and liens or wage garnishment actions by providers of air ambulance services as part of a collections process across hospital-owned or sponsored programs, municipality-sponsored programs, hospital-independent partnership (hybrid) programs, or independent programs, providers of air ambulance services operated by public agencies (such as a State or county health department), and other independent providers of air ambulance services.

(K) An assessment of the frequency of claims appeals made by providers of air ambulance services to group health plans or health insurance issuers offering health insurance coverage in the individual or group market with re-

spect to air ambulance services furnished to enrollees of such plans or coverage, respectively.

(L) Any other cost, quality, or other data relating to air ambulance services or the air ambulance industry, as determined necessary and appropriate by the Secretaries.

(2) OTHER SOURCES OF INFORMATION.—The Secretaries may incorporate information from independent experts or third-party sources in developing the comprehensive report required under paragraph (1).

(3) PROTECTION OF PROPRIETARY INFORMATION.—The Secretaries may not make publicly available under this subsection any proprietary information.

(d) RULEMAKING.—Not later than the date that is one year after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, shall, through notice and comment rulemaking, specify the form and manner in which reports described in subsections (a) and (b) shall be submitted to such Secretaries, taking into consideration (as applicable and to the extent feasible) any recommendations included in the report submitted by the Advisory Committee on Air Ambulance and Patient Billing under

section 418(e) of the FAA Reauthorization Act of 2018 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

(e) CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—Subject to paragraph (2), a provider of air ambulance services who fails to submit all information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, shall be subject to a civil money penalty of not more than $10,000.

(2) EXCEPTION.—In the case of a provider of air ambulance services that submits only some of the information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, the Secretary of Health and Human Services may waive the civil money penalty imposed under paragraph (1) if such provider demonstrates a good faith effort in working with the Secretary to submit the remaining information required under subsection (a)(2).

(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same

manner as such provisions apply to a penalty or proceeding under such section.

(f) UNFAIR AND DECEPTIVE PRACTICES AND UNFAIR METHODS OF COMPETITION.—The Secretary of Transportation may use any information submitted under subsection (a) in determining whether a provider of air ambulance services has violated section 41712(a) of title 49, United States Code.

(g) UNDERSTANDING AIR AMBULANCE QUALITY AND PATIENT SAFETY.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study and submit to Congress a report on options to establish quality, patient safety, service reliability, and clinical capability standards for each clinical capability level of air ambulances. Such report shall include analysis and recommendations, as appropriate, to Congress regarding each of the following with respect to air ambulance services:

(1) Qualifications of different clinical capability levels and tiering of such levels.

(2) Patient safety and quality standards.

(3) Options for improving service reliability during poor weather, night conditions, or other adverse conditions.

(4) Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

(5) Clinical triage criteria for air ambulances.

(h) DEFINITIONS.—In this section, the terms ''group health plan'', ''health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 11. GAO REPORT ON EFFECTS OF LEGISLATION.

Not later than 24 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report summarizing the effects of the provisions of this Act, including the amendments made by such provisions, on changes during such period in health care provider networks of group health plans and health insurance coverage offered by a health insurance issuer in the group or individual market, in fee schedules and amounts for health care services, and to contracted rates under such plans or coverage. Such report shall—

(1) to the extent practicable, sample a statistically significant group of national health care providers; and

(2) examine—

(A) provider network participation, including nonparticipating providers furnishing items and services at participating facilities;

(B) health care provider group network participation, including specialty, size, and ownership; and

(C) the impact of State surprise billing laws and network adequacy standards on participation of health care providers and facilities in provider networks of group health plans and of health insurance coverage offered by health insurance issuers in the group or individual market.

SEC. 12. TRANSITIONAL RULE ALLOWING DEDUCTION FOR SURPRISE BILLING EXPENSES BELOW AGI FLOOR.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) TRANSITIONAL RULE ALLOWING DEDUCTION FOR SURPRISE BILLING EXPENSES BELOW AGI FLOOR.—

''(1) IN GENERAL.—In addition to the deduction allowed by subsection (a) for any taxable year,

there shall be allowed as a deduction an amount equal to the lesser of—

''(A) the excess of—

''(i) the surprise billing expenses which would be allowed as a deduction for such taxable year under subsection (a) if such subsection were applied without regard to the limitation based on the taxpayer's adjusted gross income, over

''(ii) $600, or

''(B) the applicable percentage of the taxpayer's adjusted gross income.

''(2) SURPRISE BILLING EXPENSES.—For purposes of this subsection, the term 'surprise billing expenses' means expenses paid for medical care of an individual who is a participant, beneficiary, or enrollee in a group health plan or in group or individual health insurance coverage offered by a health insurance issuer (as such terms are defined in section 2791 of the Public Health Service Act), if—

''(A) benefits are provided for such medical care under such plan or coverage, and

''(B) such medical care—

''(i) is furnished by a provider without a contractual relationship with such plan

or coverage with respect to the furnishing of such medical care during a visit at a facility with a contractual relationship with such plan or coverage, or

"(ii) is furnished in an emergency department of a hospital or an independent freestanding emergency department.

"(3) APPLICABLE PERCENTAGE.—For purposes of this section, the term 'applicable percentage' means, with respect to any taxpayer for any taxable year, the percentage in effect under subsection (a) with respect to such taxpayer for such taxable year.

"(4) LIMITATIONS.—Surprise billing expenses shall be taken into account under paragraph (1) only if such expenses are paid during the period beginning on January 1, 2020, and ending on the date which is 1 year after the day before the date specified in section 2(a)(5) of the Consumer Protections Against Surprise Medical Bills Act of 2020.".

(b) CONFORMING AMENDMENTS.—Sections 105(f), 162(l)(3), and 7702B(e)(2) of such Code are each amended by striking "213(a)" and inserting "213".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2019.

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